Ethical Issues in the Elderly: Improving Care at the End of Life

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Pri-Med
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Learning Objectives

• Understand how compression of morbidity and availability of technically advanced treatment come together to require advance care planning to provide high quality care to complex patients
• Become familiar with advance care planning models and structures that improve care toward the end of life
• Become facile with tools to enhance planning for appropriate care toward the end of life including POLST.
• Recognize situations in which inappropriate treatment and decision making disagreements are common in order to reduce the likelihood of conflict.

It’s Not All Miracles: Health States People May Not Want

• Permanent vegetative state (PVS)
• Minimally conscious state
• Incapable of recognizing others
• Incapable of breathing on own
• Incapable of caring for self

Case 1: Bridge to transplant

• A 55-year-old man had a massive heart attack. He was stabilized but developed renal and respiratory failure. Airlifted to a quaternary care medical center for possible heart transplant.
• Despite the low chance of success, a ventricular assist device is implanted as a bridge to heart transplant. However, he develops infection and complications so he is no longer and will never be a transplant candidate.
• His family refuses to stop the ventricular assist device.

The Goals of the Healthcare System

• Restoration of health, saving of life
• Restoration or preservation of function
• Relief of symptoms, provision of comfort
• Steward scarce healthcare resources?
Case #2: Aspiration Pneumonia

• A 75-year-old woman with advanced dementia is admitted to the hospital from home with an aspiration pneumonia. Due to worsening function, the patient can no longer be cared for at home.  
• The family and clinicians decide to place a gastrostomy tube prior to nursing home transfer.

Quality of Care at the End of Life

<table>
<thead>
<tr>
<th>Inadequate emotional support</th>
<th>50%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not enough information</td>
<td>30%</td>
</tr>
<tr>
<td>Inadequate physician communication</td>
<td>24%</td>
</tr>
<tr>
<td>Inadequate attention to pain</td>
<td>24%</td>
</tr>
<tr>
<td>Inadequate attention to dyspnea</td>
<td>22%</td>
</tr>
</tbody>
</table>


Utilization, Transitions and Hospice before Death

<table>
<thead>
<tr>
<th></th>
<th>2000</th>
<th>2005</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice at time of death (%)</td>
<td>21.6</td>
<td>32.3</td>
<td>42.2</td>
</tr>
<tr>
<td>Hospice &lt; 3 days (%)</td>
<td>4.6</td>
<td>7.6</td>
<td>9.8</td>
</tr>
<tr>
<td>Hospitalization in last 90 days (%)</td>
<td>62.9</td>
<td>62.8</td>
<td>69.3</td>
</tr>
<tr>
<td>ICU in last 30 days (%)</td>
<td>24.3</td>
<td>26.3</td>
<td>29.2</td>
</tr>
<tr>
<td>Transitions in last 90 days (median)</td>
<td>2.1</td>
<td>2.8</td>
<td>3.1</td>
</tr>
<tr>
<td>Transition in last 3 days of life (%)</td>
<td>10.3</td>
<td>12.4</td>
<td>14.2</td>
</tr>
</tbody>
</table>


Case 3: Heart failure

• A 71-year-old man with ischemic cardiac disease gradually developed severe systolic heart failure (ejection fraction<20%) over the past 4 years.  
• No coronary artery lesions amenable to bypass or stent, cardiologist has maximized medical therapy and his renal function is now worsening.  
• Asked to complete a Five Wishes, but he never returned it.  
• Presents to an emergency room with pneumonia and pulmonary edema. A week later he is intubated in the intensive care unit in multiple organ system failure.

Obstacles to Advance Care Planning

• Not enough time  
  – Other pressing issues
• Uncomfortable conversation  
  – For patient/family  
  – For clinician
• Someone else’s responsibility
• Not the right time  
  – This can happen later when the issue arises
Importance of Understanding Patient CPR Preferences on Clinical Outcomes

Among Patients who Prefer Not to be Resuscitated

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>DNR order N (%)</th>
<th>Time to DNR order (median)</th>
<th>Resuscitated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician reports that patient prefers DNR</td>
<td>827</td>
<td>663 (79%)*</td>
<td>3 days*</td>
<td>8 (1%)*</td>
</tr>
<tr>
<td>Physician reports that patient prefers CPR</td>
<td>990</td>
<td>376 (38%)*</td>
<td>33 days*</td>
<td>42 (4%)*</td>
</tr>
</tbody>
</table>

* p<0.001; DNR=do not resuscitate; CPR=cardiopulmonary resuscitation


Factors Associated with Deteriorated Function post-CPR

<table>
<thead>
<tr>
<th>Age ≤55 years</th>
<th>Odds Ratio (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>1.13 (0.33, 3.89)</td>
<td></td>
</tr>
<tr>
<td>1.21 (0.38, 3.86)</td>
<td></td>
</tr>
<tr>
<td>5.25 (1.45, 19.1)</td>
<td></td>
</tr>
<tr>
<td>Acute physiology score (per point)</td>
<td>1.02 (1.00, 1.05)</td>
</tr>
<tr>
<td>CPR hosp day ≥4</td>
<td>8.30 (3.14, 23.3)</td>
</tr>
</tbody>
</table>


Quality of Care focused on Goals of Care

Implantable Cardioverter Defibrillator turned off prior to death
Patient participation in life-sustaining treatment decisions
Goals of care for patient on ventilator
Goals of care for patient in ICU


