Ethical challenges in developing a plan of care – Lecture guide

Case

- Mr. Latour, an 87-year-old male, presents to the ER with difficulty breathing. Unfortunately, he is unable to speak more than one word at a time and is only able to answer yes/no questions about his present symptoms – he cannot provide any more detail on his past medical history or history of presenting illness. He feels short of breath with some mild pleuritic chest pain. No history of cough or fever. He has no known past medical history (no records in our system), and no family accompanies the patient. He has decision-making capacity, but it is determined that he would like his wife to assist in making his medical decisions. His wife is not reachable by phone.
- He requires 100% oxygen via non-rebreather, is quite wheezy, and has moderate work of breathing. He is cachectic but appears well groomed. His chest x-ray shows multiple round, well-circumscribed masses in his lung parenchyma. ECG and initial troponin are unremarkable. His hemoglobin is 94, albumin is 24, and WBC are 12.1. The remainder of his blood work is unremarkable, with no liver or kidney dysfunction. VBG shows pH 7.32/CO2 34/HCO3 23.
- With some ventolin and atrovent nebulisations, he improves after 1 hour, although he still has moderate work of breathing. He is weaned to 70% FiO2. His VBG is unchanged.
- How would you manage this patient?

The Plan of Care - Is Active Treatment Appropriate?

- Often, medical decision making must occur very quickly.
- Time constraints and other factors may limit medical assessment and understanding of patient preferences.
- Asking important questions may help to determine whether a trial of active treatment may be appropriate.

Developing the Plan of Care

1. Who should make the decision?
    - Does the patient have capacity?
    - How to determine and document capacity?
    - Who is the substitute decision maker?
    - Is family available (and willing) to help with decision making?

2. What medical facts can we ascertain?

- Medical facts may include:
    - The patient's pre-morbid function,
    - Past medical history,
    - Severity of current illness, and
    - Expectation for recovery

3. What are the patient's goals? What are their needs?
    - Goals of care documentation in the chart – code status
    - Expressed wishes of the patient (If known).
    - Consider goals in terms of overall goal and daily goals to slowly achieve overall goal.
    - Needs include medical needs (intubation versus BiPAP), as well as social, spiritual, and psychological needs.

4. Is a trial of active treatment appropriate?

- Will active treatment meet the patient's goals and needs?
    - Balance between medical facts and patient goals
    - Where can the patient's goals/needs be met? (CCC, ICU, palliative care, etc)
- Are there limitations to your plan of care (CPR, time limitations, etc)?

***Check*: Is the care that we will provide within the standard of care?**

***Check*: Are there ethical principles in conflict?**

- The IDEA Framework Tool can help us further develop the plan of care.

<u>IDEA Framework – Identify the Facts</u>

- If a trial of therapy has begun, more information can be ascertained.
- <u>Identify the Facts:</u> Medical indications, patient preferences, quality of life, contextual features.
- What kind of needs does this patient or their family have?
- Is more active treatment, or even a transfer to ICU appropriate for this patient? Does it align with medicine's abilities and the patient's goals/values?
    - <u>Reasons to choose aggressive treatment may include</u>: treating to improve the patient's condition so that they may leave the hospital, or extending the patient's life.

  - Reasons to avoid aggressive treatment may include: that it goes against patient wishes, pursuing aggressive treatment will not meet the patient's goals, or will result in more harm than benefit.

- Is Palliative care more appropriate?
  - Reasons to choose palliative or comfort care may include: that the team may concentrate on alleviating the patient's pain and suffering without pursuing often painful or uncomfortable aggressive measures, or that the patient no longer wishes to pursue aggressive treatment.
  - Reasons to avoid palliative or comfort care may include: that there is a reasonable chance for the patient to recover and this is what they wish/would wish if capable.
- Other needs?
  - Social or spiritual support
  - Emotional or psychological support
  - Cognitive status needs

- What are the broad goals of care? (Of the patient, and health care team)
  - Are there daily goals that will help you reach these?
  - Continually assess capacity
  - Does the patient have capacity? If so, what are their wishes and goals of care? Ensure that capacity is being continually assessed and documented.
  - Capacity fluctuates and is necessary for consent.
  - Are there previously expressed wishes that are known?
  - Who is their SDM or POA?
  - Best interests?

- What is the standard of care in this instance?
  - Are your team's acts "in accordance with a reasonable body of medical opinion"?
  - Is there any reason for not treating within the standard of care?

Determine if there are Ethical Principles in Conflict

- What role do central principles play in the development of this treatment plan? (Autonomy, beneficence, nonmaleficence, justice)

- Is the patient or their SDM/POA making an informed decision? Are they requesting any treatment that might not typically be considered?
- How will any potential treatment plan benefit the patient? Is the patient's perception of benefit being met? Or are we only considering strictly objective medical benefit?
- What are the potential harms associated with treating this patient? Do they in any circumstance outweigh potential benefits?
- Is this patient being treated equitably? Are we able to treat other patients equitably if we pursue aggressive treatment with this patient?

