“Death in the ICU is not always preventable and should neither be unduly hastened nor delayed.” (1)

**A BRIEF HISTORY OF END-OF-LIFE CARE**

The modern history of end-of-life (EOL) care began with demands of patients to *refuse* treatments. In 1974, the American Medical Association asserted that “the purpose of cardiopulmonary resuscitation is the prevention of sudden unexpected death. Cardiopulmonary resuscitation is not indicated in cases of terminal irreversible illness where death is not unexpected” (2). Limiting resuscitation in patients with terminal illness was becoming acceptable.

In the 1976 case of Karen Ann Quinlan, the courts upheld the right to refuse potentially life-sustaining care when they permitted the ventilator to be disconnected from the supposed ventilator-dependent Quinlan (3). The *Quinlan* case was based on the general constitutional right to privacy. After mechanical ventilation was discontinued, Quinlan lived for nearly a decade, sustained by nasogastric feedings. The 1984 case of *Bartling* established the right for a competent person to refuse potentially life-sustaining care (4). For 6 months, Bartling, a competent adult patient with an incurable disease, received mechanical ventilation against his clear wishes, declaring, at one point, “While I have no wish to die, I find intolerable the living conditions forced upon me” (4). Similar in reasoning to *Quinlan*, the appellate court supported the right of a competent patient to refuse medical treatment based on the constitutional right to privacy.

The 1990 case of *Cruzan* brought about a crucial change in the right to refuse treatment (5). Several years before an incapacitating accident, Cruzan had expressed to a friend a desire not to live in a state of diminished capacity. Cruzan’s surrogates wanted to withdraw treatment, but the Supreme Court of Missouri mandated continued care because Cruzan’s informal statements did not meet Missouri’s evidentiary standard of “clear and convincing evidence” of a patient’s wish to terminate potentially life-sustaining care. The case was appealed to the United States Supreme Court, but unlike *Quinlan* and *Bartling*, the Supreme Court grounded the right of a competent patient to refuse treatment in the more powerful liberty interest of the Fourteenth Amendment, which states, “No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty or property ….” The decision upheld the rights of states to determine the standards for the level of certainty required, permitting Missouri to use the “clear and convincing evidence” standard, but also permitting other states to use different standards (5,6).

Intensive care unit (ICU) practices may also lead surrogates to demand care for their loved ones. Helga Wanglie, an 86-year-old patient in a persistent vegetative state who was receiving mechanical ventilation, is an archetypical case. The medical center believed that further therapy would be futile for Mrs. Wanglie and wanted to withdraw mechanical ventilation. When Mr. Wanglie refused the medical center request to stop mechanical ventilation, the medical center sought appointment of an independent guardian to supplant Mr. Wanglie as her guardian. In 1991, the Court declared that Mr. Wanglie was best able to be Mrs. Wanglie’s surrogate (7,8); interestingly, a court ruled similarly in 2009 (9).

In the 1995 case of *Gilgun* (10), a jury supported a unilateral refusal of potentially life-sustaining care by the health care team. Catherine Gilgun had severe brain damage and was in a coma; the family refused any limitations on therapy. The Oritum Care Committee of the hospital agreed with the physicians that providing CPR was inadvisable. The legal division, believing the physicians were acting in the patient’s best interest, approved the do-not-resuscitate order; following withdrawal of mechanical ventilatory support, she died.

Competent patients have a right to refuse potentially life-sustaining medical treatment (11). The modifier “potentially” is used before life-sustaining medical treatment to acknowledge that although clinicians may believe that a therapy is life sustaining, there is rarely certainty that the intervention will be life sustaining. For the incompetent patient, three hierarchical levels of judgment direct the decision-making process. The once competent patient’s previously expressed preferences for EOL care should be followed as is best possible. When the patient’s declared preferences are not known, *substituted judgment*, the surrogate’s intimate knowledge of the patient’s attitudes and beliefs, may be used to direct care. While these are two distinct categories, both levels require the surrogate to sufficiently know the patient to appropriately choose or interpret the patient’s preferences. These standards put significant burdens on decision-makers who may have legitimate doubts about the appropriateness of their decisions. When a surrogate has to make decisions for a patient who has never been competent, such as a young child or a mentally disabled adult, substituted judgment is impossible, and the surrogate must rely on the *best interests standard*. The best interests standard requires the surrogate to make decisions based on the surrogate’s view of what is best for the patient.

