Medico-legal and Ethical Dilemmas in Critical Care Nursing

Your Presenter:
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Objectives:

• Apply ethical and legal principles to end-of-life decision-making in the ICU.

• Interpret factors which influence patients as they make advanced-care planning decisions.

• Appraise ethical nurse behaviors to assist patients and families as they make advanced care planning and end-of-life decisions.
Introduction:
The NJ State Court Speaks
Introduction:
The US Supreme Court Speaks

Since the Cruzan decision, which upheld the perogative of States to demand "clear and convincing evidence," there has been a great interest in "living wills."
Justice Scalia argued in the Cruzan case that refusing medical treatment, if doing so would cause a patient's death, was equivalent to the right to commit suicide.

He opined that the right to commit suicide was not a due process right protected in the Constitution.

“Preserve life at all costs”

But see:

“Every being of adult years and sound mind has the right to determine what shall be done with his own body…”
(Schloendorff v. Society of New York Hospitals, 1914) NY Court of Appeals
The Four Compelling State’s Interests:

• Preservation of Life
• Prevention of Suicide/Prevention of Euthanasia
• Protection of Vulnerables
• Maintenance of Ethical Integrity of the Professions

Roe vs. Wade

Quill vs. Vacco

Schiavo vs Florida

“It’s a woman’s right to control her own destiny, to be able to make choices without the Big Brother state telling her what she can and cannot do.”
Today, some families still battle at the bedside

• What is the ethical rationale for not doing whatever is technically possible to do in patients near the end of life?

• The patient’s good is a complex notion, which cannot be reduced to its mere biomedical dimension
Patients Rights
(NYCRR § 405.7)

- The right to know who their health care provider is
- The right to confidentiality
- The right to receive information about their treatment
- The right to refuse treatment or care
- The right to be safe from abuse
- The right to participate in their care planning
- The right to access their medical records
The Legal Concerns About Death and Dying

- **Withdrawal of Treatment**
  - Raises issues of assisting a suicide, euthanasia, homicide
  - Competent patients have the right to withdraw treatment
  - Families have the right upon clear and convincing evidence (in absence of proxy or living will)

- **Withholding of Treatment**
  - Carries risk of malpractice (omission)
  - Carries risk of civil ramifications (ADA)
  - IV hydration and nutrition may not be withheld unless specifically stated in living will or wishes known to health care agent

- **Medically Futile Treatment**
  - Carries risk of malpractice (omission, hastened evaluation of brain death)

- **NYS Penal Law §§ 120.30, 125.15 Assisted Suicide and Euthanasia are Crimes**
  - Oregon, Vermont, Washington, Montana have legal assisted suicide
The Ethical Concerns About Death and Dying

Autonomy
Justice
Beneficence
Non-maleficence
Medical Futility
Egalitarian Theory
Utilitarian Theory
Liberarian Theory
Principles of Micro-Allocation in ICU

• Do all critically ill patients merit admission to ICU?

• Should those patients who merit admission be accommodated if there is a scarcity of beds?

• Should the vulnerable section of the community be protected by additional care?

• Should the benefit of ICU care be evaluated on the basis of the patient’s overall value to society?

• Should a patient who is consuming precious resources be cut off from treatment?

• Who should make the allocation rules?
The Situation Room

• Mr. B is an 83 year old widower with asthma and history of hypertension and TIAs. He has been on hemodialysis for 7 years. While having a conversation with his primary care nurse, he indicates that he wants limited life-sustaining therapies if he suffers a stroke.

• However, his only daughter resists this decision and wants everything done for him to maintain his life at all costs.
The Situation Room

• Mr. B. is brought into the ED 3 days later after suffering a CVA at home. Shortly after admission, Mr. B. experiences cardiac and respiratory arrest.

• With no written instructions available, the ED team initiates CPR. Mr. B. recovers and is transferred to the ICU on a respirator.

• Mr. B’s daughter visits and is pleased with the result. Mr. B. grumbles that the ED staff had no right to interfere with his wishes to die.
The Situation Room

• Ms. C. is a 25 year old who was in an auto accident. Ms. C was hospitalized in a coma, with ventilator assistance for 2 months. Following physical and occupational therapy, she eventually fully recovered.

• Following her full recovery, Ms. C. told her parents that if she was ever again in a coma, she would want the doctors to be “very confident” that she would never come out of it before being taken off any machines.

• One year later, Ms. C. was in a bicycle accident and is now in a coma, supported by a ventilator and feeding tube.
The diagnosis of brain death in 5 easy steps

1. The cause of brain failure is irreversible.
2. The patient is unresponsive.
3. Brainstem reflexes are absent.
4. An apnea test shows no breathing.
5. Laboratory tests are not required unless the clinical diagnosis is uncertain.

* No longer a requirement for 2 tests 6 hours apart
Who Makes the Decisions About Advanced / End of Life Treatments?

