Ethics in the ICU: Are we doing the right thing?

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April 24, 2023

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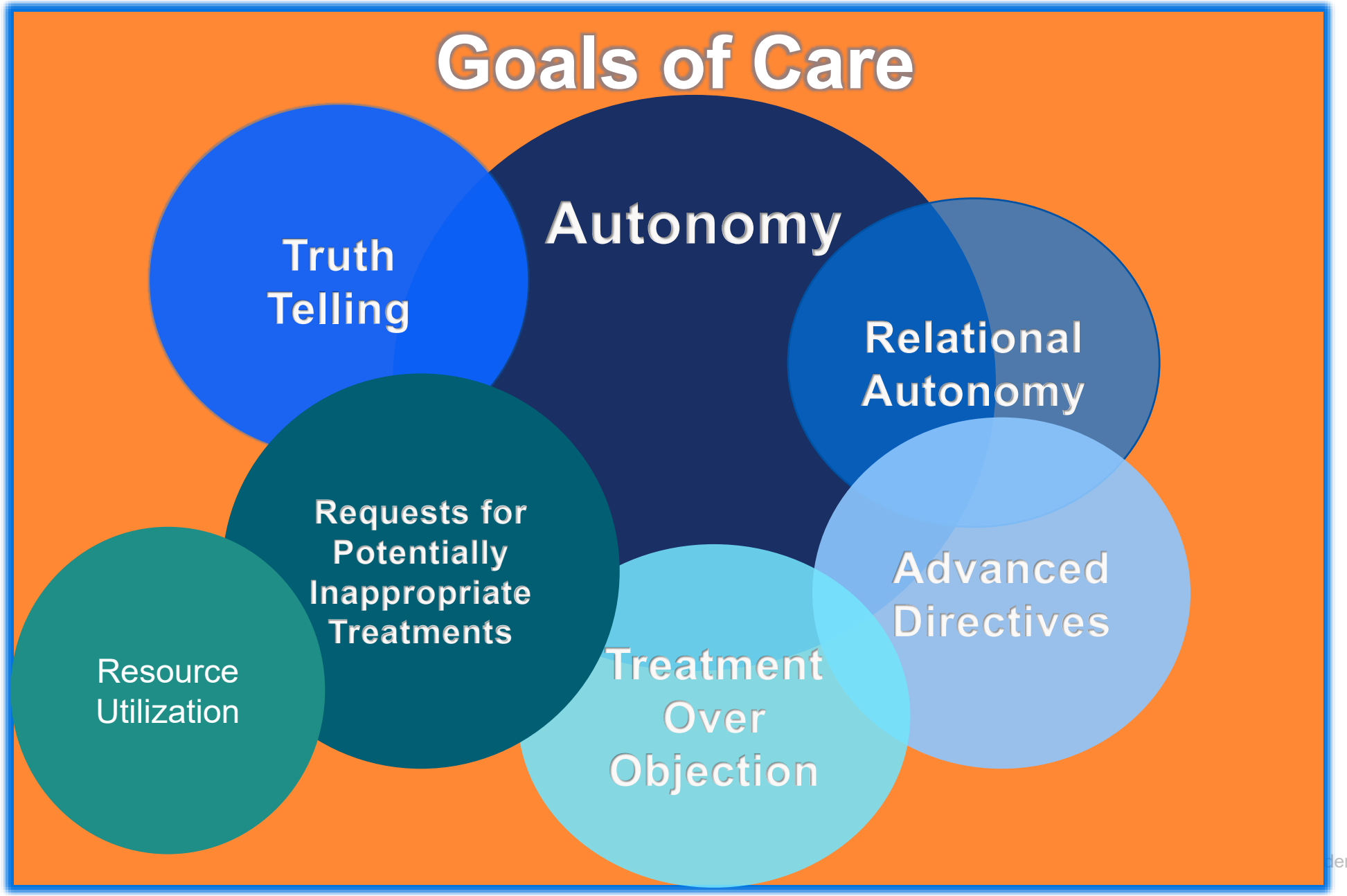
Objectives

1. Discuss common clinical ethics dilemmas confronting ICU clinicians
2. Discuss ethics principles in the context of case exemplars
3. Discuss the role of clinical ethics consultation

Relevant Terms

- ❑ Moral distress
- ❑ Moral injury
- ❑ Ethical dilemma

Common Ethical Concepts in ICU



Case #1

Harry is a 53-year-old man with metastatic colon cancer who is hospitalized for surgical management of a bowel obstruction. Post operatively he required ICU admission for intra-abdominal sepsis and multifactorial respiratory failure (infection, acute respiratory distress syndrome, possible progression of cancer). He was briefly intubated, and post extubation required high flow oxygen therapy (HFNC).

