RESPONSE OF THE U.C.L.A. MEDICAL CENTER ETHICS COMMITTEE

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This case presents a conflict in which a patient requested an urgent treatment which, due to quality of life considerations, he had previously refused. He received the aggressive treatment, contradictory to his prior wishes and his primary care physician's better judgment. His death was thereby postponed for 18 days of intensive care.

The U.C.L.A. Committee focused on the fact that the patient was not made adequately comfortable after the decision was made that the patient was going to die and that comfort was the goal. There was general consensus that the patient did not actually change his mind, but out of desperation asked for relief of suffering — in this case shortness of breath for which the immediate treatment was to be placed on a ventilator. When the course of comfort care was decided upon, the physicians had a responsibility to initiate therapy to prevent and treat this patient's suffering. Nurses pointed out that the caretaking nurse should have anticipated clinical changes and should have asked the physician for orders for specific remedies so that the patient would not suffer.

Physicians and nurses pointed out that while medicine often cannot predict the course of an illness, the stages of deteriorating physiology are rather clear. Even if the time course is unknown, the clinical changes of dying can be anticipated. Thus, in addition to deciding whether or not to resuscitate if there were to be a cardiopulmonary arrest, interventions might be outlined for a variety of expected physiologic perturbations. If hypotension develops, should vasopressors be started? For infection, should the patient receive antibiotics? Should blood products be ordered? These questions are now commonly addressed in advance yet, nurses pointed out, discomforts can also be anticipated. Physicians treat patient discomfort and suffering responsively rather than by anticipating these conditions. Shortness of breath, pain, obtundation, profuse respiratory secretions, and other discomforts receive little prospective attention. This may be, in part, because physicians may not

be present to witness the onset of discomforts or understand the progression of the dying process; yet physicians write treatment orders. Particularly when comfort measures are the goal, physicians and nurses must collaborate to ensure that comfort is the focus of therapy, not the by-product of lack of aggressiveness.

Another factor contributing to the outcome of this case was clearly the multiple team structure of the teaching hospital. While one team of physicians cared for the patient in the intensive care unit (ICU) and wrote the "transfer orders" to leave the unit, a different house staff team (which was never involved in the discussion of the comfort care decision) picked up the care on the step-down unit. The primary care attending physician remained the same, but evidently this was insufficient to ensure that comfort measures would be actively pursued. The participation of multiple consultant teams may also have been contributory to the difficulties. The pulmonary consultant may have been uncomfortable with the plan for comfort care, or may not have known how to handle the urgent situation of shortness of breath. Rather than asking the confused, short-of-breath patient whether he wanted to be placed on the ventilator, the physician could have [1] reassured the patient that he would be made comfortable and [2] arranged for the rapid administration of narcotics.

Members of the HEC pointed out that other factors may have contributed to the pulmonary consultant's reluctance to allow the patient to die. The scrutiny given to in-hospital deaths might promote a "not on my shift" mentality, though deaths are always expected in a hospital population. Additionally, some members felt that patient deaths, especially respiratory arrests, occurring in the setting of narcotic doses high enough to decrease respiratory discomfort (and therefore also respiratory drive) might be viewed with suspicion by reviewers. While the HEC believed that such thinking was seriously flawed and merited educational intervention, some members felt that it might still play a role in some physicians' behavior.

The HEC felt that the patient almost certainly would not qualify as having capacity to make the decision to be mechanically ventilated. Yet the Committee did not think that the patient's request should be ignored. Most agreed that in the emergent situation little more than an indication of wanting a life-saving procedure was needed. Once voiced, the patient's request needed to be acted upon. (Alternative strategies suggested by members included beginning narcotics to relieve respiratory drive, and psychiatric evaluation; these were rejected by the Committee.)

Social work and clergy pointed out the likely deleterious effect on the family, who were present during the short-of-breath intubation decision, when the patient's request could have been denied. Evidence given for this judgment was the ambivalence with which the family acted after the patient was returned to the ICU.

The strategy of the team following the intubation and emergent ICU transfer was identified by the Committee as the second major error. The ability to withdraw life-sustaining treatment is important. This permits decisions to prolong life in emergent life-threatening situations when there is uncertainty about what the patient would want. The Committee felt that *after* the intubation, nothing had changed about the patient's prognosis and prior preferences, and that it was sufficiently clear that the patient's request for intubation was an appeal to relieve his suffering, not a change in goals. In a timely manner (taking into account the needs of the family), comfort therapy should have been arranged and the case reviewed with the family to advise and explain why the extubation was in accord with the patient's wishes. Instead, the notes reflect that end-of-life decisionmaking was begun anew; this time the patient was unable to participate. Rather than advising the family of an appropriate therapeutic approach to meet the patient's goals, it appears that the physicians asked the family what to do next. Contributing to the problem was the fact that the primary care physician (given the notes in the medical record) became angry after the intubation. If the continuity physician does not take charge, the presence of multiple teams and consultants may simply lead to diffusion of responsibility, resulting in a slow decision-making process that focuses on *asking* patients (when sufficient information exists about the patient's values and preferences) rather than advising patients or family of an appropriate course of care.

In summary, the HEC believes that, although not consistent with the patient's ultimate goals, once the patient asked to be intubated in the midst of respiratory distress, this procedure needed to follow. However, the Committee felt that in three respects the care was suboptimal from an ethical perspective: [1] inadequate comfort measures were available for this dying patient, [2] the pulmonary consultant's approach did not adequately take into account the patient's preferences and prognosis, and [3] post-intubation decisionmaking was poorly handled. Each of these issues should be addressed by educational interventions to improve the ethical quality of medical care for future patients.