TuftsMedicine

Tufts Medicine Lowell General Hospital Ethics Grand Rounds

November 8, 2023

Lauren Rigsby, MDiv

Learning Objectives

a) Introduction to the structure of the two LGH Ethics Committees
b) Know how to request an Ethics Consult at Tufts Medicine Lowell General Hospital
c) Overview policy and procedures of ethical dilemma resolution (aka what happens after an ethics consult is requested)
d) Engage in role play to practice asking ethical questions and applying ethical principles and hospital policy

Policy: Ethical Dilemma Resolution

I. PURPOSE

I. To protect, respect, support and promote the rights of patients consistent with the hospital's mission, vision and values;

II. To provide a mechanism whereby any healthcare provider may request review of and consultation for any ethical concern or issue arising from the provision of clinical care;

III. To provide a mechanism whereby any patient or family member may request review of and consultation for any ethical concern or issue arising from the course of clinical care.

II. SCOPE

I. All Hospital Personnel

III. DEFINITION

I. Ethical Dilemma: A medical ethical dilemma exists when established ethical principles and/or personal values/beliefs are in conflict such that the appropriate clinical course of action is unclear

Two Clinical Ethics Committees

Main campus

- Not religiously affiliated
- Chaired by Rothsovann Yong-Te, MD and Lauren Rigsby, MDiv
- Committee made up of many professional disciplines
  - Medical
  - Nursing
  - Risk
  - Social Work
  - Spiritual Care
  - PT, OT, Pt Relations, Nursing Ed, CCRC, Psych

Saints Campus

- Retains Catholic affiliation and identity
- Abides by the “Ethical and Religious Directives for Catholic Health Care Services”
- Chaired by Dean Shapley, MDiv
- Includes a professional ethicist from the Catholic Archdiocese
- Follows and reviews the same hospital policies and procedures as main campus
- Membership includes similarly diverse professional disciplines

Two Committees, One Consult Process

There is no order in EPIC for an ethics consult.

Contact one of the Chairs of the Ethics Committees to request an ethics review and consult.

- **Lauren Rigsby**, MDiv, Co-Chair of the Main Campus Ethics Committee
- **Dean Shapley, MDiv**, Chair of the Saints Ethics Committee
- **Rothsovann Yong-Te**, MD, Co-Chair of the Main Campus Ethics Committee

To request an ethics review and consult, message the "L Ethics Consult" Role on TigerConnect.

