Palliative Care, Ethics, and the Law in the Intensive Care Unit

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KEYWORDS

• Palliative care • Law • Ethics • Intensive care

KEY POINTS

- Legal, ethical, and palliative issues frequently arise in the care of critically ill patients who may be facing death.
- Withholding and withdrawing life-sustaining therapies, surrogate decision making, and medical futility are frequent scenarios that critical care practitioners encounter.
- Effective communication is a key to avoiding conflict in these domains, and nurses play a key role in such communication.

INTRODUCTION

Approximately 20% of Americans die during or soon after admission to an intensive care unit (ICU).[1] Even for patients who survive, admission to an ICU often involves complex ethical decision making and management of pain and suffering, alongside extremely complex medical management. ICUs have existed in the United States since the 1950s, and over the course of the last half-century have been the setting for many ethical and legal debates in medicine. This article outlines 3 important domains that lie at the intersection of critical care, palliative care, ethics, and the law:

1. Withholding and withdrawing potentially life-sustaining therapies
2. Making decisions for critically ill patients who lack decision-making capacity
3. Approaching cases of perceived futility when patients and/or families still want "everything" done medically

Each domain is centered on an actual clinical scenario, which reviews important principles and precedents that underlie our understanding of how nurses and doctors should approach critically ill patients in the ICU who are likely to be near the end of life.

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CASE 1. WITHHOLDING AND WITHDRAWING POTENTIALLY LIFE-SUSTAINING THERAPIES

Case Presentation

A 70-year-old man with advanced chronic obstructive pulmonary disease (COPD) who has been in the hospital receiving systemic steroids, antibiotics, inhaled bronchodilators, diuretics, and supplemental oxygen over the past week for an acute exacerbation without improvement. His oxygen saturation runs between 80% and 90%, and his P_{CO_2} is in the 80s. He rates his dyspnea as averaging 7 on a 10-point scale (0 = none and 10 = extremely severe), and he is on low-dose hydromorphone to lessen his sensation of shortness of breath. He has been "full code" (full cardiopulmonary resuscitation including mechanical ventilation), but his providers fear that if he went onto a ventilator he would never get off.

In brainstorming about alternatives to long-term ventilation if he deteriorates in the near future, the treating medical team identified the following possibilities:

- *Time-limited trial of intubation and mechanical ventilation*.[2] This approach is a possibility for patients with a potentially reversible process such as an acute infection who do not want long-term invasive support or tracheostomy. If they do not respond within an agreed-upon time frame, the expectation set in advance would be that the invasive, potentially life-prolonging therapy would be stopped and the patient would die.
- *Trial of "noninvasive ventilation"* (continuous positive airway pressure or bilevel positive airway pressure [BiPAP]). This option is short of intubation and mechanical ventilation for patients who are "do-not-intubate," but may have a potentially reversible component to their illness or want to stay alive a little longer for a particular event (eg, the arrival of a loved one to "say goodbye" before death).
- *Continue current treatments without escalation of disease-directed therapy if the patient deteriorates*. This option gives the patient more time to respond to current interventions, with simultaneous efforts to palliate uncomfortable symptoms. If the patient improves, treatments are continued and adjusted accordingly. If the patient deteriorates, he or she would transition to the next option:
- *Shift goals to "comfort measures only."*[3] This approach might include continuing current noninvasive medical treatments directed at the patient's COPD because treatments that help his breathing will also be "comfort oriented." It could also include stopping laboratory panels including blood gas monitoring, and initiating more aggressive use of opioids and benzodiazepines to manage his shortness of breath, particularly if it worsens in the near future.

If the patient was already receiving mechanical ventilation and cannot be safely extubated, his additional options would include:

- *Long-term mechanical ventilation and tracheostomy*. The patient would likely have to remain in an acute medical facility until death. There are relatively few nursing facilities or home situations that can manage such patients, who are usually medically fragile and in need of constant monitoring and technical support.
- *"Sink or swim" extubation*.[4] Patients already receiving mechanical ventilation who do not want long-term ventilator support but have a small chance of living for a substantial period of time (usually weeks to months) off the ventilator might choose this option. Here the patient is made as medically stable as possible, and the endotracheal tube and ventilator are then removed with plans to not reintroduce them. In general, opioids and sedatives are minimized during