• A 77-year-old woman with hemolytic anemia, type 1 diabetes and peripheral vascular disease is admitted with a gangrenous ulcer of the plantar aspect of her left foot. A surgical consultation results in a recommendation for a below-the-knee amputation, but the patient declines the procedure on the grounds that she does not believe in transfusions and has lived long enough and wants to die with her body intact. Her internist, who has known her for 25 years, is concerned that she has been increasingly confused over the past year and now appears to be depressed. How should her physician determine whether her decision is a competent one?
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<th>Criterion</th>
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<th>Physician’s Assessment Approach</th>
<th>Questions for Clinical Assessment*</th>
<th>Comments</th>
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<tr>
<td>Communicate a choice</td>
<td>Clearly indicate preferred treatment option</td>
<td>Ask patient to indicate a treatment choice</td>
<td>Have you decided whether to follow your doctor’s [or my] recommendation for treatment? Can you tell me what that decision is? [If no decision] What is making it hard for you to decide?</td>
<td>Frequent reversals of choice because of psychiatric or neurologic conditions may indicate lack of capacity</td>
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<tr>
<td>Understand the relevant information</td>
<td>Grasp the fundamental meaning of information communicated by physician</td>
<td>Encourage patient to paraphrase disclosed information regarding medical condition and treatment</td>
<td>Please tell me in your own words what your doctor [or I] told you about: The problem with your health now The recommended treatment The possible benefits and risks (or discomforts) of the treatment Any alternative treatments and their risks and benefits The risks and benefits of no treatment</td>
<td>Information to be understood includes nature of patient’s condition, nature and purpose of proposed treatment, possible benefits and risks of that treatment, and alternative approaches (including no treatment) and their benefits and risks</td>
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<td>Appreciate the situation and its consequences</td>
<td>Acknowledge medical condition and likely consequences of treatment options</td>
<td>Ask patient to describe views of medical condition, proposed treatment, and likely outcomes</td>
<td>What do you believe is wrong with your health now? Do you believe that you need some kind of treatment? What is treatment likely to do for you? What makes you believe it will have that effect? What do you believe will happen if you are not treated? Why do you think your doctor has [or I have] recommended this treatment?</td>
<td>Courts have recognized that patients who do not acknowledge their illnesses (often referred to as “lack of insight”) cannot make valid decisions about treatment Delusions or pathologic levels of distortion or denial are the most common causes of impairment</td>
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<td>Reason about treatment options</td>
<td>Engage in a rational process of manipulating the relevant information</td>
<td>Ask patient to compare treatment options and consequences and to offer reasons for selection of option</td>
<td>How did you decide to accept or reject the recommended treatment? What makes [chosen option] better than [alternative option]?</td>
<td>This criterion focuses on the process by which a decision is reached, not the outcome of the patient’s choice, since patients have the right to make “unreasonable” choices</td>
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* Questions are adapted from Grisso and Appelbaum. Patients’ responses to these questions need not be verbal.
Who Makes the Decisions About End of Life Treatment?

- Capacity
- Competency
- Patient Autonomy: Self Determination Act
- Informed Consent
- Substituted Judgment
- Best Interests
- Clear and Convincing Evidence

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Mrs. D was a 69 year old woman admitted to the ED with acute MI. The cardiologist was a hospitalist who had never met the family.

The cardiologist asked Mrs. D. if she would want the staff to use a ventilator to help her breath if it became necessary. Mrs. D. said “no” and the MD charted her answer on the patient care record.

Later that evening, Mrs. D’s daughter approached the MD and said that she could tell that her mom wasn’t really alert when asked the question and although she might have shaken her head, anyone could see that she didn’t understand anything.
Who Makes Decisions About End of Life Treatment?

- Surrogate’s Court Procedure Act of NY
- Health Care Proxy
- Family Health Care Decisions Act of NY
- Living Will
- Medical Orders for Life Sustaining Treatments (MOLST)
Most Frequent Ethical Patient Care Issues

- Protecting patient’s rights
- Autonomy and informed consent to treatment
- Staffing patterns that negatively affect work
- Advanced care planning
- Surrogate decision making
Most Stressful Ethical Patient Care Issues

• Staffing patterns that negatively affect work
• Protecting patient’s rights
• Unethical practices of healthcare professionals
• Breaches of confidentiality
• End of life decision-making
Mr. S. is a 79 year old male admitted with acute leukemia. Mr. S. refuses to talk about advanced directives because he believes the experimental drugs he has consented to will cure him. While undergoing the course of treatment, Mr. S. develops a systemic fungal infection and fever. His platelet count continues to drop, requiring multiple transfusions.

Two months later Mr. S. suffers a respiratory arrest. With no directive from the patient, the family decides to place Mr. S. on a respirator. Two days later, frank red blood is noted in the foley and respirator tubing. Mr. S. is repeatedly pulling at the respirator tubing, and the intern restrains Mr. S’s hands. Mr. S. remains in an agitated state for the next three days.

On day five, the intern want to start another round of chemo. Mr. S’s daughter and son want the respirator removed and treatment to cease, indicating that they believe further treatment is futile. Mr. S’s wife wants treatment to continue.

**HOW SHOULD THE NURSE RESOLVE THE CASE?**