Care at the End of Life: Patients Considered for Organ Transplant

<table>
<thead>
<tr>
<th></th>
<th>Considered for Transplant (N=107)</th>
<th>Not Considered for Transplant (N=317)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advance directive (%)</td>
<td>21</td>
<td>18</td>
</tr>
<tr>
<td>DNR during admission (%)</td>
<td>87</td>
<td>92</td>
</tr>
<tr>
<td>Days from DNR to death (mean)</td>
<td>3.2</td>
<td>5.3</td>
</tr>
<tr>
<td>Ventilator withdrawn expecting death (%)</td>
<td>33</td>
<td>39</td>
</tr>
<tr>
<td>Goals of care discussion ≤48 hours of admission (%)</td>
<td>20*</td>
<td>39*</td>
</tr>
<tr>
<td>Comfort care orders (%)</td>
<td>32*</td>
<td>64*</td>
</tr>
</tbody>
</table>

*p<0.001


Advance Care Planning: Theory

• Patients have the right to direct care
  – within the goals of Medicine
• Physicians have a beneficent duty to tailor care to a patient’s clinical circumstances and preferences
  – and steward resources
• This may require:
  – specification of a surrogate
  – prospective discussion of care goals
  • documentation to inform care

Advance Care Planning: Practice

• The right conversation at the right time
  – Surrogate specification
  – Completion of an advance directive
  – Completion of additional materials
    • Five Wishes
    • Physician Orders for Life-Sustaining Treatment (POLST)

Most important is to have initiated the Advance Care Planning conversation
Case 4: The Landlord

- An 82-year-old generally healthy man with hypertension and osteoarthritis presents to establish care with a new primary care provider.
- During the history, the physician finds out that the patient has no living family and no real friends.

Doc: So, who would make medical decisions for you if you can't make them yourself?
Patient: Oh, my landlord. He knows exactly what I would want.

Advance Care Planning: Practice - 2

- Surrogate decision maker should be identified for all older patients
- Patients should be targeted for advance care planning:
  - No family or family members lack decision making capacity
  - Likely disagreements among potential surrogates
  - Surrogate likely to make different decisions than patient

Advance Care Planning: Practice - 3

- In-depth consideration of goals and values needed in particular clinical situations:
  - Advanced disease
  - High-risk procedures
  - Adverse health states

Discussing Potential Adverse Outcomes before Cardiac Surgery

<table>
<thead>
<tr>
<th></th>
<th>ACP Intervention</th>
<th>Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge</td>
<td>8.4</td>
<td>7.8</td>
</tr>
<tr>
<td>Congruence</td>
<td>2.8*</td>
<td>1.4*</td>
</tr>
<tr>
<td>Decisional conflict</td>
<td>2.0*</td>
<td>2.3*</td>
</tr>
<tr>
<td>Anxiety</td>
<td>-0.2</td>
<td>+1.3</td>
</tr>
</tbody>
</table>

*p<0.05


Case 5

A 78-year-old man has advanced heart failure and several comorbidities. During hospitalization you discuss prognosis with the patient and his son; together you decide that he does not want to be re-hospitalized, if possible, and certainly does not want CPR or ICU care. He will go to a skilled nursing facility for rehab before returning home.

Respecting Choices

- Community-wide program in La Crosse, WI
  - 15% of population had completed an advance directive at baseline
- ACP became standard of care across the community
  - advance directive educators placed at all health care facilities
  - standard policies and practices for documenting, maintaining, and using advance directives
  - community-wide education
- Two years after program implementation:
  - 85% of eligible patients had completed an advance directive
  - 98% of all deaths: treatment matched patient’s wishes

What Guides Care at the End of Life?

- Patient’s Clinical Condition
  - Prognosis
  - Quality of Life
- Treatment Options
- Patient’s Values

End-of-Life Care Plan

Case 6

- 76-year-old female with metastatic breast cancer suffers a cardiopulmonary arrest and sustains severe anoxic brain damage.
  - After 3 weeks, several neurologists declare the patient permanently comatose
- Patient lives with unmarried son. She has an advance directive:
  - Appoints son as agent
  - “I do not want my life to be prolonged if I become unconscious and, to a realistic degree of medical certainty, I will not regain consciousness...”

Case 6 (cont.)

- Son spends 24 hours each day at patient’s side
- He is convinced that his mother interacts with him, therefore:
  - Patient is not comatose
  - Advance directive preference should not apply
- As patient clinically deteriorates, son demands all life-sustaining treatments: antibiotics, pressors, hemodialysis, blood.
- For an intra-abdominal catastrophe, son demands emergent surgery.

What to do?

Powerful Motivation to Rescue

- “Our moral response to the imminence of death demands that we rescue the doomed. We throw a rope to the drowning, rush into burning buildings to snatch the entrapped, dispatch teams to search for the snowbound. This rescue morality spills into medical care where our ropes are artificial hearts.....
- Should the Rule of Rescue set a limit to rational calculation of the efficacy of technology?”


Cascade of aggressive care in the setting of rescue

Prognosis not discussed / decline not anticipated →
Patient deteriorates / next steps not discussed →
Clinical deterioration merits intensive care →
Organ failure merits more machines →
Ineffective care promotes undignified suffering →
↓ Healthcare morale, ↑ Opportunity costs, ↑ Costs

Medical Professionalism in the New Millennium: A Physician Charter

- Principle of primacy of patient welfare. .....a dedication to serving the interest of the patient...Market forces, societal pressures, and administrative exigencies must not compromise this principle.
- Principle of social justice. The medical profession must promote justice in the health care system, including the fair distribution of health care resources....
- Professional responsibility. Commitment to a just distribution of finite resources. While meeting the needs of individual patients, physicians are required to provide health care that is based on the wise and cost-effective management of limited clinical resources. ...

Rethinking Case #1

For the 55-year-old man no longer a heart transplant candidate kept alive on the ventricular assist device:

- Consider the indication for ventricular assist device
- May have a professional responsibility to stop the device based on the Goals of Medicine
- Plan for stopping the ventricular assist device should be part of the informed consent for implantation