<u>Explore the Options</u>

- Consider options, do the options fit with the patient's wishes/values? Assess the risks and benefits, do the options comply with corporate policy, regulations, and the law?
    - Ensure adequate communication when developing a plan of care!
        - Verbal and non-verbal communicative skills are indispensable.
        - Communication must include both the care team and the patient/SDM/family.
        - All conversations and relevant information must be documented in the patient's medical record. Failure to document is a significant ethical issue.
- What is this patient's code status? What code status is being offered? Is this patient a candidate for resuscitation?

**Helpful to understanding these questions is the following excerpt from the College of Physicians and Surgeons of Ontario (CPSO)'s *Planning for and Providing Quality End-of-Life Care* policy:

*"*15. Physicians **must not** unilaterally make a decision regarding a no-CPR order.

- Before writing a no-CPR order in the patient's record, physicians **must** inform the patient and/or substitute decision-maker that the order will be written and the reasons why.
- If the patient or substitute decision-maker disagrees and insists that CPR be provided, physicians **must** engage in the conflict resolution process as outlined in this policy and **must not** write the no-CPR order while conflict resolution is underway.
- If the patient experiences cardiac or respiratory arrest while conflict resolution is underway regarding the writing of a no-CPR order, physicians **must** provide all resuscitative efforts required by the standard of care, which may include CPR.*"* (CPSO, 2019)

**Also see *Wawrzyniak v. Livingstone, 2019 ONSC 4900* for more information.

Additional Considerations:

- What goals are medically (and realistically) attainable?
- Is the goal to improve functioning of the patient so that they may one day leave the hospital?
- Is this patient actively dying?
- Would palliative care be more appropriate than aggressive critical care?

- Do not offer treatments that your team is not willing to provide/are futile. Document these conversations and the rational for not offering these treatments.
- There is no ethical or legal obligation to offer/begin futile or medically inappropriate treatment, but consent is required to change a plan of care once treatment has begun.
- Are any of the options or legally problematic or do they contradict corporate policy?

Exploring the Options – Goals of Care Planning Challenges

- We cannot have a plan of care as soon as the patient walks in!
    - Treatment plans should be proposed on a time-limited basis and may include the withholding or withdrawal of interventions as a condition of consenting to that plan.
    - The Supreme court in *Cuthbertson v. Rasouli* judgment dictated that withholding or withdrawing could be built into (consented to in) a plan of care.
        - Paragraph [50] of that judgment states that consent may be obtained "…for a plan of treatment that provides for various treatments and may provide for the *withholding or withdrawal* of treatment: ss. 2(1) and 13.
        - Section 29(3) then states that if a treatment is withheld or withdrawn in accordance with a plan of treatment that the physician believes reasonably and in good faith was consented to, the physician is not liable for withholding or withdrawing the treatment. This provision would serve no purpose if consent were not required for the withholding or withdrawal of treatment in some circumstances." (Supreme Court of Canada, 2013)

Exploring the Options – Difficulties

- Consider: Is a treatment, or treatment *plan* being proposed? We may often create 'treatment plans' that are only for one particular body system, and do not address the patient as a whole.

- The Health Care Consent Act (HCCA) defines "treatment" as: "anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan..."
- "Plan of treatment" is therein defined as "a plan that, (a) is developed by one or more health practitioners, (b) deals with one or more of the health problems that a person has and may, in addition, deal with one or more of the health problems that the person is likely to have in the future given the person's current health condition, and (c) provides for the administration to the person of various treatments or courses of treatment and may, in addition, provide for the withholding or withdrawal of treatment in light of the person's current health condition."

- The plan of treatment must consider broader goals: Is the patient able to leave the hospital? And with a quality of life that they deem acceptable?
- Or, if this patient is not likely to leave the hospital alive, when is it appropriate to advocate for palliative interventions? Remember that acute care and palliative care are not mutually exclusive; they can exist concurrently.
- When exploring the options, are there some negotiable, and other non-negotiable aspects of the plan? Where might patient preferences be able to have more 'pull' on the plan of care, and where must medicine set limits?

<u>Act and Evaluate</u>

- From the above discussion, develop an action plan.
- Evaluate the plan.
- Evaluate the outcome – could you have done anything differently?

References

College of Physicians and Surgeons of Ontario (2019). Planning for and Providing Quality End-of-Life Care. Toronto, Canada. Available from: [*https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Planning-for-and-Providing-Quality-End-of-Life-Car*]. Accessed: 23 Aug. 2021.

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