Resuscitation and Life Sustaining Treatments: Developing a New Hospital Policy

William Anderson, MD, FRCPC
Intensive Care Unit, TBRHSC
Assistant Professor, NOSM
Objectives

• Discuss the development of a new hospital “Code policy”.
• Explain the different care options for critically ill patients.
• Ethics of withdrawing and withholding life sustaining treatments.
• Why patients and families want more or less than standard of care.
• Consensus-building and avoiding conflicts.
Current Code Policy

• Patient is either “Full Code” or “DNAR”
• DNAR = Do Not Attempt Resuscitation.

• What does this mean?......
What is DNAR?

• Do Not Attempt *any* Resuscitation?
• Do Not Perform Cardio-Pulmonary Resuscitation (CPR)?
• Do Not Intubate?
• Do Not provide ventilation support?
• Do Not give Medications?

• Do Not Care......?
What is DNAR?

• Unacceptably vague term
  – Usually means “No CPR”
  – Sometimes means “No Life Sustaining Treatments”
  – Sometimes means “Comfort Measures Only”

• Need greater clarity......
What is CPR?

- Cardiopulmonary Resuscitation includes:
  - Basic and Advanced Cardiac Life Support (Code Blue Protocols)
  - Response to patient with apnea or pulselessness, includes:
    - Chest compressions
    - BVM positive pressure ventilation & Intubation
    - Defibrillation
    - Advanced Cardiac Life Support drugs
What is CPR?

- Cardiopulmonary Resuscitation (CPR) is most helpful in:
  - Prevention of sudden unexpected death in a patient with a condition amenable to treatment
- There are patients who will benefit from CPR.....
- But, there are others for whom there will be no benefit and potentially, significant harm.....
A Fate Worse Than Death?

- The possible outcomes of CPR are:
  1. The patient dies (remains dead).
  2. The patient dies after receiving life support in the ICU.
  3. The patient survives with a good outcome.
  4. The patient survives with a bad outcome:
     - “Persistent Vegetative State”
     - “Minimally Conscious State”
     - Severely debilitated and in a LTC facility.
       - Highly dependent on others for their basic care.
What are ALST?

- Advanced Life-Sustaining Treatments (ALST)
  - Specialized treatment
  - Life threatening situations
  - Continuous monitoring
  - Comprehensive & Intensive Care
  ★ Intended to delay or avert imminent death
What are ALST?

- Life-Sustaining Treatments (ALST) include:
  - Non-invasive Ventilation (BiPAP)
  - Endotracheal Intubation with Invasive Ventilation
  - Inotropic / Vasopressor Support
  - Temporary Cardiac Pacing
  - Intra-aortic balloon counterpulsation
  - Hemodialysis
What’s the Difference?

- Aren’t ALST the same as CPR?
- Why would you offer ALST to a patient who is DNAR?
- Doesn’t DNAR mean “No ALST”
- Not necessarily....
What is the Difference?

– Cardiopulmonary Resuscitation (CPR)
  • “Code Blue”
  • Patient has died, attempt to revive.

– Advanced Life-Sustaining Treatments (ALST)
  • Patient is dying, needs life support.
  • Requires ICU admission
Another Fate Worse Than Death?

- The possible outcomes of ALST are similar:
  1. The patient survives with a good outcome.
  2. The patient dies in ICU:
     - Sometimes spontaneously (+/- CPR).
     - Often as a “Withdrawal of Life Support”
     - Sometimes by withholding of ALST or BLST
  3. The patient survives ICU but dies on the ward.
  4. The patient survives hospital but never goes home.
  5. The patient survives ICU, goes home but suffers with an unacceptable quality of life.
Our Responsibility

• To provide patients with the care they want within medically appropriate standards and the outcomes that are acceptable to them.
Why a develop a new Code Policy?

