PERILS OF INFORMED CONSENT

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Cross-Residency Ethics Program

An Example of Autonomy-Beneficence Conflict

March 2014

- Mr. O, a 52M with EtOH/HCV cirrhosis
- Previously doing well. Followed by outpatient GI. Compensated MELD 12 – 14 in the community. **Not OLT candidate** due to active drinking and portal vein thrombosis.
- Progressed to ESLD and became paracentesis-dependent in July 2013.
- Stepwise deterioration starting September 2013, when he developed tense ascites and spontaneous evisceration.
- Largely bedbound during this index hospitalization
- Discharged home and failed to thrive.

Emory Gastroenterology Consultation Note

1) Cirrhosis 2/2 HCV and EtOH: He has features of decompensation on physical exam with ascites.
-Continue Aldactone 100mg and Lasix 40mg daily. Will get labs today, and increase diuretics as tolerated
-UNOS MELD-15, but not a Emory transplant candidate given PV/SMV thrombosis
-Began discussing end of life issues including DNR/DNI status. Patient will work with PCP/SW to fill out proper documentation as he wishes to be DNR/DNI per our discussion.

Code Documentation signed by [redacted] at 09/13/13 2209

Author:	[redacted]	Service:	(none)	Author Type:	Resident
Filed:	09/13/13 2209	Note Time:	09/13/13 2206	Cosigner:	[redacted]

Spoke to patient about code status. He has previously documented DNR/DNI. He states that he is positive that he does not want intubation. Pt and his wife wanted more time to consider CPR and defibrillation. He stated that for tonight, he does want CPR and shock but he will talk it over with his wife and come up with a long term code status tomorrow.

Patient changed status to **CPR/DNI** upon admisson

- Admitted to Grady MICU from clinic in November 2013
  - Gram-Negative Bacteremia
  - Septic Shock
  - Encephalopathy
  - Severe Malnutrition (temporal wasting, cachexia)
- Long saga of repeated transfers between medicine ward and ICU for ongoing shock, aspiration-mediated respiratory failure, GI hemorrhage etc

SODIUM-SERUM	141 *	
POTASSIUM-SERUM	7.0 *	!!
CHLORIDE-SERUM	118 *	!
CO2 CONTENT-SERUM	12 *	!
ANION GAP	11 *	
GLUCOSE	123 *	
UREA NITROGEN-SERUM	187 *	!!
CREATININE-SERUM	4.9 *	!
GLOMERULAR FILTRAT...	15 *	!
OSMO,CALCULATED	345 *	!
OSMOLALITY,TOTAL		
PROTEIN,TOTAL-SERUM	3.9 *	!
ALBUMIN	1.6 *	!

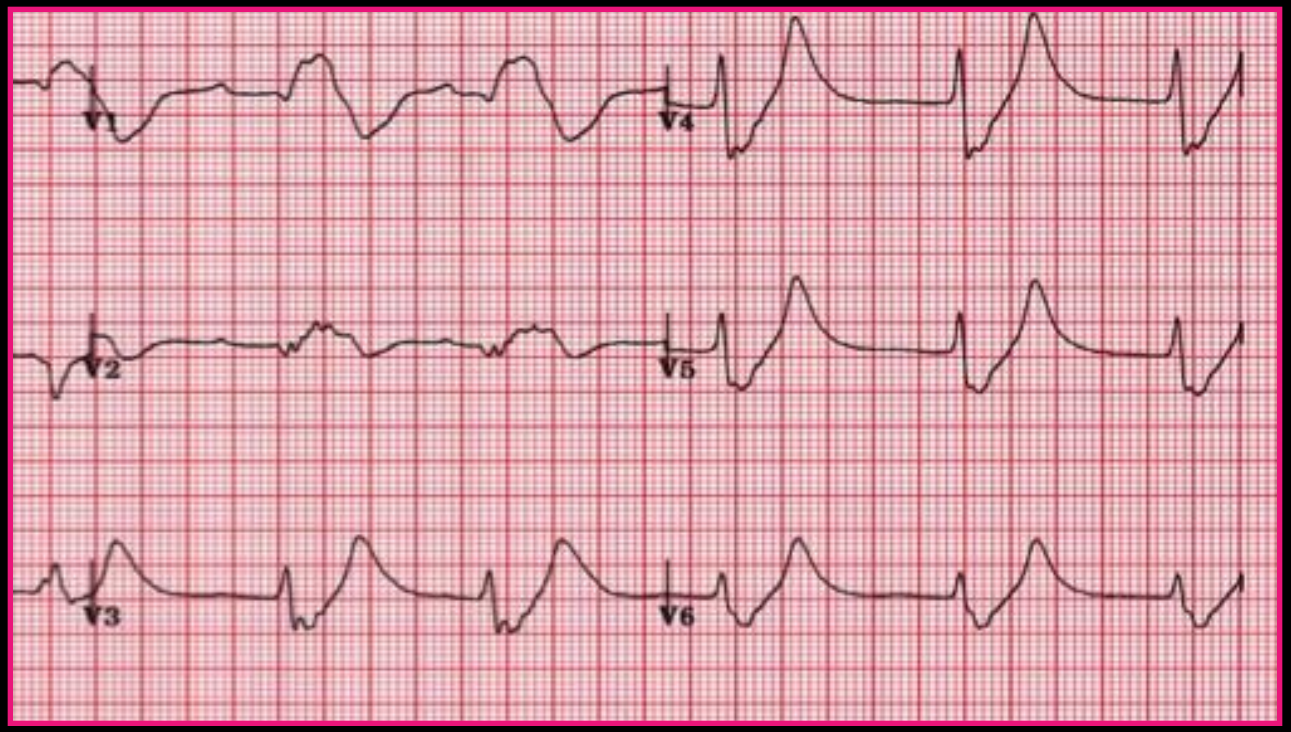
PROTHROMBIN TIME	64.0 *	!!
INR	5.4 *	!!

