

LEGAL AND ETICAL ISSUES IN WITHDRAWAL OF TREATMENT

Aim for this assignment is legal and ethical challenges that face in providing holistic care and symptom management in a patient undergoing withdrawal of life supporting treatment. In this essay, the author is looking at a case scenario to identify the main challenges illustrated in withdrawal of artificial ventilation, artificial nutrition and the management of respiratory distress.

For the purpose of this assignment the patient will be referred to as Mr J, in order to maintain confidentiality and adhere to the NMC's Code of Professional Conduct, performance and ethics (2008). Mr J, a 46-year-old Man, with a past medical history of alcohol liver disease and anorexia, presented to accident and emergencies with a 3-week history of shortness of breath, increasing lethargy, weight loss, and oliguria. Following an initial assessment and diagnostic testing, Miss M was diagnosed with decompensated liver disease and Renal failure, and she was transferred to Critical Care Unit for specialist management. Over the following week, Mr J's condition continued to deteriorated, as she was severely encephalopathic and fully dependent on artificial ventilation, inotropic support and hemodiafiltration. There is no improvement on his condition With maximum therapy, it became apparent that continuing with treatment was futile, following a discussion with the referring team and Miss M's family, it was decided that treatment should be withdrawn..

The goals of critical care are ultimately to support and treat causes of critical illness, however despite advances in medical technology, mortality rates in adult critical care units stand at approximately 17% (ICNARC, 2010). The vast majority of these deaths, like Miss M's, occur following a decision to withdraw life sustaining treatment (Bloomer et al, 2010, Lesieur et al, 2015).

The Ethics of withdrawal of treatment

British Medical Association (BMA) guidelines on withholding and withdrawing treatment (2005) describe the goal of medicine as being to benefit the patient and to act in the patient's best interest. Decisions to withdraw treatment are therefore made on the premise that if treatment fails to benefit the patient or if the expected benefits outweigh the burdens of treatment it is deemed futile, and as such, when in accordance with responsible body of medical opinion, can be lawfully discontinued (Airdale NHS Trust vs Bland (1993)). There is a clear ethical defence for withdrawing futile treatment as such as actions uphold the principles of beneficence, meaning to do good and promote benefit (Beauchamp and Childress, 2013); and non-maleficence, meaning to do no harm (Beauchamp and Childress, 2013). However, what some individuals perceive as benefit others may not, for example some people may believe that continuing futile treatment is merely prolonging the dying process and causing undue suffering and distress, whilst others passionately believe that life should be sustained at all costs. Numerous studies have found a reluctance among medical staff to discontinue treatment and an unrealistic quest by medical staff to save lives at all costs (Bucknell and Thomas, 1997; Jensen et al 2011; and McLeod, 2014). Arguably this may relate to a doctor's professional and moral obligation to protect and promote health, or equally be a result of fears of making an inaccurate clinical judgement. Additionally, some critical care practitioners perceive the shift from active treatment to end of life care as a failure (Pattison, 2004), and therefore are reluctant to make such decisions. However, the majority of life sustaining treatments have serious and unpleasant side effects, is it just to expose patients to risk or extra suffering unless there is reasonable expectation of a proportionate benefit?

Another element of this ethical debate is that critical care is a finite and costly resource, and so can it be justified for futile treatment to continue, when in doing so it may prevent the admission of another patient who may benefit from critical care? Or when the costs of futile treatment may be more effectively employed elsewhere? Nevertheless, Intensive Care Society (2003) guidelines relating to the withdrawal of treatment acknowledge that treatment decisions must not be made on the basis of cost, medical convenience or the need for an ICU bed for

another patient. Yet Cassell et al (2003) found some surgeons felt pressurized by critical care doctors to make early decisions to withdraw life-sustaining treatment in order to release critical care beds for new admissions.

