

When Patients Choose Unwisely at the End of Life: What are the Obligations of Physicians?

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As a clinical ethics consultant for the past 20 years or so, I have seen many situations where dying patients or their surrogates make decisions that cause considerable concern and moral stress to physicians and particularly to nurses who are continually at the patient's bedside. In an era where respect for patient autonomy is the paramount ethical value, we are obligated to be respectful of these preferences and decisions. But what about the cases where those preferences and decisions lead to procedures and treatments at the end of life which are entirely contrary to sound medical advice? Should physicians follow these directives even if this means that the patient will suffer needlessly and the physician will be performing painful, futile treatment? Although these dilemmas have been discussed in the overall clinical bioethics literature and systematic approaches to the ethical issues have been offered [1], these problematic cases arise in our hospitals not infrequently. My short commentary will focus more on how the context for these cases, i.e. how physicians' practice habits, legal department's risk dispositions, and lack of timely attention to patient and family preferences and needs, create the conditions for these dilemmas.

Ethics consultations are frequently called on to address issues at the end of life [2]. One of the most pressing issues involves dying patients for whom CPR would be medically inappropriate. The patient or surrogate will not give consent for a DNR order, insists on remaining full code and that "everything be done" in spite of a prognosis of imminent death. The following case, in which an ethics consultation was performed, represents this dilemma.

The patient is 70 pound, 37 year old woman with a complex medical history that includes AIDS, wasting syndrome, anal cancer, sacral and pressure ulcers, and a history of anal/vaginal carcinoma, which the doctors say may be recurring now. She was admitted in the Emergency Department of the hospital with nausea, abdominal pain and vomiting. At the time of the ethics consult, she has an obstructed bowel syndrome and her kidney function is decreasing. She is malnourished and does not eat. She has had a G-tube in the past, but does not have one currently, due to the obstruction. She had a PEG tube in the past, which, according to the nutritionist, did not work. In the past TPN was tried as well, over a period of two weeks, but according to the nutritionist, this has not been useful. She would need a biopsy to confirm a reoccurrence of carcinoma, but is not a surgical candidate. She is full code. Her physicians believe she is nearing the end of her life.

The patient is still alert and able to express her preferences. Although she is deemed to have capacity, she often states her preferences with ambiguity and frequently changes her mind. Her physicians have had candid conversations with her about her medical condition and they have recommended DNR and hospice care, which she has refused. In the past she has agreed to DNR, but now she indicates she wants CPR if she stops breathing.

How should the physicians view their obligations to this dying patient for whom palliative care is the only viable medical option?

An ethics consultation was requested to address this last question: whether we could clarify the physician's obligations. In fact what I think is being asked in this case is: Do physicians have an obligation to provide inappropriate medical treatment to a dying patient or at least, treatments that are not within the standard of care. From having done

many similar consultations over the years, it is apparent that physicians' concerns about acting consistent with their medical judgments vary in such cases. One of the most common concerns, however, is the risk of legal liability due to not following the patient's directives. Practically, and in my experience, all physicians believe the ethically right course of action is to forego CPR. Yet, not all physicians are comfortable acting in a manner which seems, to most of us, the right thing to do and even obligatory.

Based on my experiences with hospitals across the state and country, not all ethics consultation services would see this case in the same light, possibly for reasons other than their own ethical considerations per se. I know of one ethics service that routinely recommends that physicians perform CPR, even in the face of such dire medical circumstances if there is no DNR order. My sense is that ethics consultations services are almost always forced to follow the lead of the particular interpretation of state law of hospital legal departments, which greatly reflects particular risk dispositions. Again, based on my anecdotal experiences, legal departments often see risks of legal liability differently and more cautiously than ethics service. So as the ethics consultation services usually frame recommendations with the hospital legal perspective in mind, their recommendations to perform medically inappropriate CPR without a DNR order may vary from one hospital to another.

In the case presented above, the physicians had run out of therapeutic options and the patient was near death, though communicative. It was highly predictable that she would lapse into unconsciousness within a few days, and would stop breathing, which in fact did happen. If the physician would decide to perform CPR on this patient, it would entail doing an aggressive intervention that would assault this delicate patient's body to no avail, in my opinion. I saw the possibility of CPR as an instance of imminent demise futility [3] or physiological futility [4] and, therefore, something the physician was not obligated to do. Not following a patient's preferences is a serious matter, but in this case the competing moral obligation was not to cause harm by performing a violent and unnecessary procedure. Even without a formal DNR order in the patient's chart, the physician could have decided not to perform CPR on this patient, if he deemed this the appropriate medical course of action. What is more, I believe physicians should be transparent and say to the patient or surrogate, "I can't in good conscience do what you are asking me, because it will only cause you harm and provide no benefit". When physicians are willing to make this medical judgment, the ethics service should be supportive in consultation with the legal department in these circumstances. In the end, ethics advice to a

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physician is just that: advice. When the actual moment comes, when the patients stops breathing and heart stops, the physicians decide what to do.

In cases like this one, physicians want to do what is right. But they want to be sure they are within the guidelines of the law. How the physician eventually acted in this case is not as relevant as the fact that physicians across the country, across the state, in the same hospital or even on the same service often differ on how they manage such cases. Clearly this type of case goes to the heart of the intersection between clinical ethics and palliative care.

There is a serious need for more discussion of what ethical and legal standards to employ in such cases. We need to consider point at which the obligation to provide palliative care overrides the *prima facie* obligation to respect the patient's or surrogate's directives. But most importantly, these cases cry out for greater involvement of palliative care and ethics consultation, at a much earlier stage in the course of treatment for seriously ill patients. It is much easier to obviate the

possibility of conflict and discord if patient and family concerns and needs are addressed at an earlier point in the case. Too often, ethics consultations occur at the final stages of a patient's life, where a dramatic and excruciatingly difficult decision has to be made. Physicians need to be better prepared to utilize the services of palliative care and ethics consultation at a point where there is more time for discussion and planning so as to avert end of life crises. Such a change will require more education and a move toward more definitive practice standards in the management of seriously ill patients.

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