Critical Care CME Program

Module 6

Module 6 of CSA's Critical Care CME Program appears in this issue of the *Bulletin*; the final two modules will appear in upcoming consecutive issues. To receive CME credit, submit your registration page, answers to the questions, and the evaluation to the CSA office. Your CME certificate will be mailed to you. Alternatively, the full text of each module will be accessible through the CSA Web Site, **www.csahq.org**, in the Online CME Program section. Instructions to complete Module 6 online are given in the Information pages. After completing the assessment, print your CME certificate. Members will need their usernames and passwords to do the modules online.

The following Important Information about Critical Care Module 6 must be read and acknowledged before proceeding to the rest of the module. Check the acknowledgement box on the registration page.

Faculty/Disclosures

All faculty participating in continuing medical education activities sponsored by the CSA are required to disclose any real or apparent conflict(s) of interest related to the content of their presentation(s) or any of the industry sponsors of the meeting. In addition, speakers must disclose when a product is not labeled for the use under discussion or when a product is still investigational.

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Registration/Instructions

Method of Participation: The physician will read and study the materials and complete a quiz and an evaluation of the module. Some modules may have slides available online. To register for and complete this module: Complete the registration page, complete the test questions and the evaluation that can be found after the article, and submit your quiz to the CSA office by mail or fax (650-345-3269). Your CME certificate will be mailed to you.

Estimated Time to Complete the Module: One hour

Please check the acknowledgement box on the registration page that you have read everything in these introductory pages.

Availability

Module 5: Ethical, Legal and Clinical Aspects of End-of-Life Care

Release Date: June 30, 2009
Expiration Date: June 30, 2012

CME Sponsor/Accreditation

The California Society of Anesthesiologists is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

The California Society of Anesthesiologists Educational Programs Division designates this critical care program for a maximum of 8 *AMA PRA Category 1 Credit(s)*™. The program consists of eight modules with 1 credit per module. Physicians should claim credits commensurate with the extent of their participation in the activity.

Fees, Target Audience, Evaluation

The modules are free to CSA members. Nonmembers pay $30 for each module. Each module is worth *one AMA PRA Category 1 Credit*™. This program is intended for all licensed physicians, including residents. An evaluation of each module of this series is offered after the test questions.

Privacy Policy

CSA has a privacy policy that is a general policy for information obtained regarding all online interactive pages, including online CME activities. To review this policy, please go to www.csahq.org/privacy.vp.html.

Objectives

Upon completion of this CME activity, participants will be able to:

- Discuss the legal foundation of end-of-life care in the United States
- Cite important references in the scientific literature concerning clinical conduct during end-of-life care
- Identify unresolved issues pertaining to end-of-life care

Ethical, Legal and Clinical Aspects of End-of-Life Care

By Elizabeth Cordes Behringer, M.D.

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Introduction

Withholding and withdrawal of life support can be defined as the processes by which various medical interventions are not given to or are taken away from patients. The expectation is that the patient will die as a result. These processes can be carried out in a variety of medical settings. However, withholding and/or withdrawal of life support are especially prominent in the ICU where many of these life sustaining therapies are commonly employed.[1]

The ethical aspects of withholding and withdrawal of life support have been succinctly summarized by the Society of Critical Care Medicine's Consensus Report on the Ethics of Foregoing Life-Sustaining Treatments in the Critically Ill.[2] This report states that it is ethically appropriate to withhold or withdraw therapy either because a patient or their surrogate decides to forego treatment, or because a physician judges that the major goals of therapy are not achievable. A decision to withdraw a particular treatment should be held in equal weight to a decision to initiate a particular treatment. Any treatment's medical justification is derived from the benefits that a patient and physician hope to achieve

by using it. When a treatment has either achieved those benefits or can no longer do so, justification for its use is lost and it may be withdrawn.

