

GS 37 When Do We Stop and How Do We Do It? Medical Futility and Withdrawal of Care

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Introduction and Overview

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Case Scenario

- 56 yo male 5 months s/p palliative choledochoenterostomy for mass in head of the pancreas (hepatoduodenal ligament node positive for adenoca)
- >30 lb. weight loss since operation and increasing weakness/fatigue (esp. last 2 months)
- Postprandial vomiting for last 3 weeks
- Very large distended stomach with mass obstructing proximal duodenum - endoscopist unable to stent
- Patient asks you to “fix it!”

Case Scenario - continued

What should you do next?

- 1) Tell the patient: “ It’s hopeless. There’s nothing more that can be done.”
- 2) Place a PEG for gastric decompression.
- 3) Determine the patient’s understanding of the problem. What does he mean by “fix it”?
- 4) Encourage endoscopist to reattempt stenting of the obstructed segment of duodenum.
- 5) Institute NG decompression in anticipation of performing a palliative gastrojejunostomy.

Case Scenario - continued

- What is the problem here? Is it about a series of inadequate treatment options? It's really about:
 - Communication
 - Advanced Care Planning
 - Defining the goals of care (i.e., the patient's goals) even before entering the ICU

Communicating Bad News

- Find a quiet, private place - minimize interruptions
- Make sure the timing is right for the patient (and that there is enough time)
- Give the news in person - *sit* close to the patient; avoid bad body language - don't cross legs, lean forward toward the patient (+/- comforting touch)

Communicating Bad News continued

- If possible (and if wanted by the patient), have support network present (family, friends)
- Clarify the patient's understanding of the situation - *listen* to the patient.
- Reduce the element of shock - fire a "warning shot" - e.g., "I'm afraid I have bad news!"

Communicating Bad News continued

- Tell the truth - but give the patient a chance to indicate how much s/he wants to know - don't force information on someone who is not ready for it.
- Silence is good - pause after delivering the news so that patient can absorb it and react appropriately.
- Cultural differences exist (e.g., in some cultures, family will control flow of information).

Communicating Bad News continued

- Convey hope (if not for cure, at least for relief of pain and other symptoms and for the best possible quality of life remaining)
- Reassure the patient that s/he will not be abandoned!
- (Ptacek, JT and Eberhardt, TL Breaking Bad News: A Review of the Literature, *JAMA* 276: 496-502, 1996)

Case Scenario 2

- 81 yo female with advanced, widely metastatic breast cancer refractory to therapy presents in the ED with progressive SOB and debility.
- A two year old advanced directive exists stating her desire to “live as long as I have a meaningful quality of life and heroic measures are acceptable as long as there is a chance of recovery.”

Case Scenario 2

You would next:

- 1) Invoke her advanced directive and admit her to a general care ward for “comfort measures” only.
- 2) Ask the patient, “if your heart should stop or you are unable to breathe on your own, would you want us to do everything possible to get your heart started again and keep you breathing?”
- 3) Invoke the advanced directive and admit her to the ICU for workup and potential ventilatory support.
- 4) Discuss with the patient and her family their understanding of the situation, its meaning in relation to her disease process and clarify her goals of care.

Advanced Directives

- Living Will
- Durable Power of Attorney for Health Care
- Only 28% have prepared one (The George H. Gallup International Institute, *Spiritual Beliefs and the Dying Process*, A Report of a National Survey Conducted for the Nathan Cummings Foundation and Fetzer Institute, October 1997, p. 47).

Do Advanced Directives Make a Difference?

- UNC study - patients interviewed prospectively about preferences regarding aggressive measures to sustain life and then followed for six months.
- No significant association between patient willingness to receive aggressive Rx and whether the patients actually received aggressive Rx when they were critically ill. (Davis, M, et.al. A Prospective Study of the Impact of Patient Preferences on Life-sustaining Treatment and Hospital Cost, *Crit. Care Med.* 24: 1811-1817, 1996)

The ‘D’ Word

- Death - the “D” word has to come out of the closet.
- Instead of asking: “ if your heart stops, would you want us to start it again...,” try: “when (if) you die from this illness an attempt to resuscitate your body will happen (by default). Would you want this to occur? It will not change anything but potentially be disturbing for those caring for you and your loved ones who might witness it.”

Determining the Goals of Care

- Ask the informed patient. The patient's goals of care should always be a central feature of informed consent.
- Remember the context. What is realistic under the circumstances?
- Set achievable goals with the patient (e.g., patient in 1st scenario - reduce vomiting to once/day and control nausea).

The Dilemma and the Challenge

- “... in principle, people want a peaceful, dignified, comfortable death but ... in reality, they do not want it quite yet. They prefer life-prolonging care in the hope that their peaceful, dignified, comfortable death can occur later...”

The Dilemma and the Challenge

- “...We will have an impact only when we assiduously treat the uncomfortable symptoms of all seriously ill patients, whether they are receiving life-prolonging care with its treatment-induced discomforts or only palliative care.” (Ainslie, N. Letter to the Editor, *Ann Intern Med* 127: 242, 1997)