Ethical issues in trauma

Karen J. Brasel, MD, MPH
Professor, Surgery, Bioethics and Humanities
Medical College of Wisconsin
Objectives

- Outline use of informed consent in trauma
- Describe capacity assessment
- Review treatment in suicidal patients
- Describe role of conflict and some steps for resolution
- Review surrogacy
- Define futility and describe use of futility policy
Case

- 82 year-old male h/o arrhythmia with pacemaker, metastatic cancer, recently widowed, depressed
  - Attempts suicide by self-inflicted GSW to chest
  - HR 40, BP 130/80, RR 20, GCS 15

What do you do?
What principles guide your decision?
Ethical principles in play

- Autonomy
  - Patient self-determination

- Beneficence
  - Benefit the patient

- Non-maleficence
  - Do no harm to the patient

- Justice
Physicians may act without obtaining informed consent when all of the following are present:

- Patient lacks decisional capacity and
- No one is legally authorized to act for the patient is available and
- Time is of the essence and
- Serious risk of bodily injury or death and
- A reasonable person would consent
Capacity and competence

- Decisional capacity ≠ competence
  - Decisional capacity:
    - Made by physician (not necessarily psychiatrist)
      - Understanding
      - Task specific
      - Logical
      - Time specific
      - Consistent
  - Competence – judicial determination
    - Ruling on patients global decision-making ability
Assessing Capacity

- Tell me, in your own words, what you decided and why.
- What is the main problem?
  - What is the treatment offered?
  - What are the risks of treatment and non-treatment?
  - What are the benefits of treatment and non-treatment?
  - What have you decided and why?
Suicide and consent

- prima facie evidence of a psychiatric condition with lack of capacity
- act may be symbolic
- attempted suicide may be impulsive and they will later be glad that their life was saved
- if “wrong” there is no second chance

Case

- 82 year-old male h/o arrhythmia with pacemaker, metastatic cancer, recently widowed, with advanced directives including DNR, DNI, no life-sustaining interventions (prior to wife’s death), depressed
  - Exploratory laparotomy, repair of diaphragm, splenectomy, repair stomach
  - Postoperative day #5, still vented, intermittently responsive, OG feeding
  - Children request that advance directive be honored

What do you do?
What principles guide your decision?
Suicide and treatment limitations

- crucial difference in the timing of the act and the constancy of the intention
Case

- 28 year-old veteran
- MCC with devastating head injury, Grade II splenic injury, femur fracture
- GCS 6; trach/PEG recommended

Family
- Sister
- Parents
- Grandmother
Case (con’t)

- Sister active duty
  - Long discussions with brother prior to deployment
  - “Don’t want to live as a vegetable”
  - No formal Advance Directive or HCPOA
  - Does not want trach/PEG, requests extubation

- Parents, grandmother disagree

What do you do?
What principles guide your decision?
Surrogate decision making

- Standards of surrogate decision making
  - Advance directives
    - Preserves autonomy
  - Substituted Judgment
    - Surrogate makes judgment patient would make
  - Best Interest
    - Provider’s assessment of patient’s best interest
Surrogacy hierarchy--Oregon

- Spouse
- Adult designated by others on this list, without objection by anyone on list
- Adult child
- Parent
- Sibling
- Adult relative or adult friend
- Attending physician

http://www.rcjlaw.com/adv.htm
Conflict

- Between ICU team and family: 44%
  - 85% family wishing “team” to be more aggressive
- Within family members: 57%
- Within ICU team: 7%

Common reasons for conflict

- The Patient/Family
  - Lack of accurate information
  - Guilt/Fear/Anger
  - Grief—Time
  - Lack of trust
  - Cultural/Religious conflict
  - Dysfunctional family system
Family perceptions

- in high-intensity hospital service areas report lower quality of
  - Emotional support
  - Shared decision-making
  - Information about what to expect
  - Respectful treatment

Teno et al. JAGS 2005
Family Meeting

- Purpose:
  - Provide opportunity for family
  - Decision-making situation
    - Identify surrogate
  - Forum for informing family of patient’s condition and treatment
    - Consensus of information
    - Answer questions
Other contributing causes

- The healthcare provider
  - Inaccurate information
    - Overly optimistic prognosis
  - Guilt-Anger-Fear
    - Fear of malpractice
    - Fear of ethical impropriety
    - Peer pressure (perceived or real)
    - Fear of mistakes
    - Prognostic Uncertainty
  - Cultural conflict between provider values and patient values
Satisfaction

- Proportional to degree of meeting expectations
  - Quality of communication
  - Quality of interactions
  - Level of empathy
Case