WBC COUNT-BLOOD	15.4	!
RBC COUNT-BLOOD	1.97	!
HEMOGLOBIN-BLOOD	6.8	!
HEMATOCRIT-BLOOD	19.2	!
RBC MCV	98	!
RBC MCHC	35.5	
RBC RDW	18.6	!
PLATELET COUNT-BLOOD	11	!!

- Patient's clinical status continues to decline, and he remains critically ill by late November
  - Sequential Multiple Organ Failure
  - Oligoanuric
  - Severe Acidosis
  - Persistent Delirium vs Encephalopathy
  - Finally: Uremic Coma

- Medical team continues to provide temporizing care
  - Vasopressors, Abx, IVF
  - TPN
  - NGT and PRT for Lactulose
  - Management of Hyperkalemia

- Family discussion proves to be a minefield of difficulties
  - Large quorum (> 15 people)
  - Mass confusion about clinical status, chance of recovery, transplant candidacy
  - Poor intrafamilial communication
  - NOK (spouse) accosted on all sides, very timid, unable to make decisions
  - Everyone defers patient's first cousin, a general cardiologist who (1) has limited understanding of patient's wishes and (2) is inclined towards aggressive care



Patient develops sinoventricular rhythm .
Emergent HD/RRT is needed to prevent cardiac arrest.

- Intern 1
  - "We need to transfuse him STAT and place a dialysis catheter. This will give the family time to make their decisions".
- Intern 2
  - "We shouldn't even bring up dialysis, because the family will almost certainly want it, and his suffering will be prolonged in an otherwise futile situation".
- Medical Student
  - "We should consult medical ethics".
- Resident
- Attending
  - "Let's have another family meeting".

- Patient's Cousin (Cardiologist)
  - "I think [Mr. O] was encephalopathic at the time he made these code decisions. You should do everything you can to prolong life, until the very end".
- Patient's Wife (NOK and HCPOA)
  - "Do whatever you think is right"
- Patient's Extended Family (Non-Cohabitant)
  - "God isn't ready for him to leave yet, or else he would be gone."

- Nephrology

Progress Notes signed by [redacted] 11/27/13 1802

Author:	[redacted]	Service:	Nephrology-Consult	Author Type:	Resident
Filed:	11/27/13 1802	Note Time:	11/27/13 1755		

Mr Oliver is the 52 y.o. male with Liver cirrhosis (sec to hep C/ ETOH) with worsening renal function who was seen by renal service on 11/14/2013. The patient was noted to be in septic shock with ESLD and had multiple comorbidites. He was not noted to be the candidate for HD and after discussion with the family he was made DNR/ DNI. Nephrology team has signed off. Please call with questions.
This was discussed with Nephrology attending.

- Can we analyze this case using the 4-quadrant framework of Jonson and Siegler?
- Is this case equivalent or analogous to other life-supporting interventions?
  - Intubation/Trach and Mechanical Ventilation
  - Feeding Tubes
  - Cardiac Resuscitation
- What are the specific ethical conflicts in this case?

