Redundancy or Value-Added?
Ethics Consults in Hospitalized Patients with Palliative Medicine Involvement

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Background

• In many academic centers, medical teams caring for patients with serious illness have access to palliative medicine and clinical ethics consultations.
• Palliative medicine teams and clinical ethics teams both have expertise in identifying surrogate decision makers, resolving family conflict, clarifying goals of care, and mitigating moral distress amongst healthcare providers.
• Little is known about those patients who are seen by both clinical ethics and palliative medicine.
• We sought to understand what additional services, if any, are provided by clinical ethics consultations in patients who are also seen by palliative medicine during the same admission.

Methods

• We performed a retrospective chart review on all patients seen by both palliative medicine and clinical ethics during a single admission over a 2 year period (January 2016 - December 2017) at Maine Medical Center.
• Patients less than 18 years old were excluded.
• We abstracted demographic information, primary diagnosis, admitting service, level of care at time of palliative medicine consult, reason for clinical ethics and palliative medicine consultations, which consult was ordered first, number of visits by each consult services, code status, presence of advanced care planning in the chart, and discharge disposition.
• All ethics consult notes were reviewed and we abstracted verbatim recommendations. These recommendations were then analyzed using grounded theory methodology to determine the service provided by the ethics consultation.
•The ethics recommendations were coded using MAXQDA by two team members who discussed agreement/disagreement in order to reach consensus on services provided by clinical ethics.

Results

• We identified 84 patients over the age of 18 years old who received ethics and palliative medicine consultations during a single admission (Table 1).
• The median number of palliative medicine visits was three (3) and the median number of ethics visits was one (1).
• The location of the patient at the time of the palliative medicine consult was as follows:
  Intensive care unit for 35 patients (42%)
  Medical floor for 43 patients (51%)
  Emergency department for 6 patients (7%)
• A form of advanced care planning (advanced directive or POLST form) was present in the chart for 27 patients (32%).
• Use of specific language referencing legal and/or ethical recommendations were identified in consultations for 32 patients (38%).

Table 1. Baseline characteristics (N=84)

Characteristic	Number	Percent
Age Group		
<45 years	13	16
45-54 years	11	13
55-64 years	21	25
65-74 years	21	25
75+ years	18	21
Male	55	66
White	82	98
Admitting Service		
Medical/psychiatry	49	58
Surgical	35	42
Primary Diagnosis		
Trauma	20	24
Cancer	9	11
Dementia	2	2
Pulmonary disease	13	16
Cardiovascular disease	15	18
Debility	17	20
Other	8	10
Reason for Palliative Consult		
Decision making, goals of care	66	78
End-of-life issues	16	19
Pain and symptom management	2	2
Reason for Ethics Consult		
Decision making	58	69
Support	18	21
Unknown	2	2
Which Consult was Ordered First		
Palliative	50	60
Ethics	17	20
Ordered on same day	17	20
Discharge Disposition		
Home	15	18
Hospice services	14	17
SNF/Rehab	27	32
Long term care	2	2
Expired	26	31

Figure 1. Issues addressed by ethics consult

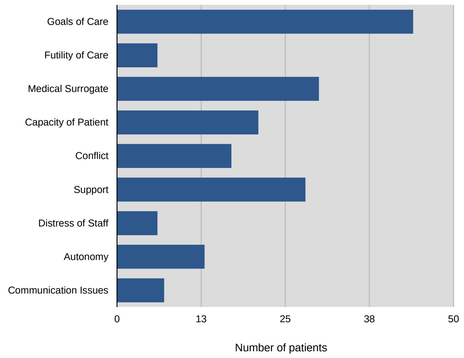


Figure 2. Specific issues relating to surrogacy addressed by ethics.

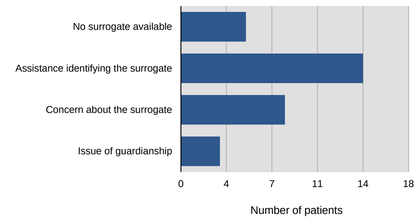


Figure 3. Specific issues relating to goals of care addressed by ethics.