- 58 year-old man in MCC
- Hypotensive, tachycardic, GCS 5
- Pelvic fracture, Grade IV liver injury, Grade III renal injury
- Angioembolization, resuscitation
- Prolonged ICU course
  - Tracheostomy
  - VAP
  - Sepsis secondary to pyelonephritis
Case con’t

- Prolonged ICU course con’t
  - No neurologic improvement day 10
  - Renal failure—in need of dialysis
- Family
  - Ex-wife
  - Estranged children
  - Brother, not involved in care

What do you do?
What principles guide your decision?
Ethical issues

- **Surrogacy**
  - Best interests standard

- **Justice**
  - fair distribution of scarce resources (distributive)
    - Fair = equal treatment
  - competing needs
  - rights and obligations
  - potential conflicts with established legislation
Justice

- ICU care as a scarce resource
  - Bed availability
- Macro-allocation
  - By policy
- Micro-allocation
  - On individual basis, “at bedside”
Futility

“Quantitative or scientific” futility
- No physiologic rationale for success of treatment
- “To ask for repeated resuscitation and for futile employment of the full panoply of medical technology when death is inevitable is an act of pride”

“Qualitative or ethical” futility
- Judgement based on perceived good of patient or potential quality of life
- More controversial, e.g. “Confusing the futility of treatment with the futility of a life itself…”

Pellegrino E. Life and Learning X 2000
Legislated futility policies
- Texas Advance Directive Act of 1999
  - Ethics committee consultation mandatory
  - 10 day waiting period to arrange transfer
  - Extension available at discretion of judge
- California Probate Code 4735-4736
  - Immediately inform patient and arrange transfer
  - Continue cares until transfer or until it appears that a transfer cannot be accomplished

Hospital policies
Hospital Futility Policy

- Froedtert Hospital, Milwaukee, 2002
- Withdrawal or withholding life-sustaining treatment on basis of futility:
  - Futile: “…cannot be expected to restore or maintain vital organ function or to achieve the expressed goals of the patient when decisional.”
  - Includes: “CPR, mechanical ventilation, artificial nutrition and hydration, renal dialysis, blood products, vasopressors, or any other treatment that prolongs dying.”
  - “Appropriate palliative care measures should be instituted.”
Hospital Futility Policy

Additional guidance:
- If patient (or surrogate) disagrees, transfer should be arranged “…if feasible.”
- No waiting period necessary to enact policy.
- “…must inform the office of the Senior Vice President for Medical Affairs.”
- Palliative medicine, social services, chaplaincy, “…strongly encouraged”.
- “..if remaining questions, physician should consult Ethics Committee.”
Our Experience with Futility Policy

- 20 patients (10 years) DNR based on futility
- 6 patients had treatment w/w based on futility
  - Each one proceeded by DNR futility order
  - Median 1 day between DNR-futility and treatment-futility (0-61)
- 14 did not have treatment-futility policy invoked
  - 8 of these (after 2002) still went on to have treatment w/w (i.e. dispute resolved after DNR-futility policy)
Ethics committee

- Required by law
- Multidisciplinary
- Can be called by any concerned party
- Summarize issues, not recommend course of action
Are the goals of therapy understood and agreed upon by the patient and medical team?

Yes

Can the planned interventions reasonably achieve the goals of therapy?

Yes

Does the patient believe that the benefits outweigh the risks associated with the intervention?

Yes

Have all other alternatives been considered?

Yes

Does the intervention violate the ethical standards or professional judgment of the members of the medical team?

No

Does the intervention require the expenditure of scarce resources or could it be harmful to the rest of society?

No

The intervention should be provided.

Yes

The intervention should not be provided, but team members should work to help the patient find alternatives to include the finding of other providers (non-abandonment).

No

Further discussions planned to assure that all parties agree on goals of therapy.

No

Advise patient or surrogate that the intervention cannot be successful and physicians are not obligated to provide such therapy (non-maleficence).

No

Avoid intervention unless or until the patient can be persuaded that the risks are "worth it" (autonomy, beneficence).

No

Other alternatives should be discussed openly (autonomy, disclosure).
Framework for ethical issues

- Identify ethical question
- Stakeholders
  - Broad definition
- Facts
- Norms
  - Legal
  - Clinical
  - Ethical
- Options
Summary

- Informed consent not required—beneficence
- Capacity is situation-specific, any MD can assess
- Treatment of suicidal patients requires context and time
  - Beneficence
  - Non-maleficence
  - Autonomy
Summary con’t

- Conflict may be inevitable—communication key
  - Usually over withdrawal/withholding life-sustaining treatment
  - Time is an ally
- ICU care may be scarce resource
- Futility both quantitative and qualitative