**ADVANCE CARE PLANNING**

Advance care planning permits patients to declare preferences for medical treatment if they become incapacitated. Respecting these preferences is how physicians honor the ethical principle...
of respect for autonomy, in which patients have the right to make substantially informed decisions about medical therapy and the resultant trajectory of their lives.

Advance care planning is designed to minimize the likelihood of undesired overtreatment and undertreatment of the patient. Three types of advance care planning are used: advance directive, durable power of attorney for health care decisions (DPAHC), and Physician Orders for Life-Sustaining Treatment (POLST). Although advance directives allow patients to declare the extent of desirable interventions, they are often unable to directly address the subtleties that characterize clinical situations. The difficulty of applying advance directives to clinical situations limits their effectiveness and leads some to prefer the greater flexibility provided by the DPAHC, in which the surrogate decision-maker can consider the specific details when making clinical decisions. DPAHCs permit patients to designate surrogate decision-makers—including nonfamily members—to make decisions for them, should they become unable to make such decisions for themselves. Surrogacy is not always effective, particularly for patients who do not make their preferences clearly known to the surrogate before losing their decision-making capacity. Surrogates may forget that they are merely a conduit to relay the preferences of the patient, and instead they feel responsible for the actions taken, thus limiting the wherewithal to make decisions that limit therapy.

Advance directives and DPAHCs are inadequately discussed, documented, disseminated, and followed. Interventions focusing on communication can increase the use of advance planning documents and may improve the quality of communication during the treatment process (12). In one study (13), a video improved the ability of patients and families to understand and use the terminology of CPR as compared to patients who were given the usual care of a standard pamphlet.

Over the past two decades, significant effort has been made to make advance care planning orders more portable and thus more actionable across health care settings. With these objectives in mind, the POLST Paradigm was started in Oregon in 1991 and has since spread nationally with the establishment of the National POLST Paradigm Task Force in 2004 (14). At present, all but six states have begun developing or have developed a POLST (also known as MOST, MOLST, POST, or TPOPP, among others, depending on region program). Although each state's program and documentation requirements differ, the paradigm aims to ensure that a patient's EOL care wishes are honored by promoting timely advance care planning discussions in the setting of a known condition and encouraging shared clinician–patient decision-making. The patient's wishes are recorded as a set of medical orders on a visible, portable, standardized form that will accompany the patient across different health care settings. POLST documents are meant to complement Advance Care Directives, and are intended for patients with an expected prognosis of one year or less.

The power of the POLST over advance directives is that POLST is rooted in using physician orders. Several small studies have demonstrated that care frequently matched the POLST instructions and that health care providers believe that the POLST facilitated EOL discussions and prevented unwanted resuscitation (15). Patients who have a POLST are more likely to die at home than those patients who only had an advance directive (16). POLST seems successful in transferring across settings, and that the preferences underlying a POLST are consistent with prior decisions and do not change over time (17).

Advance care planning should be used in conjunction with an ongoing alliance with surrogates. Successful conversations focus on advance care planning as an ongoing process and are designed to help guide decision-making. Discussion of practical questions permits intensivists to highlight the inherent uncertainties of prognostication in medicine and the value of speaking in likelihoods.

While competent patients may modify their previously declared preferences, demented patients who previously made an informed choice to limit certain therapy may express an interest in receiving that therapy (18). If a patient manifests evidence of decision-making capacity, such as being able to provide internally coherent reasoning, their wishes to receive therapy should be honored. However, the process of resolving this situation in a patient without decision-making capacity, and with almost no likelihood of regaining decision-making capacity, is more complex. It would be quite easy to simply provide therapy; however, that is unlikely to reflect their true desires if they had decision-making capacity. In this situation, it is better to choose therapy based on multiple sources, including significant others, documentation, and the best interests standard.

REQUESTS FOR TREATMENT BELIEVED TO BE INADVISABLE

A therapy is labeled physiologically futile when it cannot accomplish its intended physiological goal, for example, when mechanical ventilation cannot accomplish pulmonary gas exchange. But when referring to therapy that has a low likelihood of achieving the intended goal, it makes more sense to use the concept of inadvisable care rather than focus on the muddled concept of futile therapy (19).