The SCCM Report notes that there is no intrinsic moral difference between categories of treatment (CPR, Ventilatory Support, Medications such as pressors and antibiotics, as well as the provision of hydration and nutrition by artificial means). Any treatment should be considered from the patient's perspective in terms of the overall benefit it may offer, as well as the burden it entails and the professional duties involved in it. Treatments that only prolong the dying process should not be employed. The indefinite maintenance of a patient in a persistent vegetative state raises ethical concerns for patient dignity and the inappropriate utilization of healthcare resources.

A basic tenet of the SCCM consensus statement is that the wishes of an informed adult patient with decision making abilities should be the primary consideration in almost all decisions regarding treatment. When the patient (or their surrogate in cases where the patient is unable to make decisions) and the physician and other members of the healthcare team agree that therapy should be limited, it generally should be. When the patient or surrogate requests therapy that the physician considers non-beneficial, the physician should clarify the goals of treatment with the patient. The physician may accede to the patient's wishes. However, the physician is not ethically obligated to provide therapy and may attempt to transfer the patient's care.

The SCCM consensus did not discuss the following situations:[2]

a) The patient or their surrogate disagrees with physicians but care cannot be transferred
b) Role of the ethics committee in resolving conflicts
c) The place of healthcare institutions in the development of policies regarding the withholding or withdrawal of non-beneficial care
d) How the physician-patient relationship is affected by the growth of healthcare reform and managed care

U.S. Court Decisions Regarding End-of-Life Care

Physicians' attitudes are influenced by actual or perceived legal requirements in their attitudes regarding the withholding or withdrawal of life support. Some of these attitudes have come from statutes regarding brain death or organ transplantation. The vast majority are based on case law. Courts in the United States have been consistent in their rulings with regard to end-of-life issues. They have underscored the right of patients to refuse treatments, affirmed the concept that human life is more than a biologic process that must

be continued in all circumstances, defined how therapies may or may not benefit patients, argued against a distinction between withholding and withdrawal of life support, established guidelines for limiting life-sustaining treatment and approached the resolution of disagreements among physicians and patients or their surrogates.

The case of Karen Ann Quinlan, in 1976, was the first major judicial decision regarding the withholding and withdrawal of life support.[3] In the Quinlan case, the father of a girl in a persistent vegetative state petitioned the court to be appointed guardian with the power to remove her from mechanical ventilation. The New Jersey Supreme Court reversed the initial decision to deny the petition for surrogacy. That court reasoned that patients would accept or refuse medical treatment on the basis of that treatment's ability to support life over mere biologic existence. The court granted the father's petition, allowing him to exercise "substituted judgment" for his daughter. The court stated that life support could be withdrawn if Karen's physicians and a hospital ethics committee agreed that such support did not alter Ms. Quinlan's underlying medical condition. The Quinlan decision was the first such ruling underscoring the importance of surrogate decision making in the face of critical illness.

Another landmark case involved *Barber v. Superior Court of California* (1983).[4] Two California surgeons performed a surgical closure of a patient's ileostomy. The patient suffered a cardiopulmonary arrest, was revived, but suffered anoxic brain injury and an irreversible coma. Five days later, with consent of the patient's family, the physicians withdrew the patient from mechanical ventilatory support, intravenous fluids and nutrition. The patient died. Although the patient's family did not find fault with the physicians, the local district attorney accused the two physicians of murder. The case of *Barber v. Superior Court of California* was eventually tried at the level of the California Court of Appeals, which ruled that the physicians had not failed to perform their duties because they believed it to be medically non-beneficial to continue treatment. That court did not distinguish between the withdrawal of mechanical ventilation, nutrition or IV fluids because each of these interventions could either benefit or burden the individual. The Court of Appeals finally held that, without evidence of malevolence, family members are the proper surrogate for patients who cannot make decisions, and that prior judicial approval is not necessary if surrogates and physicians decide to limit care. The Barber case underscored the initial findings of the Quinlan case.