What Happens Next

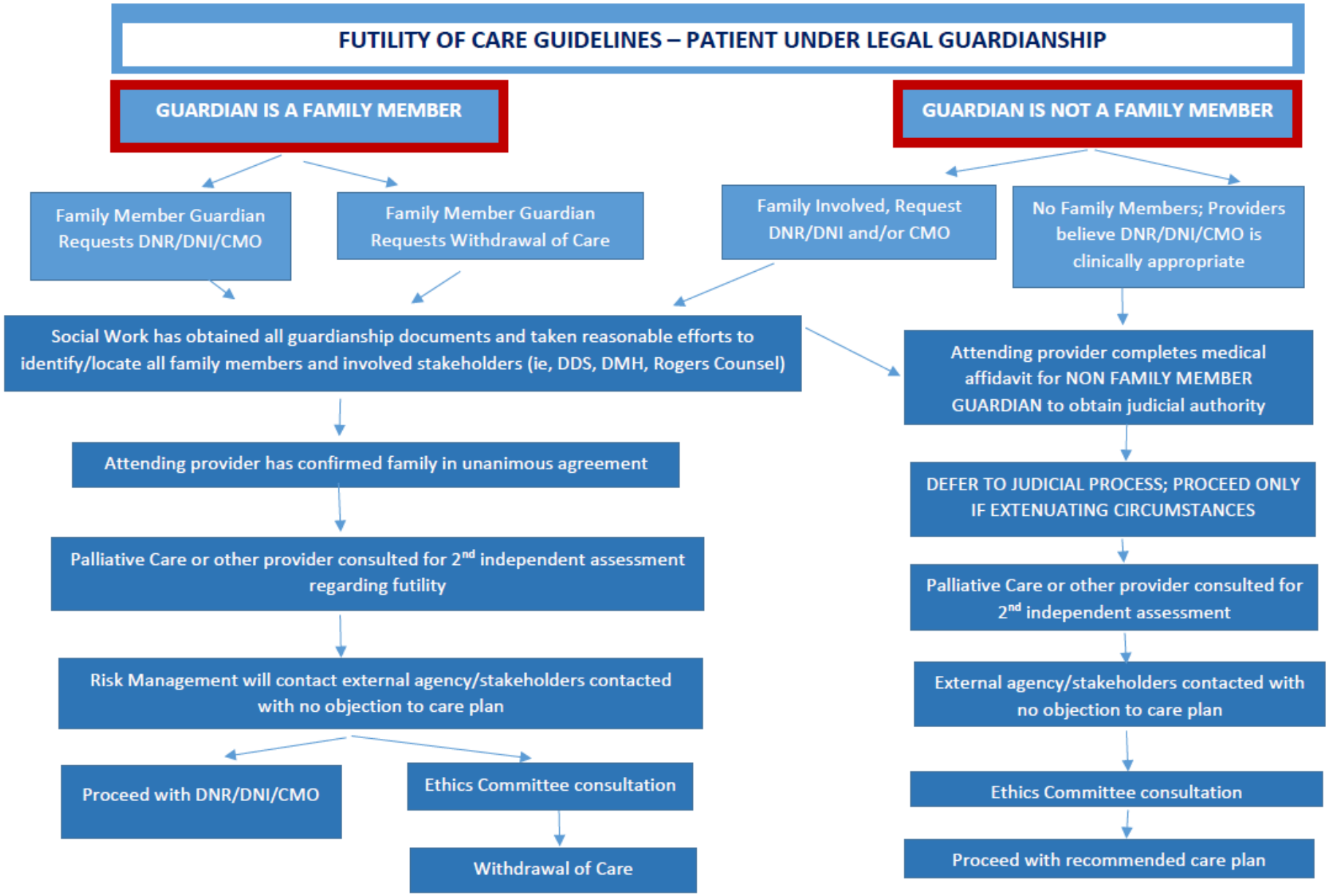
1. **Let's talk**
2. Give the ethics chair time to review and get back to you
3. Chairs will likely recommend steps before an ethics consult
4. If still unresolved, the chairs will set up an ethics consult
    1. Consult will likely be on Zoom in the afternoon
    2. Attending's presence is required
    3. All other members of the treating team are encouraged to attend
    4. Specialists are invited as needed (thank you for attending when invited!)
    5. Students are welcome
    6. Quorum of Ethics Committee: at least 5 members of the committee (Medical, Continuity of Care, Risk, Social Work, Spiritual Care)
    7. Consult discussion is confidential
    8. Recommendations from an Ethics Consult are non-binding and advisory

Let's practice!

Case Study 1

Maria Thompson is a 47 year old Hispanic Catholic woman on IMC/R3 who just completed IV antibiotic treatment for recurrent aspiration pneumonia. Her respiratory status declined this morning, and she is now maxed out on high flow. Maria has a MOLST that says DNR/DNI. She has a past medical history of Down Syndrome, Congestive Heart Failure, Chronic Kidney Disease stage 2, COPD, seizure disorder, prior trach (decannulated in 2020) and is PEG dependent. She has had 4 hospitalizations for aspiration pneumonia this year. After consultative conversations with Infectious Disease and Pulmonology specialists, the Attending recommend a Comfort Measures Only plan of care to Maria's family.

Maria's mother, Claudia, is her legal guardian. Claudia has already been to court for expansion of her decision-making authority. The court granted Claudia authority to execute a MOLST making Maria DNR/DNI. The updated court documents and MOLST can be found in the patient's record. Claudia reports that she was already working with DDS (Department of Developmental Services) to petition the court for the authority to sign Maria on to hospice due to a continuous decline this year. Claudia asks if she can make Maria comfortable during this hospitalization following your CMO recommendation.



In The Matter of Shirley Dinnerstein, 6 Mass.App.Ct. 466 (1978)

Futility of Care: *No reasonable chance of meaningful recovery following comprehensive assessment and completion of reasonable course of care; Potential risks of additional treatment outweigh potential benefits*

*Note this is specific to Lowell General Hospital, not Tufts Medicine.

Ethical and Religious Directives for Catholic Health Care Services, *Sixth Edition*

UNITED STATES CONFERENCE OF CATHOLIC BISHOPS

"57. **A person may forgo extraordinary or disproportionate means of preserving life.** Disproportionate means are those that in the patient's judgment do not offer a reasonable hope of benefit or entail an excessive burden, or impose excessive expense on the family or the community."