Decisions to withdraw treatment

Although the competent patient has the right to choose, after provision of full information, whether to undergo any aspect of treatment that is offered, critically ill patients, such as Mr J, are commonly unable to participate in decisions, as they may be unconscious, sedated, intubated and ventilated (Bell, 2007). Indeed as few as 5% of patients are able to participate in decisions about their care at the end of life (Prendergast and Luce, 1997). The treatment of such patients is covered by the Mental Health Act 2005, under which, an act done or decision made for or on behalf of a person who lacks capacity must be done, or made in his best interests (Department for Constitutional Affairs and the Department of Health, 2005). Under UK law, the ultimate authority for medical care of the incompetent adult rests with the treating physicians (Bell, 2007). Whilst this legislation may seem to adopt a paternalistic approach, decisions to withdraw treatment are dependent upon medical knowledge such as causes of disease, prognosis, treatment options, and preventive strategies. Additionally, in adopting this approach relatives are spared from the significant emotional burden that would be placed upon them if they were otherwise left to decide whether treatment should be withdrawn (Prendergast and Puntillo, 2002). From experience however, some relatives want to shoulder that burden and indeed feel that it is their right to do so.

Best interests, are not solely based on best medical interests, but also the patient's wishes and beliefs when competent, their general well-being and their spiritual and religious welfare (Department of Health, 2001). This therefore, places a legal responsibility on the treating physicians to consult with those closest to the patient, as in order to attain this information, and acknowledge respect for autonomy, consultation and communication is vital. Professional and local Trust guidelines also recognize this, advocating that such decisions be

made in consultation with those close to the patient and with the rest of the healthcare team (British Medical Association, 2007; General Medical Council (GMC), 2010; Leadership Alliance for the Care of Dying People, 2014; National Institute of Clinical Excellence (NICE) 2015; and Nursing and Midwifery Council (NMC), 2015). Whilst shared decision making occurred in Mr J's case. Ferrand (2003) however, acknowledges that decisions to withdraw treatment often leave families and staff dissatisfied, excluded and confused. Abbott (2001) interviewed families of patients who were considered for withdrawal or withholding of life-sustaining treatment about their experience and found that 46% of respondents perceived conflict during their family member's ICU stay, the vast majority of conflicts were between themselves and the medical staff and involved communication or perceived unprofessional behaviour (such as disregarding the primary caregiver in treatment discussions).

Despite spending the most direct time with patients and their relatives, and often being required to manage the process of treatment withdrawal (Puntillo and McAdam, 2006), nurses can often feel excluded from the decision-making process (Viney, 1996; Bucknall and Thomas, 1997; and Robichaux and Clarke, 2006).

Indeed, in survey work involving 1961 physicians across 21 countries, Yaguchi, Truog, and Curtis (2005) found that only 29% of respondents included nurses within the decision-making process. Benbehishty, Ganz, and Bulow (2006) however, found a higher inclusion rate within Europe, with 78% of nurses engaging in decisions to withdraw treatment, although this still indicates a degree of nurse exclusion. Perhaps this reluctance to involve nurses within the decision-making process can be attributed to findings that nurses are less optimistic than medical staff in relation to patient outcome in critical care (Kirchlohoff et al, 2000). However Latour et al's (2009) European study demonstrated that the majority of critical care nurses are actively involved in the decision making process. Additionally, Hov, Hedelin, and Athline (2007) found that physicians only occasionally listened to nurses and the degree to which a nurse's contributions were taken seriously was dependent upon their

relationship with the individual physician. Nurses however, have a professional duty to act as an advocate for those in their care (NMC, 2015), and therefore it could be argued have a professional and moral right to be involved in the decision-making process. However, research suggests that many nurses feel inadequately prepared to act as advocates in decisions relating to withdrawal of treatment owing to the complexity of decisions and the ethical principles involved (Dean, 2002). This would suggest the need for a greater level of training in the areas of ethical decision making, and highlights the need for nurses to be included in the decision-making process in order gain more knowledge and skills.