To date, the only case involving withholding or withdrawal of life support to reach the U.S. Supreme Court involved *Cruzan v. Director, Missouri Department of Health* (1990).[5] Nancy Cruzan was a woman in a persistent vegetative state who required tube feeding. Her parents did not believe that she would want

to live in such a state. Her parents asked that her tube feedings be withdrawn and were authorized to do so by a trial judge in Missouri. The Missouri Supreme Court reversed this decision, arguing that no one could exercise Ms. Cruzan's right to refuse treatment on her behalf. That court also stated that the state of Missouri had an interest in preserving life, regardless of its quality. Life support could be withdrawn only if clear and convincing evidence of Ms. Cruzan's opinion to reject such treatments were made available.

The United States Supreme Court acknowledged that patients had a constitutional right to refuse any form of life-sustaining treatment. They also concluded that the constitution did not prohibit the state of Missouri, or other states, from requiring evidence of a patient's wishes regarding life support. However, the Supreme Court did not require that other states follow the state of Missouri's mandates. The Supreme Court's decision underscored the desirability of advance directives, living wills and durable powers of attorney for health care in order to facilitate medical decision making, if and when an individual should become critically ill. The Cruzan case was instrumental in the currently ubiquitous use of Advanced Directives, Living Wills and Durable Powers of Attorney for health care.

Clinical Literature

The medical literature has two types of source documents concerning how and why life support is withheld and withdrawn: physician survey data and observational studies.

In 1990, a survey of the 1,970 physician members of the critical care section of the American Thoracic Society was mailed.[6] Ninety-six percent of the 879 respondents, adult intensivists in the U.S., had withdrawn or withheld life-sustaining treatment, and most did so frequently. Eighty-nine percent of physicians had withdrawn mechanical ventilation, 88% had withdrawn vasopressors, and 80% had withdrawn blood or blood products. Thirty-four percent of physicians had refused to withdraw ventilation. Seventy-seven percent of this subgroup had done so believing that the patient still had a reasonable chance of recovery, and 39% did so believing that the patient's surrogate was not acting in the best interest of the patient. Eighty-three percent of physicians had unilaterally *withheld* life sustaining treatment at some time on the basis that it was non-beneficial, often without the patient's or surrogates' knowledge or consent. Eighty-two percent had *withdrawn* treatment on the same basis. Mechanical ventilation and vasopressors were the interventions most commonly withheld or withdrawn under these circumstances.

There was a retrospective review of 2,185 patients admitted to the medical ICU at the University of Florida from March 1984 to June 1988, during which there were 650 deaths.[7] A DNR decision was made under conditions other than brain death in 237 (9%) patients after MICU admission. Death occurred in 96% of DNR patients prior to hospital discharge. Similar findings have been published in subsequent studies in the scientific literature.

Conclusions

The clinical aspects of withholding and withdrawal of life support in the United States have been acknowledged through scientific publications. These studies indicate that limiting care in the critically ill occurs commonly in ICUs. Patients or their surrogate family members usually initiate or agree that care should be limited. However, physicians sometimes limit care without patient or surrogate agreement or knowledge. Withdrawal of life support occurs more commonly than withholding life support. Mechanical ventilation and vasopressors are the forms of life support most commonly withdrawn.

References

1. Luce JM. Withholding and Withdrawal of Life Support: Ethical, Legal, and Clinical Aspects. *New Horizons* 1997; 5:30
2. Task Force on Ethics of the Society of Critical Care Medicine: Consensus report on the ethics of foregoing life-sustaining treatments in the critically ill. *Crit Care Med* 1990;18:1435
3. In RE: Quinlan, 70 NJ 10 (1970)
4. *Barber v. Superior Court*, Cab Rptr , 147 Col. App. 3d 1054 (1983)
5. *Cruzan v. Director*, Missouri Department of Health, 497 U.S. 261 (1990)
6. Asch DA, Hansen-Flaschen J, Lanken PN. Decisions to limit or continue life-sustaining treatment by critical care physicians in the United States: Conflicts between physicians practice and patients' wishes. *Am J Respir Crit Care Med* 1995: 151:288
7. Koch KA, Rodeffer HD, Wears RL. Changing patterns of terminal care management in an intensive care unit. *Crit Care Med* 1994; 22: 233