• Current policy is Full Code vs DNAR.
  – Implies a “Do everything vs Do nothing” dichotomy.
  – Doesn’t reflect current clinical practice.
  – Doesn’t facilitate the provision of best clinical care.
  – Doesn’t encompass the patient’s needs or wants.
Code Status Discussions

- Often are Ad-hoc
- Don’t usually happen until a crisis
- Often insufficient time to understand and consider treatment options
- Poor understanding of treatment options
- Sometimes decisions are poorly informed
- Result: needless suffering, inappropriate use of clinical resources.
Key Changes – Eliminate DNAR

- Will no longer use term “DNAR”
- Instead, will use “No Code” vs “DNAR”
- “Levels of Care” will replace old dichotomy of “Full Code” vs “DNAR”
Key Changes – new Terminology

• “ALST” = Advance Life Sustaining Therapies.
  – Includes: Ventilation, Inotropes, Vasopressors, Cardiac Pacing, Aortic Balloon Pump (IABP), Acute Hemodialysis.

• “BLST” = Basic Life Sustaining Therapies.
  – Includes: Hydration, Nutrition, Medications, Surgery, etc.

• “Comfort Care”
  – Includes: measures solely directed at providing for the patient’s comfort and dignity at the end of their life.
Key Changes – Levels of Care

- Level 5: Full Resuscitation
- Level 4: Limited Resuscitation
  - No CPR but Trial of Invasive Ventilation.
- Level 3: No CPR, Trial of Non-invasive Ventilation.
- Level 2: No CPR, No Ventilation.
  - otherwise full medical and surgical care.
- Level 1: Comfort care only.
  - patient is palliative.
New Code Policy

• Levels of Care may seem more complex.
• Actually provide greater clarity.
• Provides a better framework for code status discussions.
• Helps to define and delineate what the patient really wants.
• Clarifies clinical expectations.
• Allows for provision of “the right care, to the right patient, at the right time”.
Ethical Principles

• A decision not to initiate CPR or ALST does not imply the withholding or withdrawing of other treatments or interventions.

• No CPR (DNAR) does not mean “No Care”.
New Code Policy Development

- Two year process thus far.
- First year involved formation of committee comprised of multiple stakeholders.
- Multiple revisions over the next year.
- Ethical and Legal review.
- Plan to implement early in 2013.
- Plan to expand to include SJCG and LTC.
- Plan to expand to entire LHIN.
Case #1

- 68 yo Male with End-Stage COPD
  - $\text{FEV}_{1.0} = 22\%$, $\text{FVC} = 29\%$, Home $\text{O}_2$ @ 3 lpm.
- Presents with worsening dyspnea, cough, increased sputum, very poor AE, wheezes, accessory muscle use, very cachectic.
- Vitals: HR 123, BP 145/76, RR 44, 90% on flush O2, Temp 38.3°C.
- ABG: pH 7.15, PaCO2 97, PaO2 62, HCO3 33.7, 89%
- CXR shows dense RUL infiltrate.
- Dx: Pneumonia with Acute Exacerbation of COPD.
Case #1

- 68 yo Male with End-Stage COPD, Pneumonia and AE-COPD:
  - What does he need?
    - Life Sustaining Therapies
      - Antibiotics and Ventilatory Support
  - Should he receive ALST?
  - Should he receive CPR in the event of a Cardiac Arrest?
Case #1

- How many would?
- Provide NIPPV (BiPAP) and Antibiotics?
- Intubate if necessary?
- Tracheostomy if necessary?
- Offer long-term ventilation (transfer to SJCG)?
- Provide CPR in the event of a cardiac arrest?
- None of the above and offer comfort care only?
Case #1

68 yo Male with End-Stage COPD and Pneumonia:

- Antibiotics given, put on NIPPV (BiPAP) and brought to ICU.
- Initially stabilizes, with RR ↓ to 30s, SpO₂ ↑ to mid 90% range.
- But now increasing somnolence, worsening ABG despite maximal NIPPV, PaCO₂ rising.
- Patient also has elevated Troponin I and Creatinine.
- Family “wants everything done” b/c “Dad’s a fighter”.
Case #1

- 68 yo Male with End-Stage COPD, Pneumonia, Respiratory Failure, Renal Insufficiency and acute MI:
- Now what does he need?
- What is this man’s prognosis?
- What are his likely outcomes?
- Should you escalate care or set limits?
- Remember the family wants “everything”.
Case #1

- 68 yo Male with End-Stage COPD, Pneumonia, Respiratory Failure, Renal Insufficiency and acute MI:

- Now what does he need?