"58. In principle, there is an obligation to provide patients with food and water, including medically assisted **nutrition and hydration** for those who cannot take food orally. This obligation extends to patients in chronic and presumably irreversible conditions (e.g., the "persistent vegetative state") who can reasonably be expected to live indefinitely if given such care. Medically assisted nutrition and hydration become morally optional when they cannot reasonably be expected to prolong life or when they would be "excessively burdensome for the patient or [would] cause significant physical discomfort, for example resulting from complications in the use of the means employed." **For instance, as a patient draws close to inevitable death from an underlying progressive and fatal condition, certain measures to provide nutrition and hydration may become excessively burdensome and therefore not obligatory in light of their very limited ability to prolong life or provide comfort**."

https://www.usccb.org/resources/ethical-religious-directives-catholic-health-service-sixth-edition-2016-06_0.pdf

No ethics consult needed

- ✓ Guardian is a **family** member and everyone involved agrees with the plan for CMO.
- ✓ Social Work is involved and has documented any involvement and agreement of other agency entities like DDS, DMH, Rogers Council.
- ✓ Risk has reviewed and is in agreement.
- ✓ Formal, independent second medical opinion is in agreement and is documented.

Note:

This plan of care will ONLY be honored while Maria is an inpatient here.

If Claudia's goal is to take Maria home with hospice, then she will need to petition the court for expanded authority.

Welcome to the Ethics Consult!

Ethics Consult Framework

1. Welcome, Opening Remarks by Chair
2. Introductions
3. Presentation of Clinical Information by patient's Attending and Team
    1. Personal Narrative of Patient
    2. History of Any Previous Admissions and Treatment
    3. Relevant Medical Overview of diagnoses, current condition, and prognosis
    4. Patient's known wishes regarding goals, types of treatment, and values/beliefs affecting wishes
    5. Surrogate and/or family view of patient's condition, wishes, prognosis, options
4. Questions and Clarification of clinical and other relevant information
5. Identify and Clarify the Ethical Question or Concern and Ethical Principles
6. Identify and apply relevant policies and regulations
7. Consensus building discussion, vote
8. Advisory Recommendation to Attending
9. Documentation
    1. Ethics Chair Note in patient's medical record
    2. Patient Attending document ethics consult and advisory recommendation in patient's medical record

Case Study 2

Robert Jones is a 39 year old transgender man intubated on ICU-G with endocarditis and a new embolic stroke on blood thinners. Robert has a past medical history of a TBI in 2022 which resulted in his permanent residence at Tewksbury State Hospital where he is dependent for all ADLs. Robert has a history of CKD stage 5 on chronic HD MWF schedule. Robert's HD line was the suspected source infection and was pulled yesterday. He now has an EF of 10%. *Cardiology's assessment… Neurology assessment and prognosis… high risk for cardiac event and high risk for herniation in the next 48 hours with limited treatment options, and no treatment options that could reverse further damage if he codes.* Calls were made to transfer him to TMC, however he is not a candidate for * and they would not treat him any differently.

He has no involved family and a legal guardian who is not family. Robert is FULL CODE.

Legal guardian states he does not have end-of-life decision making authority. Legal guardian also shares that the patient's family does not wish to be involved or updated per the letter read in court during the guardianship hearing.

ICU Attending asks for an Ethics Consult for DNR due to futility of resuscitation

What Are Your Clarifying Questions?

- **Medical questions**
- **Social questions**
- **Patient wishes questions**
- **Other clarifying questions**

Principles of Healthcare Ethics

Beneficence	Nonmaleficence	Autonomy	Justice
Promoting the patient's best interest and providing the best care	Avoiding actions likely to cause the patient harm	Supporting and facilitating the capable patient's exercise of self-determination in health care decision making	Allocating fairly the benefits and burdens related to health care delivery and access
What is the medical recommendation? How did you come to that recommendation?	What are the risks or burdens of this plan?	What are the patient's wishes or values?	Are there other factors or biases influencing the medical recommendation?

Futility of Care Policy

"The goal of medicine is to benefit the patient. While respect for a patient's autonomy and personal choices is paramount to this goal, the process should also respect the dignity and integrity of the health care providers and staff members involved. It is Lowell General Hospital's policy that no patient should be compelled to undergo and no health care provider or staff member should be required to provide: (1) treatment or interventions that are harmful and confer no beneficial outcome; or (2) treatment or interventions that are medically futile and contrary to generally accepted health-care standards. Resource consumption, membership in a protected class, inability to pay, and rationing are not criteria to be considered when defining medical futility."