Good collaboration in care planning and decision making is essential for smooth functioning of critical care units (Rose, 2011). Kichhoff et al (2000) found that where there was a lack of collaboration, good end of life decision making was hindered and often delayed. Such delays in decision making often result in unnecessary suffering for patients and their families, and often exacerbate the grieving process. Intensive care units typically have large interprofessional health care teams composed of members from different educational and philosophical backgrounds, which can influence the approach to treatment provision (Bowman, 2000), and contribute to inconsistency and lack of continuity in care (Hylton-Rushton, Williams, and Hartman-Sabatier, 2002). Indeed, in examining the experiences of nurses during withdrawal of life sustaining treatment Vanderspank-Wright et al (2011) found that conflict resulted from members of the team not being on the same page with regard to goals of care. This briefly occurred in Mr J's case, when the hepatologist disagreed with the initial decision to withdraw treatment however following a review after 48 hours and a multi-professional meeting, it was agreed that treatment should be withdrawn. Local trust guidelines state that decisions regarding withdrawing treatment should ideally be agreed by two critical care consultants and the shared care consultant, in Mr J' case the Hepatologist. Puntillo and Mc Adam (2006) advocate multi-professional discussions as a means of enhancing collaboration, as they allow time to reflect upon the aims of care.

The Process of Withdrawing Treatment

The Intensive Care Society guidelines for the limitation of treatment for adults requiring intensive care (2003) states treatments aimed at primarily maintaining organ function but which may prolong death should be withdrawn. Examples of these may include: mechanical ventilation, vasopressors, haemodialysis, antibiotics, blood products, intravenous fluid and nutrition. These guidelines however give no precise instructions on how to withdraw treatment, expect to state that the withdrawal of respiratory support may involve: reducing oxygen to 0.21%; lessening ventilator support; and eventually where appropriate extubating the patient. They also stress that adequate analgesia and sedation are essential but paralysis must be avoided. With little guidance on how undertake withdrawal, the process varies considerably between (and within) units and teams (Pattison, 2011).

Treatments withdrawn In Mr J's case included ventilator support, haemodialysis, and inotropic support. When withdrawing the ventilator support the immediate withdrawal method, was favored over gradual withdrawal, owing to concerns regarding further prolonging death and causing undue suffering. In accordance with guidance oxygen was reduced to 21% and pressure support and positive end expiratory pressure discontinued. Upon a late request of the family the endotracheal tube was removed. This was not done initially owing to fears that removal of the endotracheal tube may cause airway collapse, and increase dyspnea and secretion retention. Dyspnea and excessive pulmonary secretions are a common symptoms associated with withdrawal from mechanical ventilation (Kompanje, Van Der Hoven and Bakker, 2008). In effort to help control her excessive secretions and ease dyspnea, Mr J was given 400mcg of Hyoscine hydrobromide and 2.5mg of morphine via subcutaneous bolus injection in accordance with local trust guidelines relating to the management of respiratory tract secretions and dyspnea (See appendix). Research proves however, that managing secretions pharmacologically requires early intervention, as medication have little or no impact on existing secretions

(Owens 2006; Mercadante, Villari, and Ferrera 2011). In addition to pharmacological measures to ensure symptom control and comfort Mr J's position was altered to ensure she was in an optimal position to ease the work of breathing and allow for the drainage of secretions. Montagnini and Moat (2004) also suggest the use of gentle suctioning to remove secretions, however in Miss M's case this appeared to cause agitation. Given that Mr J was severely encephalopathic at the point of withdrawal, the presence of respiratory tract secretions and dyspnea, along with other distressing symptoms such as pain, agitation, restlessness, nausea and vomiting, were detected and assessed, through direct observation of her: breathing pattern; facial expressions; vocalisations; and body movements; and the presence of audible secretions. As per local trust guidelines anticipatory prescribing was used in order to ensure that there is no delay responding to symptoms. Good management of physical symptoms at end of life allows the patient and relatives time and opportunity to manage emotional, psychological, and spiritual issues (Clary and Lawson, 2009).

