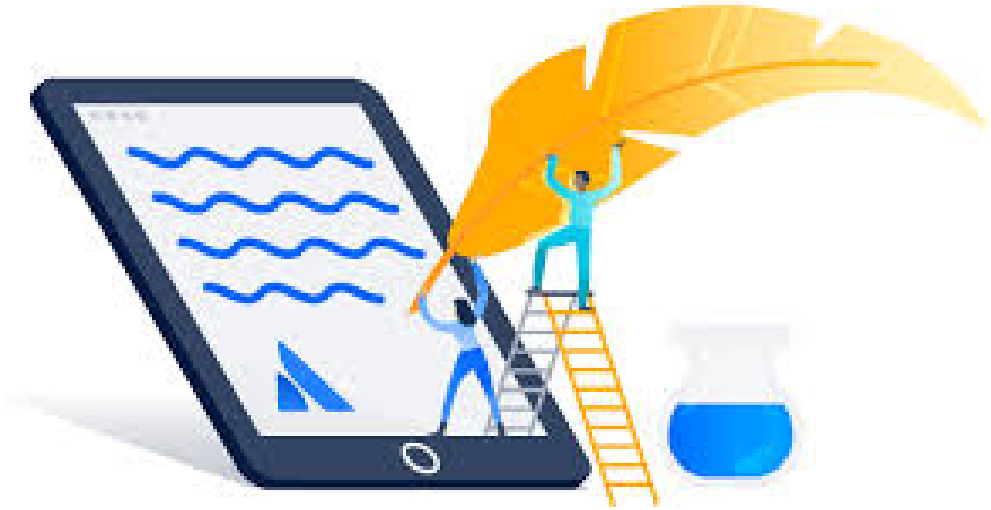
Documenting a Bioethics Consultation in the Medical Record



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Disclosures

- Financial conflict of interest: none
- Board Certifications:
  - Internal Medicine
  - Rheumatology
  - Hospice and Palliative Medicine
- Current position: Director, Clinical Ethics, Banner Health
- Faculty: U of A COM-P, Case Western Reserve, Mayo Clinic, Cleveland Clinic, Clarkson University
- Prior lives
  - Palliative Medicine, Banner Baywood, Mesa AZ
  - Cleveland Clinic Florida: Founding Director Clinical Ethics, Palliative Medicine Staff
  - Cleveland Clinic Ohio: Fellowship in Advanced Bioethics 2 years
  - Rheumatology, northern Colorado ~17 years
  - Medical Director, Hospice of Northern Colorado ~5 years
  - Ethics committees ~30+ years

Disclaimers

- Many ways to document ethics consultations
- This is ONE way
- Refined over the years; now over 1000 ethics consultations
- Can be adapted to a committee note
- You are welcome to use my template

Acknowledgments: Dr Bob Orr, Dr Wayne Shelton, Cleveland Clinic Ethics Dept

Objectives

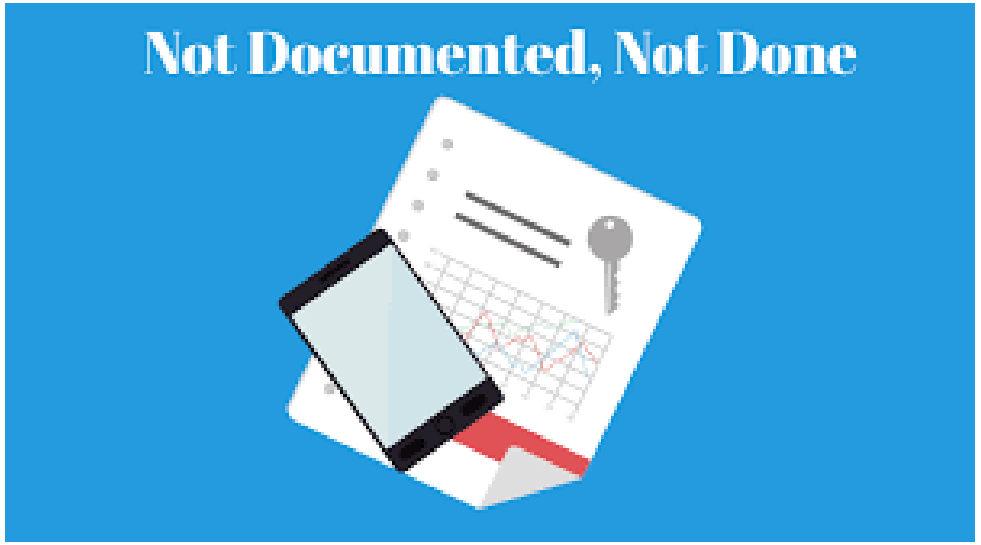
- Recognize the utility of bioethics consultation notes in the chart
- Identify crucial elements of a useful note
- Demonstrate documentation using a targeted template

Remember:

- You are giving recommendations
- Actual ethics directives are uncommon
- Be careful with your language

Why Document Ethics Consultations?

