Ethical Issues and Palliative Care in the Cardiovascular Intensive Care Unit

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KEYWORDS

• Medical ethics • Bioethics • Palliative care • Advanced heart failure • Medical technology • End of life

KEY POINTS

- Palliative care has been shown to improve outcomes for patients in the intensive care unit (ICU), particularly in improving symptom control and satisfaction with care plans.
- Patients who are hospitalized in the ICU should have a care conference to define the goals of care within 5 days of admission, and have such meetings every 7 days during their stay in the ICU, not to discuss "withdrawal of support" but rather to focus on the complexity of multidisciplinary care.
- It is morally and ethically permissible to withhold a treatment or withdraw a treatment once started if it is not consistent with a patient's goals of care, and granting such requests is not akin to euthanasia. Such treatment includes cardiac devices such as pacemakers, defibrillators, ventricular assist devices, and total artificial hearts.
- Advance care planning can be helpful in avoiding ethical dilemmas, particularly related to issues of surrogate decision making and goals of care, when patients are critically ill and possibly approaching the end of life. Ongoing discussion and reassessment of goals is critical to patient-centered outcomes.
- There is a distinct difference between hospice and palliative care in that palliative care can be provided at any point in the continuum of illness and is not synonymous with dying or "giving up."

INTRODUCTION

Millions of Americans suffer from life-limiting, life-threatening illnesses caused by a vast array of cardiovascular maladies.[1] Although a large portion of this population suffers from advanced heart failure often related to ischemic heart disease, other congenital, electrophysiologic, and structural cardiac issues contribute to significant morbidity and mortality. Over the past few decades, there has been a relative explosion of pharmacologic and therapeutic interventions that have dramatically altered the course of many of these complicated cardiac ailments. Beyond medications, technology has advanced, providing an unfathomable array of devices that can improve symptom burden and survival for patients who previously had fatal cardiac diseases.

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The growth of treatment options and the associated *technological imperative* to use these treatments has essentially defined the average daily census in the modern cardiovascular intensive care unit (CICU).[2,3] The care of patients in the CICU has evolved since the days of almost certain death from cardiac illness owing to lack of effective therapies, or several weeks of close "observation" following a major acute coronary syndrome that was the norm decades earlier.

Today's CICU is a fast-paced, increasingly complex milieu where clinicians, patients, and their loved ones attempt to make the best decisions possible from a vast array of pharmacologic, surgical, and interventional therapies, each with a unique set of risks and benefits. Patients are faced with numerous decision points in situations where health is unstable and emotions and stakes are high, which can lead to a host of ethical conundrums. All of this occurs against a background of uncertainty, particularly regarding our ability to accurately prognosticate in these complex situations with therapies that are ever evolving.

Despite major successes regarding survival and length of stay of patients in the CICU, this remains an area where ethical challenges are frequently encountered and where palliative care opportunities remain plentiful. This article presents an overview of some of the ethical and palliative care issues encountered in the CICU, with recommendations for initial approaches to these issues and consideration of when specialist involvement by an ethics or palliative medicine consultation may be warranted.

ETHICAL ISSUES IN THE CICU

As discussed in the introduction, there are countless treatments available in the setting of advanced cardiac illnesses. Indeed, the topics covered throughout in this issue of *Cardiology Clinics* discuss many of these technological triumphs. In its most basic sense, medical ethics strives to go beyond the question of what we *can* do in a clinical situation, and rather seeks solutions to the questions of what we *should* do. As there may be varying competing ideals about what the goals of medicine are and how those can be best achieved, there may be inherent tension created out of a desire to satisfy those competing ideals.

Beauchamp and Childress[4] are credited with a widely used approach to ethical issues known as principlism or the 4-principle approach, whereby each of the benefits in a situation is evaluated. Their approach focuses on consideration of beneficence (our desire to do good for the patients), nonmaleficence (our desire to avoid harming patients), respect for the patient's autonomy, and an evaluation of issues of justice in how care is provided. As one can imagine, care in the CICU often pits many of these ideals against one another.

Consider the following case vignette. An 81-year-old man is admitted to the CICU with high-grade heart block and is being considered for implantation of a permanent implantable pacemaker. Telemetry confirms the finding and the patient's heart rate can only be sufficiently augmented by use of transvenous pacing, suggesting the need for an implantable device. The patient's history is notable for advanced dementia whereby he lives in a care facility and can speak only a few words, only intermittently recognizes his 2 daughters, and does not participate in activities of daily living. Both daughters are the patient's duly appointed surrogate decision makers by an advance directive if the patient lacks capacity. What should the next step be?

This situation, or a similar one, may be very familiar to the reader. Several aspects of the case could be in conflict and need to be considered before a course of action can be decided upon. Determining what is "best" for the patient, what may help or harm the patient, and what quality of life exists for this patient are questions that consider beneficence and nonmaleficence. In considering autonomy, one may ask questions regarding whether the patient has the capacity to make a decision, who the surrogate decision maker should be if the patient lacks decision-making capacity, and how to approach situations whereby surrogates are in conflict with each other.

Justice, however, involve a more global and society-wide approach to ethical issues. Questioning whether placement of the pacemaker is fair and equitable in this situation does not affect whether it is fair and equitable for *this* patient to receive a device. Rather, such questions should be posed at a societal level to determine if certain criteria should be in place that guide whether the pacemaker is fair and equitable across the medical landscape. This point is important to consider because justice issues are often invoked at the bedside, although clinicians should not consider these resource utilization issues in the context of an isolated patient encounter.

This case vignette represents one example of the clinical challenges encountered in the CICU. While the issues presented do illustrate complexity in medical decision making and the role of technology in patient care, this case may fall on the side of

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