■ MEDICAL INDICATIONS

The Principles of Beneficence and Nonmaleficence

1. What is the patient's medical problem? history? diagnosis? prognosis?
2. Is the problem acute? chronic? critical? emergent? reversible?
3. What are the goals of treatment?
4. What are the probabilities of success?
5. What are the plans in case of therapeutic failure?
6. In sum, how can this patient be benefited by medical and nursing care, and how can harm be avoided?

■ PATIENT PREFERENCES

The Principle of Respect for Autonomy

1. Is the patient mentally capable and legally competent? Is there evidence of incapacity?
2. If competent, what is the patient stating about preferences for treatment?
3. Has the patient been informed of benefits and risks, understood this information, and given consent?
4. If incapacitated, who is the appropriate surrogate? Is the surrogate using appropriate standards for decision making?
5. Has the patient expressed prior preferences, eg, Advance Directives?
6. Is the patient unwilling or unable to cooperate with medical treatment? If so, why?
7. In sum, is the patient's right to choose being respected to the extent possible in ethics and law?

■ QUALITY OF LIFE

The Principles of Beneficence and Nonmaleficence and Respect for Autonomy

1. What are the prospects, with or without treatment, for a return to normal life?
2. What physical, mental, and social deficits is the patient likely to experience if treatment succeeds?
3. Are there biases that might prejudice the provider's evaluation of the patient's quality of life?
4. Is the patient's present or future condition such that his or her continued life might be judged undesirable?
5. Is there any plan and rationale to forgo treatment?
6. Are there plans for comfort and palliative care?

■ CONTEXTUAL FEATURES

The Principles of Loyalty and Fairness

1. Are there family issues that might influence treatment decisions?
2. Are there provider (physicians and nurses) issues that might influence treatment decisions?
3. Are there financial and economic factors?
4. Are there religious or cultural factors?
5. Are there limits on confidentiality?
6. Are there problems of allocation of resources?
7. How does the law affect treatment decisions?
8. Is clinical research or teaching involved?
9. Is there any conflict of interest on the part of the providers or the institution?

MEDICAL INDICATIONS	PATIENT PREFERENCES
▪End-stage liver failure, terminally decompensated ▪Multiple organ failure ▪Cardiac arrest from hyperK+ is imminent ▪Obtaining HD access would be a high-risk procedure ▪Not a transplant candidate, and far too ill for the procedure even if UNOS listed	▪Comatose ▪No mention of his prior wishes, no advanced directive ▪CPR/DNI
QUALITY OF LIFE	**CONTEXTUAL FEATURES**
▪Patient with severe chronic pain from multiple decubitus ulcers, immobility, peritonitis, and surgical abdominal wound ▪Patient would likely require lifelong HD in the event of survival ▪Dialysis/RRT would awaken patient from uremic state and restore awareness of pain etc	▪Patient and family deeply religious ▪ICU bed shortage/crunch ▪Wife (NOK) likely to be estranged from extended family if she advocates to decelerate care ▪Family medical authority (cousin) highly in favor of HD, even if it results in increased awareness

What do you think about the limits of informed consent in this situation? Do physicians have an ethical responsibility to bring awareness of all possible treatment options to patients and/or surrogates? Even if such options are futile and may produce a negative outcome?

I think physicians do have an ethical responsibility to make all possible treatment options known. But I think it is equally obligatory that we emphasize the futility of those options. I remember the discussion we had [...] that day was specifically in regards to whether physicians had the right to choose how our patients die. And I don't believe [it's] something we get to choose.

Sometimes, it is the case that we are much more informed than our patients [...] about the process of dying - what it involves, how painful or painless it could be. But unless a family or patient asks, I would not comfortable recommending one way or the other. Mostly because at the end of the day [...], each patient is still different, and we can't be 100% sure what will happen.

[...] it is our job as physicians to make the patients and their families aware of all that we have to offer. I think it is right to tell families what we think may happen given our experience, studies, and the data. But ultimately, since there can be no certainty about the future, we cannot withhold information and we cannot make the decision for them.

- Long and structured conversation had between (resident, intern) and **key** family members (spouse, father)
- Decided on care plateau. Would not perform HD and would not escalate or decrease current medical therapies.
- Declined transfer to hospice unit
- Understood that death may be imminent
- Patient expired 6 hours after this discussion