- We document everything in medicine
- Clarify recommendations
- Not binding but usually followed
- Explains the “why”
- Transparency
- Accuracy
- Part of the medical plan



Type of Notes

- Individual consultant note
- Committee deliberations
- Small group note
- Placeholder note

Crucial Elements

- Ethics Question
- Background - include medical situation
- Advance Directives
- Relevant Policies/Procedures/Statutes/References
- Ethical Discussion
- Recommendations

Ethics Issue/Question

- Most consults: *Please help – this is a mess!*
- So, what if there isn't a question?
  - Is it actually: CM/SW, risk, admin, palliative medicine?
  - It can be very difficult to figure out the question – it might come last!
  - Try to formulate a single question to answer – your job as a consultant

- If your consultation does not answer an ethics question and/or offer recommendations – it isn't of much practical help to the team

Ethics Issue/Question - Examples

- Team asks:
  - Must we perform CPR in the event of cardiac arrest in a patient with a Full Code status who cannot be oxygenated?
  - Must we perform CPR in a patient with a Full Code status when we don't think CPR is a good idea?

- Ethics was asked to render an opinion regarding a treatment direction for this patient without capacity whose diagnosis is unclear and for whom diagnostics recommended by the team are refused by the patient's surrogate.

- Ethics was asked by the medical teams to opine whether palliative surgery to prevent expected future obstruction from a newly discovered colon cancer is ethically supportable in a patient with a neurologically grim prognosis.

Ethics Issue/Question - Examples

- Team asks: Can we force a patient without capacity to start lifelong dialysis and live in a SNF without knowing her wishes?

- Ethics was asked to render an opinion regarding whether/how to honor this terminally ill patient's request to discontinue medical treatment and die (without him personally telling his daughters he wishes to do so) or to accede to his daughters' requests for continued aggressive treatment.

- The ethics committee was asked to render an opinion regarding a family's decision to pursue end of life care in a patient with a treatable condition.

Background: Paint a picture

- Relevant (brief) medical information
  - Current major medical conditions
  - Location in hospital (ICU, ED, MedSurg, peds)
  - Other conditions affecting current situation (ex: underlying dementia)
- Relevant social information
- Capacity: yes, no, unclear, waxes and wanes….
- Goals of care: everybody
- Conflicts: Who? Over what?
- Discussions/Meetings: Use quotations – including “#$^%@”, rather than your own summary/interpretations

Background: Example #1

- 84 y/o woman intubated in the ICU for bilateral pneumonia, now in renal failure on dialysis and with underlying metastatic cancer on an experimental therapy, response to that therapy unclear
- Was doing ok living alone, widowed, 2 daughters nearby
- Capacity: none at present
- Goals of care: unclear at present
- Conflicts: one daughter wants to continue aggressive therapy, the other wants comfort care
- Meetings/Discussions: (Enter details….)

Background: Example #2

- 78 y/o man with no prior medical history admitted to med-surg with gangrenous toes
- Lives with a roommate, no living family, self-described “hermit”
- Capacity: full per treating team
- Goals of care: return home, be “left alone”, not have surgery
- Conflicts: vascular team opines patient needs an amputation and is at high risk for sepsis/death if not done. Patient refuses amputation.
- Meetings/Discussions: “No damn way are they cutting off my foot.”

Crucial Elements

- Ethics Question
- Background - include medical situation
- Advance Directives
- Relevant Policies/Procedures/Statutes/References
- Ethical Discussion
- Recommendations

Advance Directives

- MPOA
- LW
- MOLST/POLST
- Current Code Status
- Others

- Discussion

Advance Directives: Example #1

- MPOA: none on chart; per AZ statute daughters are surrogate decision makers
- LW: none on chart
- MOLST/POLST: none
- Current Code Status: FC

- Discussion: regarding any of the above

Advance Directives: Example

- MPOA: on chart, dated 11/12/2020, signed and witnessed names Martha as MPOA
- LW: on chart, dated 11/12/2020, specifically requests “all measures to continue my life unless I am judged to be in a terminal condition”.
- MOLST/POLST: none
- Current Code Status: FC

- Discussion: There are four daughters, Martha, Annie, Becka and Sally. Sally says: “That MPOA is a fake and I should be the decision maker – not Martha.”