- Cardiopulmonary Support
  - Intubation
  - Ventilatory support
  - Reduce cardiac demand

- Renal Support
  - Aggressive hydration
  - Preserve renal function
Case #1

- 68 yo Male with End-Stage COPD, Pneumonia, Respiratory Failure, Renal Insufficiency and acute MI:

- Now what does he need?

- What is this man’s prognosis?

- Poor
  - 60 - 80% mortality
  - High potential Morbidity
  - Already a “Respiratory cripple”
  - Possible “Cardiac cripple”
  - Possible Chronic Renal Failure with long-term Hemodialysis
  - Possible long-term ventilator dependence
Case #1

- 68 yo Male with End-Stage COPD, Pneumonia, Respiratory Failure, Renal Insufficiency and acute MI:
  - Now what does he need?
  - What is this man’s prognosis?
  - What are his likely outcomes?

- Long term Intubation
- Tracheostomy
- Possibly dying on the ventilator
- Extensive morbidities
- Potentially futile......
  - “Delaying death, not prolonging life”
Case #1

- 68 yo Male with End-Stage COPD, Pneumonia, Respiratory Failure, Renal Insufficiency and acute MI:

- Now what does he need?

- What is this man’s prognosis?

- What are his likely outcomes?

- Should you escalate care or set limits?

- Remember the family wants “everything”.

- What do YOU think?

- Only Non-Invasive Ventilation?

- Intubation?

- Tracheostomy?

- Cardiac Support?

- Vasopressors/Inotropes

- Angiography?

- Balloon Pump?

- Hemodialysis?
Case #1

• 68 yo Male with End-Stage COPD, Pneumonia, Respiratory Failure, Renal Insufficiency and AMI

• Was intubated and quickly trached.

• Weaned off ventilator fairly quickly.

• Went to ward then SJCG.

• Subsequently enjoyed two Christmases at home.

• Returned to ICU several times thereafter with AE-COPD and survived all admissions over the next two years.

• Presented an ongoing ethical dilemma for the ICU Group.
Case #1

- 68 yo Male with End-Stage COPD on home O2, previous MI, multiple ICU and hospital admissions.
- Showed progressive decline with each admission.
  - Inevitable progression of underlying disease.
  - Spent more time in hospital than at home.
- Returned to hospital in respiratory failure.
  - Received usual aggressive Rx, but failed to respond.
  - Ultimately, was denied re-intubation despite his and his family’s request.
- Died in ICU with NIV and appropriate palliative care.
Discussion

• Was it ethical to deny this patient ALST?
• On what ethical/legal basis did the attending physician withhold ALST?
• What is the difference between withholding and withdrawing therapies?
• Why do patients/families demand “EVERYTHING”?
“Do Everything”

• What does this mean?
  – everything within medically appropriate limits?
  – every possible medical/surgical intervention?
  – no consideration for the outcome?
  – life at all costs, no matter how miserable?

• Do patients & families understand what “everything” means?
“Do Everything”

• What if it isn’t appropriate?
• Do patients and families have a right to demand “everything”?
• Do Healthcare Providers have a right to refuse “everything”?
Ethical Principles

• Health care providers have an ethical obligation to provide quality care that is:
  – consistent with the patient’s wishes
  – consistent with medical standards of care

• They have a further obligation to facilitate informed decision making by the patient and/or their substitute decision maker (SDM).
Informed Consent

- The patient or SDM must be informed of:
  - the nature of the proposed treatment
  - the expected benefits of the treatment
  - the risks and side effects of the treatment
  - alternative courses of action
  - the expected outcomes of the disease process or condition
Ethical Principles

- Capable* persons have a right to refuse any and all treatment, including CPR and ALST.
Capability

• A person is capable if:
  – They can understand the information that is relevant to a decision and,
  – appreciate the reasonably foreseeable consequences of their decision.