A therapy may be considered inadvisable because of the burden to the patient, cost, or uncertain benefit. Policies to resolve differences of opinions about inadvisable care should be procedurally based. Good policies are public, reflect the moral values of the community, and include processes for identifying stakeholders, initiating and conducting the policy, starting an appeal process commencing appellate mechanisms, and determining relevant information. Discussions about inadvisable treatment should bear in mind qualitative and quantitative considerations. The qualitative aspects define the goals of the treatment, and the quantitative aspects define likelihood of achieving a defined result. When offering likelihoods of a result, clinicians should be clear whether the information used to form the estimation is from intuition, clinical experience, or rigorous scientific studies. Scoring systems useful for population-level predictions should be considered as contributory but not determinative for decision-making for individuals. Clinicians should keep in mind that the clinical value of a therapy changes over time, and that previously indicated therapies became outdated (20).

It is not surprising that patients and families ask for what clinicians may consider to be inadvisable care; media and lore spur false hopes. On a societal level, inadvisable care is expensive, with some estimating that 11% of ICU patients were
receiving inadvisable care, meaning that in addition to the expense, ICU beds may not be available (21,22).

In 1999, the Texas State Legislature passed the Texas Advance Directives Act (TADA) (23). TADA allows attending physicians to refuse to honor a patient’s advance directive or a treatment decision made by or on behalf of the patient if the physician deems the care to be futile (“futile” in this case means unlikely to accomplish a specific nonphysiologic goal, such as hospital discharge). In order for care to be withdrawn, TADA requires that the case be reviewed by an ethics or medical committee of which the physician is not a member, and that the patient or surrogate is given a 48-hour notice of and an invitation to the case review. The patient or surrogate must receive patient transfer policies and potential accepting physicians and facilities, TADA requires 10 days—from time of receipt of committee’s findings—for continued care to allow for transfer in the event that care is deemed futile (23).

A survey of Texas Hospital Association member institutions demonstrated that only a minority of hospitals used TADA to review specific cases and that, among those that did, discontinuation of potentially life-sustaining therapy against the will of the patient or their representative occurred in few cases (24). Supporters of TADA believe that the statute allows the due process standard to be upheld while allowing for more timely resolution of EOL therapy disputes, presumably minimizing patient suffering (25,26). Opponents, however, question whether TADA is too effective in terminating care, and whether an ethics committee can truly appreciate and represent the breadth of cultural and socioeconomic backgrounds that inform the decisions of patients and their surrogates (27). Opponents argue that unilateral physician declarations are insufficiently respectful of patient autonomy and that negotiation nearly always resolves these problems, belying the need for unilateral action. Aside from Texas’ statute, case law has generally supported physicians and hospitals unilaterally refusing to provide inadvisable treatment (20).

### CARE OF THE DYING PATIENT

“End-of-life care seems too early until it is too late—too often.” (28)

Management of pain, dyspnea, and other distressing physical and psychological symptoms needs to be integrated into the routine of intensive care. By aggressively providing medical, emotional, psychological, and spiritual care, the patient is able to focus on decision-making and related matters (Table 2.1). Poor-quality EOL care harms more than the patient; one-third of family members who have relatives die in the ICU have post-traumatic stress syndrome (29).

Good EOL care requires successful communication between families, nurses, other clinicians, and physicians. In one study, 10% of family members in the ICU believed they received contradictory information from clinicians, and more than half of family members did not know the roles for each clinician (30). Factors that improve communication among clinicians and family include minimizing hierarchy, implementing protocols for multidisciplinary communication, and using team training to improve communication skills and diminish the effects of differences in training (31). Studies indicate that assorted interventions improve communication, particularly when using a standardized approach to communicating with families (32,33), daily goal sheets and checklists (34,35), daily medical updates and additional support personal (36), and proactive EOL conferences (33). Some of the interventions decreased length of stay, mortality, and costs, and improved the response to bereavement. Given the variety of successes, it may be reasonable to suggest that simply having a reasonable protocol improves communication.

 Patients and families prioritize effective and honest communication and shared decision-making, which enables patients and families to avoid undesirable therapy, prepare for the future, receive compassionate care, and have trust and confidence in the clinicians. Families are concerned about financial matters, and patients are concerned about an adequate environment for care and minimizing physical and emotional burdens on family members (37).

 Race, socioeconomic status, and gender may affect receiving good EOL care. Difficulties associated as a member of a minority group include inadequate access to care secondary to finances, geography, and language differences; due to historical abuses, members of minority groups may mistrust the health care establishment. Mistrust may spur them to attempt every therapy and to forgo palliative care, even though these choices may not be in the best interests of the patient, because of the suspicion that clinicians are not making their recommendation in the patient’s best interests.