Relevant Policies/Statutes/References: Examples

- Health system
  - System policy #123: End of Life Care
  - System Policy #456: Surrogate decision makers
- State statutes
  - ARS 36-3231: Surrogate decision makers: priorities, limitations
- References from the Medical Literature
  - AGS Position Paper on Feeding Tubes in Advanced Dementia (J Am Geriatr Soc. 2014 Aug;62(8):1590-3)
  - CCM Definition of Futility (*Crit Care Med,* September 2016)
  - Assessment of Patients' Competence to Consent to Treatment, *NEJM* 2007; 357:1834-40.

Ethics Discussion

- List the specific issues/resolutions and explain reasoning
- Delineate the current conflict in ethics terms when possible
- Discuss reasons one course of action is preferable to another
- Give an answer if needed

(Consult notes are not directed to a philosophy class…)

Ethics Discussion- Example

(advance directives of patient without capacity conflict with surrogate demands)

1) Decision Making: When a patient lacks decision-making capacity, a surrogate decision-maker should be utilized to make decisions on behalf of the patient. The surrogate has an obligation to honor patient wishes if known. If not known, surrogate should apply a substituted judgment standard, that is to make the decision the patient would make if she had the ability to do so. Absent knowledge to use a substituted judgment standard, the surrogate should apply a best-interest standard.
2) Patient Wishes: In this situation, the patient's request for DNR/DNI status, no tube feedings and comfort care conflict with the son's requests for aggressive treatment. Absent mitigating information (which we do not have here), decisions the patient has made *for herself* take precedence over surrogate requests. This honors the patient's autonomy over her body regarding her medical care.

Ethics Discussion- Example

(patient without capacity, unclear surrogate, family member demands a specific surgery)

1) Surrogate decision making: A patient with capacity may name any person he wants to serve as his MPOA in the event of incapacity. He clearly appointed XYZ as his MPOA, and this directive must be honored. If XYZ is unable/unwilling to serve, surrogate duties would default to "majority of adult children" per AZ statute (ARS 36-3231).
2) Basis of decisions: The MPOA (or statutory surrogate) has an obligation to make the decision the patient would make if able to do so. Generally, decisions should be based on a) **Known Wishes of the patient** or, in the absence of that b) **Substituted Judgment** (what the MPOA/surrogate believes the patient would want) or, failing that knowledge c) **Best Interest** of the patient.
3) Autonomy: Adult patients with decision making capacity (or the MPOA in this case) have the right to decide amongst treatments offered by the treating teams. However, patients/MPOAs/surrogates do not have the right to insist on treatments medical teams feel are not appropriate or will not benefit the patient.
4) Professionalism: MPOA/surrogate may not dictate medical or surgical details of treatment - such as what kind of surgery is appropriate. Such decisions are the responsibility of the treating physicians.

Ethics Discussion- Example

(patient stated his wishes, then lost capacity, now surrogate disagrees with his decisions/wants full aggressive therapy plus she refuses to allow pain meds for him)

1) Autonomy gives patients with capacity the right to accept or reject treatments that are offered, and medical teams are obliged to honor such patient decisions. In this case, the patient has clearly expressed his refusal to accept CPR, intubation, oxygen, any other aggressive measures.
2) Surrogacy: When a patient lacks decision-making capacity, a surrogate decision-maker should be utilized to make decisions on behalf of the patient. The surrogate has an obligation to apply a substituted judgment standard, that is to make the decision the patient would make if he had the ability to do so. Although the wife is the statutory surrogate, her primary obligation is to support the patient's wishes, preferences and values and not her own. In cases where the surrogate is clearly asking us to act against the wishes of the patient, we are obliged to refuse.
3) Nonmaleficence: One of the oldest tenets in medicine is the dictum: "First, do no harm." This patient has clearly expressed his rejection of medical therapies during his terminal illness and considers them a harm (as evidenced by the extensive notes quoting his adamant refusals of continued aggressive therapy). Continuing aggressive therapy would violate this dictum.
4) Surrogate refusal of comfort medications or treatments: Patients may refuse comfort measures if they wish, but others do not have the right to force a patient to suffer by withholding comfort measures intended to relieve suffering.