Futile	Any course of treatment that offers no reasonable likelihood that it will achieve a medical goal or is medically ineffective and contrary to generally accepted health-care standards.
Harmful	A medical intervention should be considered "harmful" if the likely suffering or other harm grossly outweighs any realistic benefit to the patient.

Futility of Care Policy

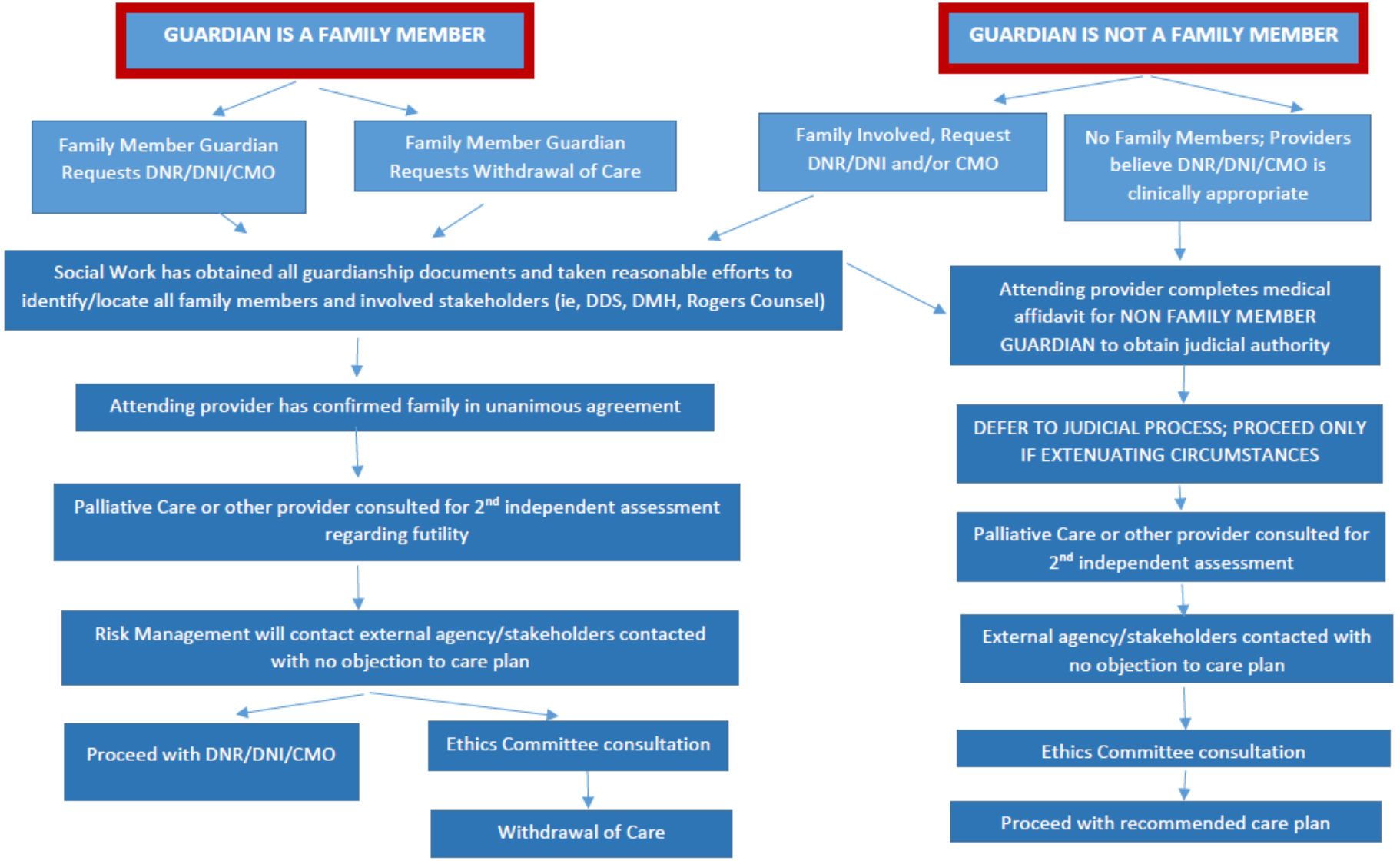
"In undertaking the care of a patient, it is the intent of Lowell General Hospital healthcare providers and staff to **offer all available medical interventions that have a reasonable likelihood of meaningfully advancing the patient's goals without an overwhelming burden of suffering**. For example, if a patient's highest goal is extension of life, then continuation of life support is usually appropriate. If, however, a point is reached where **no further medical intervention offers any reasonable possibility of prolonging life without an inordinate risk of suffering, despite maximum efforts to prevent or alleviate suffering, the healthcare providers and staff will not be required to provide further life-prolonging medical intervention**. Nevertheless, the healthcare team will **continue to care** for the patient, ensuring that any suffering is minimized and the patient's dignity is fully respected.