• If a person is incapable, then the decision regarding CPR and ALST must be made by an appropriate Substitute Decision Maker.
Ethical Principles

• Substitute Decision Makers (SDM) must consider:
  – The Patient’s previously expressed wishes
  – If not known then the Pt’s “best interests”:
    • The patient’s values and beliefs
    • The potential for benefit of CPR or ALST
    • The potential for harm
    • Do the benefits outweigh the risks?
  – What would the patient want for themselves?
Hierarchy of SDMs

1. A legal guardian
2. Attorney for personal care (POA)
3. Representative appointed by the Consent & Capacity Board
4. A Spouse or Partner
5. A Child or Parent or Children’s Aid Society
6. A Parent who has only a Right of Access
7. A Sibling
8. Any other Relative
9. The Public Guardian and Trustee (last resort)
Ethical Principles

• Each member of the healthcare team has a role in identifying a patient’s wishes regarding CPR and ALST.

• The MRP is responsible for providing the Patient/SDM with the potential risks and benefits of CPR or ALST to facilitate an Informed Decision by the patient or SDM.
Ethical Principles

• There is *no ethical or legal obligation* for the Healthcare Team to provide a treatment that will “almost certainly not benefit the patient” or a treatment that is outside the “standard of care”.

• The key terms here are “benefit” and “standard of care”.

“Decision Making for the End of Life” College of Physicians & Surgeons of Ontario
Levels of Benefit

1. Likely to Benefit
   • There is a good chance that CPR or ALST will restore or maintain organ function. High likelihood of discharge from hospital.

2. Benefit is Uncertain
   • Unknown if CPR or ALST will restore or maintain organ function. Prognosis is unknown or uncertain.

   *In these cases one would err on the side of providing CPR or ALST.*
Levels of Benefit

3. Almost Certainly No Benefit

- The underlying illness makes recovery or improvement virtually unprecedented
- The person will be permanently unable to experience any benefit

- If there will be “almost certainly no benefit” then there is no obligation to offer CPR or ALST!
Standard of Care

• “The care provided by a reasonable health care provider who possesses and exercises the skill, knowledge and judgement of the normal prudent practitioner of his or her special group”
Back to Case #1

• Was it ethical to withhold intubation from that patient? Was it legal?
• According to the CPSO and hospital policies, yes to both questions.
• The Healthcare Consent Act states:
  – there is no legal obligation to offer a treatment that will not be beneficial (eg: intubation)
  – but, withdrawal of a treatment requires consent (other treatments were not withdrawn).
Withholding vs Withdrawing

• What’s the difference?
  – Acts of omission vs commission.
  – Often “feel different” to the family or clinicians.
• Is there really a difference?
  – a subject of much debate in the ethical literature.
• Practical consequences:
  – denial of a potentially life-saving therapy.
  – unable to stop a therapy once begun?
  – wasted healthcare resources.
  – denial of resources to those who could benefit.
Withholding vs Withdrawing

• An extreme example is in Israel:
  – Orthodox Jewish faith prohibits withdrawal of life sustaining therapies, once begun.
  – Doesn’t matter how futile the case.