Although there is no distinction from an ethical or medical standpoint between withdrawing mechanical ventilation, vasoactive drugs, dialysis, antibiotics, blood products, intravenous fluid or nutrition (Rubenfield, 2004), multiple studies have shown that physicians are reluctant to stop artificial hydration and nutrition. Solomon, O'Donnell, and Jennings et al (1993) surveyed 687 physicians and 759 nurses in 5 hospitals in the USA, and found that 42% of respondents agreed that even if life support such as mechanical ventilation and dialysis were stopped, food and water should always be continued. Similarly, Christakis and Asch (1993) also found that internists were least likely to remove tube feedings, and intravenous fluids compared with other forms of life support, however out of the 862 American internists who were invited to participate in this study, only 458 responded, questioning the representativeness of the sample. In Mr J's nasogastric feeding was also continued despite the withdrawal of other forms of life sustaining treatments. Van der Riet et al (2006) acknowledges that it is not uncommon for health care professionals to be nervous about discontinuing nutrition and hydration at end of life. Perhaps

this can be explained when considering that practitioners have a duty of care to patients, inherent in which is the provision of adequate fluid and nutrients (Holmes, 2010). Withdrawing nutrition and hydration may therefore be perceived by some as neglect. In addition, there is a common belief that lack of food or fluids causes discomfort (Antoun, Merad, and Gabolde, 2006). However for the majority, the natural dying process is accompanied by loss of thirst and appetite, as the body's digestive tract and renal system cease to function (Twycross and Lichter, 2010). Additionally, evidence suggests that in renal failure, the kidneys become less able to excrete urine, causing pulmonary oedema (General Medical Council (GMC), 2010), this may arguably be exacerbated by the provision of medically assisted hydration. However research suggests that medically assisted hydration can lessen nausea (Cerchiatti, 2000), and decrease sedation and myoclonus (Bruera, Sala, and Rico, 2005), in terminally ill cancer patients. Additionally, local trust guidelines relating to withdrawal of treatment acknowledge that while enteral nutrition may be discontinued if deemed clinically appropriate, intravenous fluids must be continued to ensure the patient does not suffer the symptoms of dehydration. Research conducted by Morita (2005) supports the view that medically assisted hydration lessens dehydration, but also found that it worsens peripheral oedema, ascites and pleural effusions. This would suggest that the potential benefits of artificial hydration therapy should be balanced with the risk of worsening fluid retention symptoms, and advocate the need for continuing strict fluid balance.

Conclusion

In conclusion, it is clear from the literature that with advances in medical technology and knowledge withdrawal of treatment is being common place with critical care. Decisions to withhold or withdraw life sustaining treatments are driven by the principle of best interests, and there is a clear ethical defence

for this as it upholds the principles of beneficence and non-maleficence. Whilst under UK law the ultimate authority for medical care of the incompetent adult rests with the treating physicians, consultation with those closest to the patient and rest of the healthcare team, is required in order to truly establish best interests. Owing to a lack of precise guidance relating to methods of withdrawal of treatment, inconsistencies in practice exist, thereby highlighting the need for further research and greater guidance in this area. Despite the obvious need for effective communication in end of life care health professionals feel inadequate trained, thus illustrating need for improved training relating to communication and end of life care in critical care

Recommendations for practice therefore are that current education relating to withdrawal of treatment and end of life care be enhanced. Holding post withdrawal debriefings may too be beneficial in identifying learning opportunities, reducing stress, and enhancing collaboration. Further research and audit is also required in order to gain greater insight and develop further guidelines. The forming of a multidisciplinary team incorporating professionals from both critical care and palliative care, prepared to educate staff, monitor and evaluate practice, and provide resources and support to staff, may assist in this. Finally support networks with palliative care should be expanded in order to enhance end of life care and assist in the transfer of knowledge and skill.