 The future of assessing EOL communication and decision-making may be the implementation of quality indicators. A Canadian panel of experts proposed 34 quality indicators within the four categories of Advance Care Planning, Goals of Care Discussion, Documentation, and Organizational/System Aspects (38). Table 2.2 lists 10 indicators that were rated “extremely important” by the panel.

### Time-Limited Trials

While ethically equivalent, there is an emotional difference between withdrawing and withholding care. But trying and then withdrawing therapy is superior to withholding therapy, because a trial of therapy will let patients, families, and clinicians know whether the therapy could be applied with an acceptable benefit-to-burden ratio.

A time-limited trial is “an agreement between clinicians and a patient/family to use certain medical therapies over a defined period to see if the patient improves or deteriorates according to the agreed on clinical outcomes” (39). Time-limited trials may help advance the discussion when there is tension between shifting to full comfort measures and proceeding with potentially burdensome treatments.

Explicit goals, straightforward cases, and clear ownership of the process by a clinician or service improve the success of time-limited trials. Goals may either be broad, such as the ability to do certain activities by a specific time, such as following simple commands, or they may be narrow and based on data, such as ventilatory support or laboratory values. The decision about which type of goal to use is determined by the patient and family, the clinical issue, the clinician, and the habits of the unit.

Barriers to initiating time-limited trials include patients and surrogates not being ready or feeling pressured into doing a time-limited trial, clinicians disagreeing about whether to do a trial or the proposed timeline and goals of the trial, and when
### TABLE 2.1 Quality End-of-Life Care

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<tr>
<th>Honor Patient</th>
<th>Address Needs of Clinicians</th>
<th>Address Needs of the Family</th>
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<tr>
<td>- Have a system for continually evaluating and communicating EOL preferences.</td>
<td>- Commit to a multidisciplinary practice that leads to respectful and productive collaboration and communication.</td>
<td>- Have a presentable senior team member inform family of bad news in private using nontechnical language.</td>
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<td>- Review therapies at specified intervals to assess whether they are legitimate and consistent with the patient's desires.</td>
<td>- Provide ongoing education about palliative care and cultural beliefs.</td>
<td>- Help families find meaning in the death of their loved one.</td>
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<td>- Treat iatrogenic events by outcome and not by etiology.</td>
<td>- Provide opportunities for bereavement, debriefing, and psychological support.</td>
<td>- Accept, support, and comfort the family.</td>
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<td>- Consider whether care guidelines apply to the specific patient.</td>
<td>- Provide time and space for professional conversations and personal reflections.</td>
<td>- Assure family of patient comfort.</td>
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<td>- Reassess advance care planning continuously and by focusing on the patient.</td>
<td>- Identify objectives.</td>
<td>- Enable family to be with and help the patient.</td>
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<td>- Initiate EOL discussions early.</td>
<td>- Review medical facts and options for treatment.</td>
<td>- Clarify roles of clinicians to family.</td>
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<td>- Withdraw ventilatory therapy in a manner that permits recognition of distress; aggressively treat discomfort with opioids and sedatives.</td>
<td>- Agree on a care plan and on criteria to define success or failure of a plan.</td>
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<td>- Incorporate palliative care into intensive care.</td>
<td>- Understand and respect the narratives and perspectives of others.</td>
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<td>Hold regular meetings with family and team to clarify intermediate and long-term goals.</td>
<td>- Seek out perspectives on dying, dependence and loss of function.</td>
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<td>Work to improve EOL care.</td>
<td>- Use multidisciplinary approach to keep family informed.</td>
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<tr>
<td>- Perform EOL research.</td>
<td>- Provide sufficient time for questions.</td>
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<td>- Measure and assess EOL care.</td>
<td>- Maintain knowledge of EOL guidelines and care.</td>
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<td>- Promote a change in attitude toward EOL care.</td>
<td>- Maintain knowledge of EOL law.</td>
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Palliative Care

Palliative care is designed to improve the quality of life for patients and families by treating the symptoms and stress of a life-threatening illness. Table 2.3 lists the more extensive World Health Organization definition (41). The future of palliative care is centered on implementing systems of care, including ensuring that quality palliative care is available to all patients, and systems to evaluate outcomes (14,42). Defining and documenting quality measures such as adequate pain control as part of the electronic health record will provide global and individual assessments for institutions and clinicians.