• Solution:
  – Random power outages in Israeli ICUs.
  – No obligation to restart the ventilator
  – If a patient dies, it is the “will of God”
Withholding vs Withdrawing

• We prefer a more reasonable approach:
  - sometimes we don’t know if a therapy will work until we try it.
  - “Trial of ALST”
    • don’t withhold in cases of doubt
  - planned withdrawal of ALST if:
    • the patient is not responding
    • the ultimate outcome would be unacceptable
    • prolonged suffering is unacceptable
  - allows for best patient care.
Avoiding Conflict - Consensus Building

- Sometimes, patients or their SDMs request medically inappropriate treatments.
  - This often causes distress for patients, families and the healthcare providers.
  - Resolving these conflicts is essential for the provision of good patient and family centred care.
  - Also important to minimize distress in the healthcare team.
Avoiding Conflict - Consensus Building

- If possible, an overall plan of treatment should be developed in collaboration with the patient or SDM.
  - Must consider the patients beliefs, values, spiritual and cultural needs.
  - Discussions should focus on outcomes, not specific therapies.
  - Must also consider whether CPR or ALST are indicated treatment options for this patient?
  - Give expert medical guidance as appropriate.
  - Don’t offer therapies that won’t be beneficial.
Resolving Conflicts

1. Interdisciplinary Team Consensus
2. Communication with Patient/SDM
   a. Discuss patient’s prognosis, goals of care and anticipated outcomes of treatment.
   b. Explore the patient’s hopes and wishes for the outcome of CPR or ALST.
   c. Discuss the rationale for not offering CPR or ALST.
   d. Emphasize that not offering CPR or ALST does not negate other therapies.
   e. Offer hospital resources to help with the patient’s psychosocial, cultural, spiritual needs.
   f. Document discussions in patient record.
Resolving Conflicts

3. Negotiation
   a. Attempt to negotiate a plan of treatment that is mutually acceptable.

4. ICU Consultation
   a. Obtain expert opinion regarding therapeutic options and probable outcomes.

5. Second Opinion
   a. Offer the patient/SDM opportunity for additional medical and/or surgical consultation and assist as required.
Resolving Conflicts

6. Patient Transfer
   a. If agreement cannot be reached, patient or SDM should be given opportunity to identify another MD or hospital willing to assume care of the patient.

7. Notice of Intention not to offer CPR and/or ALST.
   a. Patient/SDM should be notified as soon as possible.
   b. If there is still disagreement then legal options must be pursued.
Resolving Conflicts

8. Contact Risk Management Department
   a. Hospital lawyer
   b. Application to Consent & Capacity Board
      a. If it is believed patient is not capable.
   c. Public Guardian and Trustee
      a. If it is believed that SDM is not acting in patient’s best interests.
      b. If there is conflict between equal SDMs.
   d. Application to Court, etc.
Avoiding Conflict - My Approach

• Talk to the patient and their family.
• Explore their hopes, wants, needs, fears and expectations.
• Use clear language.
• Focus on outcomes.
• Give realistic expectations - ‘best and worst case scenarios’.
• Find out what outcome(s) would be acceptable.
Avoiding Conflict - My Approach

• Act as the medical expert - advise and counsel.
• Provide support and comfort to the patient and family.
  – Offer additional spiritual and social support resources.
• Give them time to understand and accept the reality of a bad situation.
• Emphasize the patient’s best interests.
• Don’t offer therapies that clearly won’t be of benefit.
In Summary

• We have developed a new Code Policy at TBRHSC.
  – Key change is Levels of Care
  – Less ambiguity
  – More patient focussed
  – Closely follows current standards of care
  – More clearly delineated process for conflict resolution.
In Summary

• Discussed the different care options for critically ill patients:
  – CPR
  – ALST
  – BLST
  – Comfort Care
In Summary

• Discussed the ethics of withholding and withdrawing life sustaining therapies.
  – acts of omission vs commission
  – may “feel different”
  – functionally sometimes the same
  – withholding may deny the patient possible beneficial treatments
  – not withholding may only delay death
  – wasted hospital resources?
In Summary

• Discussed why patients and families may want more or less than standard care:
  – often the care options are not clear
  – don’t really understand what “everything” can mean
  – physician’s job is to explain care options and set realistic expectations
In Summary

• Discussed ways to build consensus and avoid conflict with patients and families
  – Outlined new policy process
  – Discussed my approach
Thank You!