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Ethics in Emergency Medicine

SHOULD EMERGENCY DEPARTMENT PATIENTS WITH END-OF-LIFE DIRECTIVES BE ADMITTED TO THE ICU?

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□ Abstract—Background: Whether emergency physicians should utilize critical care resources for patients with advance care planning directives is a complex question. Because the cost of intensive care unit (ICU)-level care, in terms of human suffering and financial burden, can be considerable, ICU-level care ought to be provided only to those patients who would consent and who would benefit from it. **Objectives:** In this article, we discuss the interplay between clinical indications, patient preferences, and advance care directives, and make recommendations about what the emergency physician must consider when deciding whether a patient with an advance care planning document should be admitted to the ICU. **Discussion:** Although some patients may wish to avoid certain aggressive or invasive measures available in an ICU, there may be a tendency, reinforced by recent Society of Critical Care Medicine guidelines, to presume that such patients will not benefit as much as other patients from the specialized care of the ICU. The ICU still may be the most appropriate setting for hospitalization to access care outside of the limitations set forward in those end-of-life care directives. On the other hand, ICU beds are a scarce and expensive resource that may offer aggressive treatments that can inflict suffering onto patients unlikely to benefit from them. **Goals-of-care discussions are critical to align patient end-of-life care preferences with hospital resources, and therefore, the appropriateness of ICU disposition. Conclusions:** End-of-life care directives should not automatically exclude patients from the ICU. Rather,

ICU admission should be based upon the alignment of uniquely beneficial treatment offered by the ICU and patients' values and stated goals of care. © 2018 Elsevier Inc. All rights reserved.

□ Keywords—ethics; end-of-life decision-making; critical care resources; emergency medicine; palliative care; Physician Orders for Life-Sustaining Treatment (POLST); advance care planning

CASE REPORTS

Case 1

A 75-year-old woman with a history of severe chronic obstructive pulmonary disease presents to a community emergency department (ED) with fever, respiratory distress, and altered mental status. She is found to have pneumonia, and after antibiotics, glucocorticoids, beta agonists, and a period of time on noninvasive positive-pressure ventilation (NIPPV), begins to improve. However, she is still requiring venturi mask at 40% O₂ to maintain saturations of 93%, and has an elevated respiratory rate. The patient, formerly a nurse in the hospital, is too altered to participate in decision-making and no surrogates are available, but her electronic record contains a

Physician Orders for Life-Sustaining Treatment (POLST) form used in the state, with cardiopulmonary resuscitation (CPR) in case of cardiac arrest the only intervention she prefers not to have. The emergency physician (EP) believes that her chances of meaningful recovery are good, though she is likely to need the close attention of the intensive care unit (ICU) and may need intubation in the short term. The EP calls the hospitalist who covers the ICU overnight for admission. The hospitalist is reluctant to admit the patient to the last-remaining ICU bed, mentioning that according to the Society of Critical Care Medicine guidelines, the patient has a “low priority” for ICU admission because her care-limiting document precludes CPR.

Case 2

An 80-year-old man with severe heart failure is brought by ambulance to a rural ED in acute respiratory distress. He has rales in all lung fields and produces frothy pink sputum and is mildly altered. The EP starts a nitroglycerin drip, loop diuretics, and places the patient on NIPPV. An hour later the patient remains altered but his work of breathing is improved. He is oriented but does not appear to have capacity to make health care decisions. The EP is unable to reach the health care proxy listed, and looks through the electronic medical record trying to find information about advanced directives or surrogates and finds a “Comfort One EMS CPR Directive” that indicates a do-not-resuscitate (DNR) preference as well as an advance directive that indicates “If my death is imminent, I choose not to prolong my life. If life-sustaining treatment has been started, stop it; but keep me comfortable and control my pain.” The EP decides to trial the patient off of NIPPV and the patient becomes more dyspneic and looks uncomfortable. The EP then contacts the intensivist at the referral hospital where all patients requiring ICU care including positive pressure ventilation are admitted from this ED. The intensivist is reluctant to admit the patient to her ICU because she is not sure that ICU-level care is consistent with the patient’s goals of care.

INTRODUCTION

Whether EPs should utilize critical care resources in the population of patients with advance care planning documents is a complex question. On the surface, the cost of aggressive and invasive ICU-level care in human suffering and financial burden can be dramatic, and this level of care ought to be provided only to those patients who would consent and who would sufficiently benefit from it. Limiting critical care resources to only this population can prove difficult. Not enough patients have end-of-life (EOL) care discussions with their providers, and

EOL care preferences are often not elicited from patients, even in populations of patients with critical or terminal illnesses (1). When EOL care discussions do occur between patients and providers, they often inadequately address patients’ preferences and lack any focus on goals of care. These discussions sometimes lead to discordance between patient preferences communicated to their providers and those that are documented on their advance care planning documents (2,3). These deficiencies are somewhat understandable given the prevalence of inadequate training among residents and fellows to conduct EOL care discussions, which inevitably limits their practice once they become attendings (4,5).

Weaknesses inherent in EOL care documents further complicate attempts to bring aggressiveness of care in line with patient preferences. Patients with EOL care documents often have advance directive (AD) documents or portable DNR orders. ADs include living wills and durable medical power-of-attorney documents, which were designed to improve communication of EOL care preferences. Many years of effort to promote their use, however, have resulted in a limited prevalence of AD completion. In a study conducted in 2010 designed to be representative of the U.S. population, just 26% of respondents had an AD (6). Much higher rates of AD completion, up to 70%, are reported in patients with advanced illness and in deceased residents of nursing homes (7,8). Although ADs have become much more popular in recent years, a large number of patients’ EOL care preferences remain undocumented.

Furthermore, when EOL care documents do not contain specific guidance for specific clinical scenarios, clinicians sometimes more broadly interpret those documents to make decisions about how aggressive to be with the care provided. Garrouste-Orgeas et al. found low agreement among physicians regarding whether elderly patients in hypothetical clinical scenarios should be admitted to the ICU (9). Although no physicians opposed patient preferences regarding life-sustaining treatment, when availability of an additional bed was assumed, physicians who had refused to admit for noninvasive ventilation and mechanical ventilation changed their mind in 38.6% and 13.6%, respectively (9). In fact, physicians may use “implicit rationing” without conscious awareness, basing triage decisions on their own biases and perceptions of a prospective patient’s age, survivability to hospital discharge, and quality of life, rather than following data-driven protocols or ICU triage guidelines (10). This observation is troubling, particularly because Frick et al. concluded that future quality of life cannot reliably be predicted by either doctors or nurses (11).

Previous studies suggest that patients with EOL care documents are treated differently, even when the care involved is not specifically addressed by their EOL care

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