Recommendations

- Be clear
- Be concise
- Be careful
- List options when/if they exist
- Ethically supportable…
- Ethically obligatory…
- Ethically prohibited….

Recommendations – Example

(need to clarify surrogate; family demands specific surgery)

1) Since this patient lacks the capacity to make his own medical decisions, it becomes obligatory to contact XYZ and determine whether he is willing and able to serve as the MPOA. If he is - he should be the point of contact. He can discuss the patient's medical care with other persons as he deems appropriate (i.e. according to what he believes the patient would want).
2) If XYZ is unwilling/unable to serve - surrogate duties would then fall to the two sons. They must accept or reject options offered by the treating teams based on what they believe the patient would want.
3) The medical and surgical teams should offer the treatments (including surgeries) they believe will benefit the patient. They should not proceed with treatments/surgeries requested by a surrogate decision maker if such treatments/surgeries are medically inappropriate

Recommendations – Example

(patient wanted cc; spouse refuses, spouse also refuses use of pain meds)

1) His code status is and should remain DNR/DNI per his own request.
2) It is ethically obligatory to shift to comfort care as the patient has repeatedly demanded be done.
3) His surrogate (wife) should be informed of the patient's decision and supported as much as possible within the boundaries previously set regarding her behavior and language.
4) Because comfort care heralds EOL, the usual EOL visiting rules will apply; surrogate needs to be made aware and supported.
5) It is ethically obligatory to provide medications for relief of symptoms - especially to relieve pain, SOB and anxiety.

Recommendations – Example

(full committee met and agrees with withdrawal of LST)

1) The committee supports the clinical team's decision to discontinue medically inappropriate treatments (including "life-sustaining" therapy) in this terminally ill man and discussed ways to proceed.
2) Examples of ethically supportable ways to proceed with the decision – to include transparent discussion with the family are as follows……
3) The treating team and a committee representative will meet with the proxy and family to inform them of this decision and to provide ongoing emotional support and comfort. If the family disagrees …
4) The proxy and family will continue to be offered as much support as they will accept – including…
5) ICU team will be meeting with the family … to communicate this plan and …

Template

Ethics Issue/Question:

Ethics was asked by ____ to render an opinion regarding

Background

I reviewed the EMR and spoke to ....
Medical info:
Capacity:
Goals of care:
Discussion:
Conflicts:
Meetings held:

Advance Directives:

MPOA
LW
MOLST/POLST
Current Code Status
Others

Relevant Policies and References:

Hospital policy
Hospital Staff By- Laws
Arizona Statutes
References from the medical literature

Ethics Discussion:

Respect for persons/autonomy
Nonmaleficence (do no harm) and Beneficence (do good):
Professionalism
Justice concerns
Potentially inappropriate/non-beneficial treatments
Truth telling
Many more are possible…

Recommendations:

It would be ethically supportable to…..
It is ethically obligatory to…
It is ethically prohibited to…
Followup
SIGNATURE

Complete Note – Example

Ethics consult called by ICU: Must we perform CPR in the event of cardiac arrest in a patient with a Full Code status who cannot be oxygenated and whose surrogate is unavailable?

Background:
- I spoke to ICU. Patient is intubated, on maximal respiratory settings and cannot be adequately oxygenated. Oxygen saturations continue to fall and cardiac arrest due to hypoxemia is imminent. Family not present but code status is listed as "FULL".

- Medical info: as above
- Capacity: intubated, not responsive

Advance Directives:
- MPOA: none; statutory surrogate not established
- LW: none
- Current Code Status: FC

Relevant policies/references/medical facts:
- **-** "Provision of Appropriate EOL Care", Policy XYZ

Complete Note – Example - cont'd

Ethical Discussion:

- Physicians should offer only medically appropriatetreatments**.** CPR is a medical procedure and whether or not to offer it is a medical decision. A patient may reject CPR if it is offered but may not demand CPR if the medical team considers it to be "not medically indicated, without benefit, or harmful". (Policy XYZ)

- It is ethically obligatory to withhold a treatment/procedure that will harm with no possibility of benefiting the patient. This is consistent with the primary principle of medical treatment: *Primum non nocere* - first do no harm. In this case CPR is physiologically futile.

Recommendations:

- Write the appropriate medical order (in this case DNR)
- Inform the surrogate as soon as it is possible to do so
- If the surrogate absolutely objects to the DNR …(*explanation of process*)
- Please call again if I can assist further

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Thank you

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- Questions?