Barriers to integrating palliative care and critical care include assuming that palliative care and critical care are mutually exclusive instead of complementary, confusing palliative care with hospice, and presuming palliative care hastens death. Clinician training in palliative care is inadequate, and clinicians and units are inadequately incentivized to provide quality palliative care, leaving them to prioritize higher profile concerns (43).

Palliative care and hospice have subtle but critical differences. Palliative care is for the patient with a serious illness, is not based on prognosis, can coexist with being in the ICU and receiving intensive care therapy, and does not require limitations on therapies, including resuscitation therapies. Hospice care is based on prognosis, usually has therapy limitations, particularly on resuscitation therapies, and is managed by the hospice team.

Palliative Sedation

Palliative sedation (also known as terminal sedation) is the administration of medications to decrease or obliterate consciousness to minimize or eradicate the patient’s experience of distressing symptoms. Palliative sedation should be used only in extreme circumstances when all other interventions,
The patient must clearly, voluntarily, and repeatedly request to die. The patient’s judgment must not be distorted. The patient must have an incurable condition associated with severe, unrelenting, and intolerable suffering. The physician is obligated to ensure the request is not made out of inadequate comfort care. PAS should be done in context of a physician–patient relationship. Consultation with other experts should be made to review and verify the facts about prognosis and current comfort management. Document above and fulfill reporting requirements.

received prescriptions, and 35 patients died from taking the prescriptions (48); in 2014, 155 patients received prescriptions, and 105 people died from taking the prescriptions (48). The financial and educational status of patients did not seem to play a role in the request for PAD. Primary concerns of patients were loss of autonomy, inability to engage in enjoyable activities, and loss of dignity. Interestingly, losing control of bodily functions, the situation being hard on family, and inadequate pain control were cited less than half of the patients.

In 2013, in Washington State, 173 patients received prescriptions (47); of the 173 patients, 159 are dead, 119 patients ingested the medication, 26 patients died without ingesting the medication, and in 14 patients the ingestion status was unknown. Prescriptions in Washington State are also increasing in frequency, and the data for underlying illnesses are similar to Oregon’s data.

**DISTRIBUTIVE JUSTICE AND RATIONING IN THE ICU**

Distributive justice refers to an equitable allocation of resources. Distributive justice can be viewed as a substantive request, such as determining a fundamental and inviolable level of health care for all members of a society; it can also be viewed as a process for achieving justice, using approaches including queuing and potential benefit to determine valid distribution. These approaches belie simplicity; consider the different interpretations of benefit, such as quality-adjusted life years, functional status, or the fair innings approach, which aims to level the playing field for characteristics such as gender that are not under control of the individual.

It is helpful to consider three taxonomic categories of rationing (49). The first is the limited availability due to external constraints, such as not giving a medication that is not on a formulary or diverting ambulances from an emergency department of an overfull hospital. This form of rationing is beyond the clinician’s control.

A second category of rationing occurs from the following clinical guidelines. For example, local hospital policies may define pathways for evaluation of certain diseases, such as requiring a specific radiologic study before proceeding to a more costly study. Deviations from clinical guidelines should be based on patient characteristics and scientific literature, not on personal idiosyncrasies.

The third category of rationing is based on clinical judgment; it is used when there is ambiguity about how guidelines should be applied or when guidelines do not exist. Clinical judgment is imperfect; decisions about therapy are influenced by a patient’s ethnicity, pre-illness employment status, the intensivist’s interest in rationing, and the political power of clinical services.

Fair rationing policies have the decision-making process and rationale publically available, a framework for principled decision-making as a means for resolving disputes, and an appeal process (50). When considering rationing, one should recognize the difference between the statistical patient and the individual, or identifiable, patient. Clinical guidelines are developed in reference to the statistical patient. It is easier and more proper to discuss rationing using the statistical patient, such as whether society should spend dollars on preventive care, primary care, or tertiary care. When participating in those debates on a macro level, clinicians may wish to consider their obligation to their patient community as well as to society.

Clinical judgment refers to the known individual patient. When faced with an identifiable patient whose situation does not align precisely with guidelines or studies, it is improper for a clinician to determine and implement rationing based on distributive justice at the bedside (49).