While patients with decision-making capacity have a right to accept or refuse life sustaining treatment, they do not have a right to receive treatment which falls outside the accepted standards of medical practice. …

Although respect for patient's autonomy is paramount, there is not an ethical obligation for Lowell General Hospital healthcare providers and staff to provide life-sustaining treatment if such treatment falls outside the bounds of accepted medical practice even if requested by a patient or surrogate healthcare decision-maker.

Lowell General Hospital subscribes to the consensus in the medical literature that there is no ethically relevant difference between withholding and withdrawing a life-sustaining treatment."

FUTILITY OF CARE GUIDELINES – PATIENT UNDER LEGAL GUARDIANSHIP



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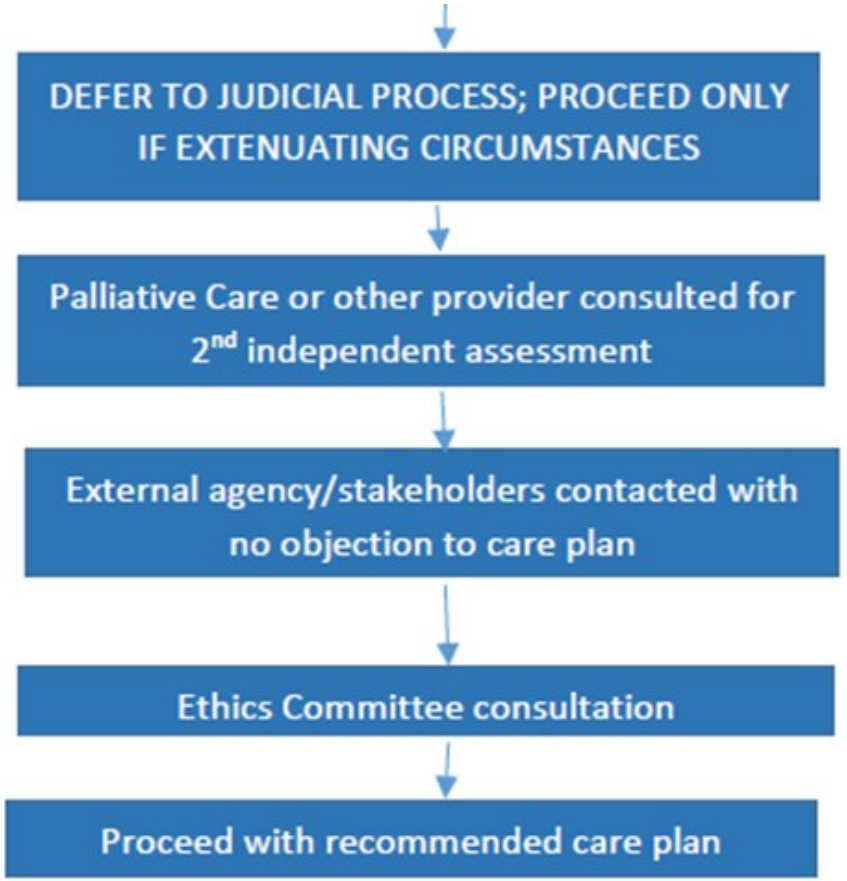
Applying Policy

- ❑ What is the extenuating circumstance requiring a action now instead of (or before) a judicial process?
- ❑ Has there been a formal, independent second opinion from a Lowell General Hospital physician? Is it documented?
- ❑ Are further specialist opinions needed?
- ❑ Do all stakeholders agree with plan (any family and all involved agencies like DDS)?



Discussion and Vote

Insert visual interest here

Documentation in the Medical Record

An advisory Medical Ethics Consultation occurred on November 8, 2023 with a quorum of committee members along with members of the patient's multidisciplinary care team. The medical ethical principles were reviewed alongside name's clinical history and hospital course. The advisory recommendation of the Ethics Consultation is to endorse the assessment of multiple providers that cardiac resuscitation would be futile and endorse changing Robert's code status to DNR.

Questions

Tufts Medicine

Thank You

for more information:
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Next meeting: Nov. 13