INTRODUCTION

The discussion is based, in large part, on years of ethics consultation in different healthcare settings.

The role of the Ethics Consultation Service is to contribute to good decision making in difficult situations by identifying and applying the most relevant considerations and guidelines.
In the past 35 years, most hospitals have established an Ethics Committee to serve as a resource in addressing the variety of ethical issues that arise in the institution, primarily in regard to patient care.
ETHICS CONSULT SERVICE

The Ethics Committee has a threefold role and responsibility:

Education  - Policy  - Consultation

In each of these three roles, much of the work of the Ethics Committee has been focused on ethically appropriate decisions about medical treatment.
ETHICS CONSULT SERVICE

The practical question addressed in the work of the Ethics Consultation Service is:

“What is the right or best thing to do in these circumstances, all relevant responsibilities considered?”
ETHICAL ISSUES IN PALLIATIVE CARE
Examples of some questions or issues encountered by the Ethics Consultation Service that are related to Palliative Care.....
ETHICAL ISSUES IN PALLIATIVE CARE

1. The patient had executed an Advance Directive several years ago, in which he appointed a family member his “patient advocate” and provided treatment directives stipulating that he did not want mechanical life support when his condition is “irreversibly terminal.” Who decides when this time has come?
ETHICAL ISSUES IN PALLIATIVE CARE

2. The patient is in the ICU, has a poor prognosis, and, in the judgment of the physicians caring for the patient, is not expected to survive to discharge. The family wants “everything” done and wants a “full code.”
ETHICAL ISSUES IN PALLIATIVE CARE

3. The assessment of the Palliative Care team is that the incapacitated patient is suffering. The family has made an explicit request that stronger pain medications not be used.
4. While the patient had decision-making capacity, she decided that she did not want resuscitation efforts made. A No CPR ordered was entered. Now she is no longer able to speak for herself and the family insists that she was not her real self when the No CPR decision was made. They want to change the order.
5. The patient is 17 years old and has declined chemotherapy for the treatment of Hodgkin’s lymphoma, even though the physicians indicate that they think that she has about an 85% chance of survival with treatment. Her mother supports her decision.
TREATMENT DECISIONS: ETHICS GUIDELINES
ETHICS GUIDELINES

The attention paid to clinical ethics over the last four decades has resulted in some well-established ethical standards and guidelines.

The following are examples of the standards and guidelines that are used by Ethics Committees.
ETHICS GUIDELINES

1. Physicians have the responsibility a) to inform the patient/surrogate of the diagnosis and prognosis, b) to determine which treatments should be recommended or offered, based on available evidence and the patient’s clinical condition and c) to inform the patient/surrogate of the potential benefits and burdens of different courses of treatment.
ETHICS GUIDELINES

2. Patients/surrogates have the responsibility to accept or decline recommended or offered treatment on the basis of the patient’s values and beliefs.
3. Except in limited circumstances, clinicians have a responsibility to accept the decision on the part of an informed adult patient (or appropriate surrogate decision maker) to decline unwanted treatment, regardless of the nature of that treatment and regardless of the benefit that the treatment is expected to provide.
ETHICS GUIDELINES

4. Patients/surrogates should not receive treatment interventions that physicians have judged medically non-beneficial, even if they strongly desire that these efforts be made.
ETHICS GUIDELINES

5. A conscious adult patient should be considered to have decision-making capacity until it is determined otherwise.
ETHICS GUIDELINES

6. The surrogate for incapacitated adult can be an individual with Power of Attorney for Healthcare, a court-appointed guardian, or the next of kin.
ETHICS GUIDELINES

7. The surrogate for a previously competent patient should use the “substituted judgment” principle when possible – what would the patient say if the patient could speak for self at this point.
ETHICS GUIDELINES

8. Decisions for minors, for those who have never been competent, or for those whose previous preferences are totally unknown should be based on the “best interest” principle.
9. Not all conversations about treatment efforts near the end of life should be conducted in exactly the same manner. The approach should depend upon the patient’s condition and prognosis.
10. A request that “everything” be done near the end of life should be understood as “everything that has a reasonable chance of providing medical benefit” or “everything consistent with sound medical practice” in these circumstances, not as everything that is technically possible.
11. The surrogate decision maker does not have the right or the authority to decline treatment that is necessary to relieve the patient’s pain or distress when there is no clear indication that the patient would decline that relief.
ETHICS GUIDELINES

12. When parents withhold consent for treatment for their minor children, healthcare providers should seek legal authorization to treat without parental consent only in those cases where the absence of the specific proposed treatment is likely to result in unnecessary and serious harm to the child.

These directives do not change the physician’s responsibility to base treatment recommendations on evidence-based determinations regarding medical benefit.
14. The patient’s faith-based beliefs about the nature and goals of medical treatment are often effective in helping to clarify what a patient would find acceptable treatment.

These beliefs do not change the physician’s responsibility to base treatment recommendations on evidence-based determinations regarding medical benefit.
DISCUSSION