The Ethical Practice

Case #3

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A 67 year-old woman presented to the ER with dyspnea. With the onset about four hours before presenting to the ER, she believed her “COPD” was the cause. She underwent a diagnostic survey in the ER and was admitted to telemetry with a diagnosis of Acute Exacerbation of COPD. Prior to her admission, in spite of a diagnosis of COPD, she was active, living alone, caring for herself and able to enjoy family and friends. The patient has a living will, but did not bring it with her. That evening she had a rapid decline and required intubation and was transferred to the ICU. The family, upon hearing of her being on “life support,” became quite upset stating, “Mom would never allow this.“ The living will was placed on the chart and the family “demanded” it be implemented. Cardiology and Pulmonary consultants believed this was not a terminal event, but rather more likely an episode of acute coronary insufficiency and recommended she be continued on the ventilator until there could be a determination of the cause of her rather rapid decline. The family became quite upset and her two sons demanded that her Living Will be honored. The following morning, all family members were present and were advised again of the consultants’ opinion. They again demanded the ventilator and all support be discontinued. They were advised that an effort to wean the patient by accepted protocol would be made and gave their permission for an additional 24 hours of support; however, they requested a “Do Not Resuscitate” status. The following morning, the patient was stable enough for extubation. She was alert and oriented and in the presence of family she was advised what had occurred and was asked what she would like done should she require a ventilator for critical care again. She asked that the DNR be removed from the chart as well as her Living Will and advised her family she would want to “try and get better” before giving up.

Ethical Analysis

This clinical case is not an uncommon scenario in the practice of Internal Medicine today. Often, this results from living wills being written in a very vague manner. In order to analyze this case from an ethical perspective, a few assumptions that are not mentioned in this case scenario need to be made. First, there is not a mention as to whether this woman had lost decisional capacity, even though she became acutely ill and required mechanical ventilation. As long as someone maintains decisional capacity, even though acutely ill, the living will does not go into effect. From the tone of this case, it is reasonable to assume this woman has lost decisional capacity. The case presentation also does not indicate whether the patient’s advance directive identifies the sons as her Durable Power of Attorney for Health Care. If her sons are clearly identified as her proxy spokesperson and if this woman no longer has decisional capacity then they are empowered both ethically and legally to make decisions for her. If this woman does not have an identifiable Durable Power of Attorney for Health Care, one would turn to the living will for direction. From a legal perspective, whether a living will is applicable only when a person has a terminal illness varies form state to state. Ethically, however, most would view the living will should apply when a person can no longer speak for him or herself. Often, living wills are written in such a vague manner that it is difficult to discern exactly how a patient would decide based on the specific circumstances that may currently exist. For example, in this case, would this woman refuse mechanical ventilation for a very short period even though it may offer the ability to completely return her to her previous functional status? The physicians felt adamantly that short term mechanical ventilation would offer significant benefits to this woman. They did the right thing by trying to negotiate with the sons, who felt strongly that they were representing their mother’s will. An additional resource that both the medical staff and the family would have to aid in the disagreement is to consult the Hospital Ethics Committee. Ethics committees are often very helpful in conflict resolution such as this.

If the sons were unyielding in their view that their mother would not want mechanical ventilation, most would agree both ethically and legally it should be withdrawn. On the other hand, the treating physicians should not be compelled to provide care they think is ethically flawed. They should have the opportunity to transfer service to another physician who could comply with the request of the sons. Further on in this case scenario, we learn that this woman gains decision making capacity and rescinds the DNR order and her living will. Clearly, the son's decision to forego mechanical ventilation was not consistent with what she would have chosen. Data in the literature support what we observe here that often the family will underestimate the scope of interventions their parents would choose regarding end-of-life decisions. This case also illustrates how vague living wills may create significant confusion in end-of-life choices.

While both the sons and the physicians acted appropriately, this case underscores the need for more education on the role of living wills and advance directives. Living wills are best completed with careful input from treating physicians who understand the patient's medical condition and can provide the patient with the risks and benefits of various interventions. Likewise, health care proxies and the individuals they represent need to have meaningful dialogue so they can be adequately represented when they no longer are able to speak for themselves. While living wills and advance directives may be very helpful in the identification of end-of-life choices, they may also pose some significant challenges.