Triaging is a special consideration of distributive justice. Utility principles encourage actions that maximize “the greatest good for the greatest number,” and are at the heart of permitting unequal outcomes as long as overall health is maximized. For example, clinicians in the midst of a mass casualty will choose to provide discrete, rapid, and potentially life-sustaining care, such as chest tubes and endotracheal intubation, to many patients before devoting these resources to the treatment of a single resource-intensive head injury (51). Implicit in the utility principle is that like patients are treated similarly, without regard to other factors, such as socioeconomic status. The utility principle is suitable for a mass casualty situation in which all patients are equally unknown and no prior relationship with the patient has been established. It may, however, be less suitable for considering distribution of an absolute scarce resource, such as extracorporeal membrane oxygenation. In this case, many would suggest that the presence of a patient–physician relationship, current use of the resource, the appropriateness of the claim to the resource, and the idea that every person should have an equal chance to potentially life-sustaining resources should weigh heavily in these complicated balancing-act decisions.

**Conscientious Objections**

Conscientious objections can be defined as “as objections to providing or disclosing information about legal, professionally accepted, and otherwise available medical services based on a clinician’s judgment that to do what is requested would be morally wrong” (52). These may include, for example, offering palliative sedation, or informing about the option of withdrawing nutrition and hydration. It is important to honor what would seem to be an inappropriate authority not to offer appropriate services, because there is value in enabling clinicians to maintain ethical integrity. On the other hand, permitting use of conscientious objections could harm vulnerable patients, burden other clinicians, and provide an out for those who wish not to honor professional commitments. The American Thoracic Society has made policy recommendations designed to protect clinicians’ moral integrity and to protect patients’ access to legitimate medical services (52). Institutions should develop policies and processes to manage and prospectively identify conscientious objections. Institutions should try to accommodate conscientious objections as long as there is no impediment to the patient’s access to medical services or information, it will not create hardship for other clinicians, and the objection is not based on discrimination or other unjust reasons. A conscientious objection should not be considered a valid excuse to unilaterally forgo treatment of potentially inappropriate medical services; other mechanisms of resolution should be used in those cases.
HEALTH CARE ETHICS CONSULTATION IN THE ICU

Health care ethics consultation (HCEC) is defined as “a set of services provided by an individual or group in response to questions from patients, families, surrogates, health care providers, or other involved parties who seek to resolve uncertainty or conflict regarding value-laden concerns that emerge in health care” (53). The overriding goal of HCEC is to “improve the quality of health care through the identification, analysis, and resolution of ethical questions or concerns” (53). The process of HCEC is to gather relevant data, clarify relevant concepts and related normative issues, help identify a range of morally acceptable options within the context of the situation, and facilitate consensus among involved parties (54).

In larger adult hospitals, about half of all HCEC requests come from the ICU, and the most common categories relate to appropriate decision-making, goals of care, and EOL management. The most common topics were withdrawing or withholding treatment, patient wishes and respect for autonomy, and decision-making capacity (55,56). HCEC can help address treatment conflicts, reduce costs without diminishing quality, and limit inappropriate or unwanted interventions. In a randomized, prospective, cohort study in which addressing medical uncertainty or conflict were compared, patients in the intervention group, who received an ethics consultation, had a shorter length of ICU and hospital stays and significantly improved achievement of agreement of the goals of medical care (57). The frequency of HCEC will likely increase, given the aging population, continuing technological advances, the easy availability of information, and the increased participation of patients and families in determining care.

Key Points

• Treat patients and families with the grace and consideration you would want you and your family to be treated—that is, with respect for personal values, feelings, and preferences.
• Evaluate and implement continuing quality improvements in ICU communication and decision-making.
• POLST have the authority of physician’s orders and are transferrable and actionable across clinical sites and states POLST is likely more effective in ensuring patient’s wishes are followed than other forms of advance care planning.
• The concept of inadvisable care has replaced the concept of futility when considering whether to use a therapy with a low likelihood of success and a questionable benefit-to-burden ratio.
• Time-limited trials, trying a certain therapy over a defined period to see the benefits and burdens of therapy, is more ethically supportable than withholding therapy, because it gives an opportunity to see if a therapy provides an acceptable benefit-to-burden ratio.
• Palliative care is designed to improve the quality of life for patients and families by treating the symptoms and stress of a life-threatening illness. It is complementary to critical care, is not based on prognosis, and requires no limitations on therapy.
• Palliative sedation, using sedation to depress consciousness to minimize the experience of distressing symptoms, only should be used as a last resort and to treat symptoms that are present.
• The process of HCEC is to gather data, interview stakeholders, clarify relevant concepts, identify morally acceptable options, and facilitate consensus among involved parties. HCEC may decrease ICU stay and improve agreement on goals of care.

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