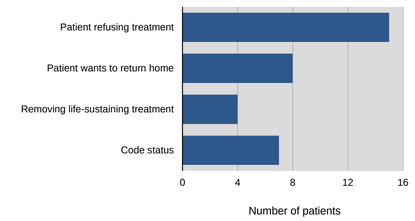


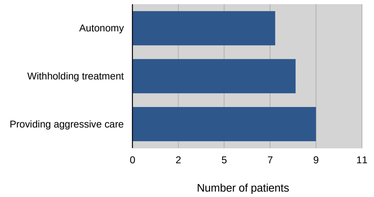
Table 2. Examples of legal and ethical recommendations.

Surrogate	In planning goals of care and treatment interventions, the general directive from (the POA) to continue aggressive treatment, should be respected. If, however, the surrogate is not reasonably available, then under Maine Law, in the absence of POA paperwork, the next person listed as next of kin should be contacted and asked to make decisions on behalf of (the patient). In the meantime, when (the POA) is unavailable to give consents, the primary team should treat the patient within the standard of care according to the plan in place.
Autonomy	Patient has capacity and has been given the most appropriate medication for pain control without withdrawal. He is choosing to be discharged and is in agreement with the plan. Discharge at this time is ethically justified according to best interests standard and patient's ability to exercise his right to autonomous decision making.
Futility / withholding care	The team discussed the patient's current interventions and possibilities to extend life in an effort to allow the wife to see him before he dies. Unfortunately, these options are limited (and) highly likely to be futile measures, meaning that they add to the suffering during the dying process without giving the patient a substantial likelihood of more time. Limiting care that carries risks and burdens, but no benefit is ethically appropriate.
Continue aggressive care	Given patient's psychiatric diagnoses and possible lack of appropriate judgment and insight into medical conditions and prognosis, it is ethically appropriate to make a presumption in favor of maintaining aggressive care, according to the standards of care at this time, especially in the absence of a surrogate decision maker. However, if (the patient's) clinical condition were to significantly deteriorate a review of goals of care would be indicated. If unable to secure an appropriate surrogate decision maker, state guardianship may need to be the next step.
Determine code status	Given that (his) decisional capacity waxes and wanes, it is difficult to determine at this time what his authentic preferences are concerning code status. For this reason it is ethically sound to make a presumption in favor of continuing (his) full code status. However, (the POA) is legally authorized to make decisions as though he were the patient himself, when the patient lacks capacity. In the event that (the POA) is adamant that (his) code status is changed to DNR, and directs the attending physician to do so, then this can be followed and is an ethically reasonable option.

Ethics consultations and the use of legal and ethical language in recommendations.

• Legal recommendations were noted in consults for 12 patients (14%) and addressed specific issues such as surrogacy.
• The use of specific language stating it is "ethically appropriate to …" was present in consult notes for 26 patients (31%) (Figure 4).

Figure 4. Common issues relating to ethical recommendations.



Conclusions

• The three most commonly identified themes of ethics consultation in cases in which there also was a palliative care consult were goals of care, medical surrogate issues, and providing support to staff, patients, and families.
• Palliative medicine consults also assist with goals of care, medical surrogate questions, and provide support.
• The frequent use of language specific to legal and ethical recommendations noted in ethics consults may be providing another layer of reassurance for medical teams.
• In most cases, the ethics consultation addressed multiple issues, suggesting a high level of complexity in this patient population. This may be one reason medical teams request involvement from both clinical ethics and palliative medicine.
• Further education about the full range of palliative medicine services may help clarify when an ethics consult will be most appropriate.
• Future research could evaluate whether or not teams would be sufficiently reassured if palliative medicine teams made explicit statements about legal and/or ethical principles in their recommendations.

Literature Cited

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