Initially post extubation, the patient had requested a DNR order be placed on his chart but did not want his wife (healthcare proxy) to know. He subsequently rescinded the DNR after a discussion with the ICU team and his wife.

Case #1

In the ensuing days, he had progressive hypoxia requiring 85-100%/50L via HFNC and non-rebreather mask with worsening dyspnea and increased work of breathing.

Additionally, he required multimodal pain and anxiety management for severe pain and anxiety further contributing to respiratory decline and delirium.

Multiple goals of care discussions were held with the patient and his wife while his clinical condition continued to deteriorate. The patient and his wife would not consent to intubation but would not consent to a DNR.

Questions:

1. What are the ethical dilemmas in this case?
2. What are the medical facts?
3. What are the concerns, values, and preferences of the clinical staff?
4. What are the concerns, values, preferences of the patient and his wife?
5. What ethical principles are at stake?
6. What practical considerations need to be addressed?

Case#2

Rosa is a 60-year-old woman with ovarian cancer who underwent debulking with total pelvic exenteration. Post operatively she was admitted to the ICU for management of acute hypoxic respiratory failure due to a multifocal pneumonia requiring 80%FIO2/50L via HFNC and paroxysmal atrial fibrillation.

In the ICU she was managed with dexmedetomidine for agitated delirium, BiPAP, and low dose vasopressor support. A repeat echo revealed acutely worsening pulmonary hypertension and right heart failure. Lower extremity dopplers in ICU were negative for DVT. She was unable to lay flat for CT scan.

On exam, she was tachypneic with RR 30s-40s, with progressively increasing work of breathing.

Case#2

Goals of care discussions held by surgery and ICU – the patient repeatedly refused intubation but wanted to remain “full code” and was amenable to intubation “if absolutely necessary.”

She declined central venous catheter placement for vasopressor therapy and arterial catheter placement.

She appointed her husband to be her healthcare agent.

Despite her worsening hypoxia, she continued to adamantly decline intubation. The family wanted “everything done.”

Questions:

1. What are the ethical dilemmas in this case?
2. What are the medical facts?
3. What are the concerns, values, and preferences of the clinical staff?
4. What are the concerns, values, preferences of the patient and her husband/family?
5. What ethical principles are at stake?
6. What practical considerations need to be addressed?

Case #2

She was ultimately intubated and immediately post intubation suffered cardiorespiratory arrest.

ROSC achieved after 3 minutes and she was maintained on dual vasopressor therapy.

Two days later, she developed 3 successive cardiac arrests requiring quadruple vasopressor therapy. The family is requesting “everything” to be done.

Case #2

1. What are the ethical dilemmas in this case?
2. What are the medical facts?
3. What are the concerns, values, and preferences of the clinical staff?
4. What are the concerns, values, preferences of the patient and her husband/family?
5. What ethical principles are at stake?
6. What practical considerations need to be addressed?

Clinical Ethics Consultation

- ❑ Bring stakeholders together to open discussions
- ❑ Help clarify patient/family values and preferences
  - ❑ protect agency
- ❑ Clarify team goals of care
  - ❑ mitigate misinformation
- ❑ Engage in benefit/burden analysis
- ❑ Mediate conflict
- ❑ Clarify normative issues
  - ❑ societal values
  - ❑ ethical standards
  - ❑ state and federal law
  - ❑ hospital policies

“Listen with curiosity. Speak with honesty. Act with integrity. The greatest problem with communication is we don’t listen to understand. We listen to reply. When we listen with curiosity, we don’t listen with the intent to reply. We listen for what’s behind the words.”

– Roy T. Bennett, author

Thank you for being a great audience!

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