Questions

1. The Society of Critical Care Medicine Consensus Report on the Ethics of Foregoing Life-Sustaining Treatments in the Critically Ill published in 1990 does not elucidate which of the following issues:
    a. The patient or their surrogate disagrees with physicians but care cannot be transferred
    b. The role of the ethics committee in resolving conflicts
    c. The place of healthcare institutions in the development of policies regarding the withholding or withdrawal of non-beneficial care
    d. All of the above

2. The case of Karen Ann Quinlan in the state of New Jersey was the first U.S. court case to underscore the validity of which of the following:
    a. Advanced Directives
    b. Durable Powers of Attorney for Health Care
    c. Family Members as patient surrogates
    d. Do Not Resuscitate Orders

3. To date, the only case to have a ruling from the United States Supreme Court is:
    a. *Barber v. Superior Court of California* (1983)
    b. *Cruzan v. Director, Missouri Department of Health* (1990)
    c. *Quinlan* 70 NJ 10 (1970)
    d. None of the above

4. The SCCM Task Force Consensus Statement notes that there is no intrinsic moral difference in withholding or withdrawal of all of the following categories of treatment ***except:***
    a. Narcotics
    b. Mechanical Ventilatory Support
    c. Pressors
    d. CPR

5. The U.S. Supreme Court's ruling in the *Cruzan* case underscored the desirability of which of the following:
    a. Do Not Resuscitate Orders
    b. Durable Powers of Attorney for Health Care Decisions
    c. Family Members as Surrogates
    d. Institutional Ethics Committees

6. A decision to withdraw a particular treatment should be held in equal weight to a decision to withhold a particular treatment.
    a. True
    b. False

7. According to a 1990 Survey of the Critical Care Section of the American Thoracic Society, what percentage of responding critical care physicians had unilaterally withheld life sustaining treatment on the basis that it was non-beneficial?
   a. 33%
   b. 51%
   c. 83%
   d. 99%

8. Which of the following statements describes the clinical practice of End-of-Life Care in the United States?
   a. Withdrawal of Life Sustaining therapies occurs more frequently than Withholding of Life Sustaining Therapies
   b. Withholding of Life Sustaining Therapies occurs more frequently than Withdrawal of Life Sustaining Therapies
   c. Withholding and Withdrawal of Life Sustaining Therapies occurs with equal frequency.
   d. None of the above

9. Which modality of Life Support is most commonly withdrawn in ICUs in the United States?
   a. Blood Products
   b. Mechanical Ventilatory Support
   c. Hydration
   d. Antibiotics

Evaluation of Module 6

As part of the CSA Educational Programs Division's ongoing efforts to offer continuing medical education, the following evaluation of this program is requested. This is a useful tool for the EPD in preparing future CME programs.

1. How well were the learning objectives of this program met?

Very Well	5	Above Average	4
Average	3	Below Average	2
Not Well at All	1		

2. How relevant was the information in this program to your clinical practice?

Very Relevant	5	Above Average	4
Average	3	Below Average	2
Not Relevant	1		

3. How would you rate this program overall?

Excellent	5	Above Average	4
Average	3	Below Average	2
Poor	1		

4. Did you detect any commercial bias in this module? Yes No

Registration

Complete this form, the test, and the evaluation, and **mail or fax** all three to the CSA office at 951 Mariner's Island Boulevard #270, San Mateo, CA 94404 or FAX to 650-345-3269. The CSA CME journal courses are also available on the CSA Web Site at www.csahq.org.

Critical Care CME Course, Module 6
Available June 30, 2009, to June 30, 2012

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❑ **I acknowledge that I have read the Important Information about Module 6.**

Critical Care CME Program

In this issue of the *Bulletin*, Module 6 of the Critical Care CME Program is available. There will be eight modules for this program. After each module is published in the *CSA Bulletin* (one per season), it is posted on the CSA Web Site at www.csahq.org. Each online module uses a self-assessment and evaluation; once these are completed, you may print your CME certificate. You may also contact the CSA office at 800-345-3691 to obtain the materials by fax or mail.