

# MORAL BALANCE

- ETHICAL DECISION MAKING AT ICU ADMISSION

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FICM Professional Standards

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Midlands

Clinical Lead for Organ Donation



# THE ETHICAL CHALLENGE

- 49yr woman decompensated cirrhosis, new pneumonia, sepsis.
- 78yr co-morbid man, perforated viscus & shock
- 34yr subarachnoid heamorrhage- brain stem dead in ED?
- 22yr poorly compliant asthmatic, worsening, refusing Arterial line

# THE CHALLENGE - OPINIONS

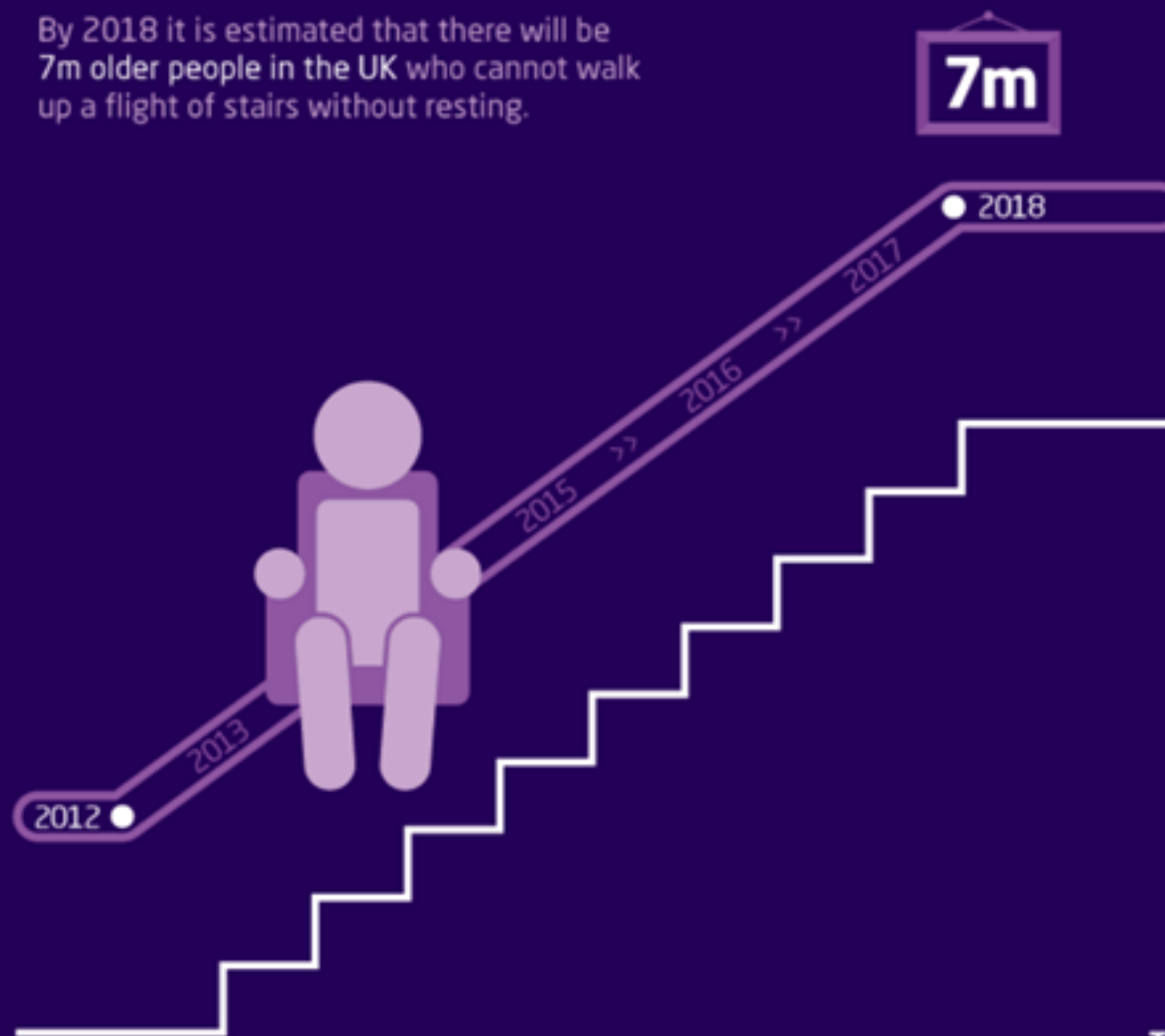
- *“For full escalation”*
- *“pneumonia & sepsis reversible, cirrhosis stable, mortality high with ICU but 100% without it - it’s unethical not to offer her that chance”*
- *“she hasn’t got capacity, it’s your decision”*
- *“I’ve talked to the family - they want us to try everything”*
- *“The outcome here is the same whether we admit or not - so I’m not admitting”*





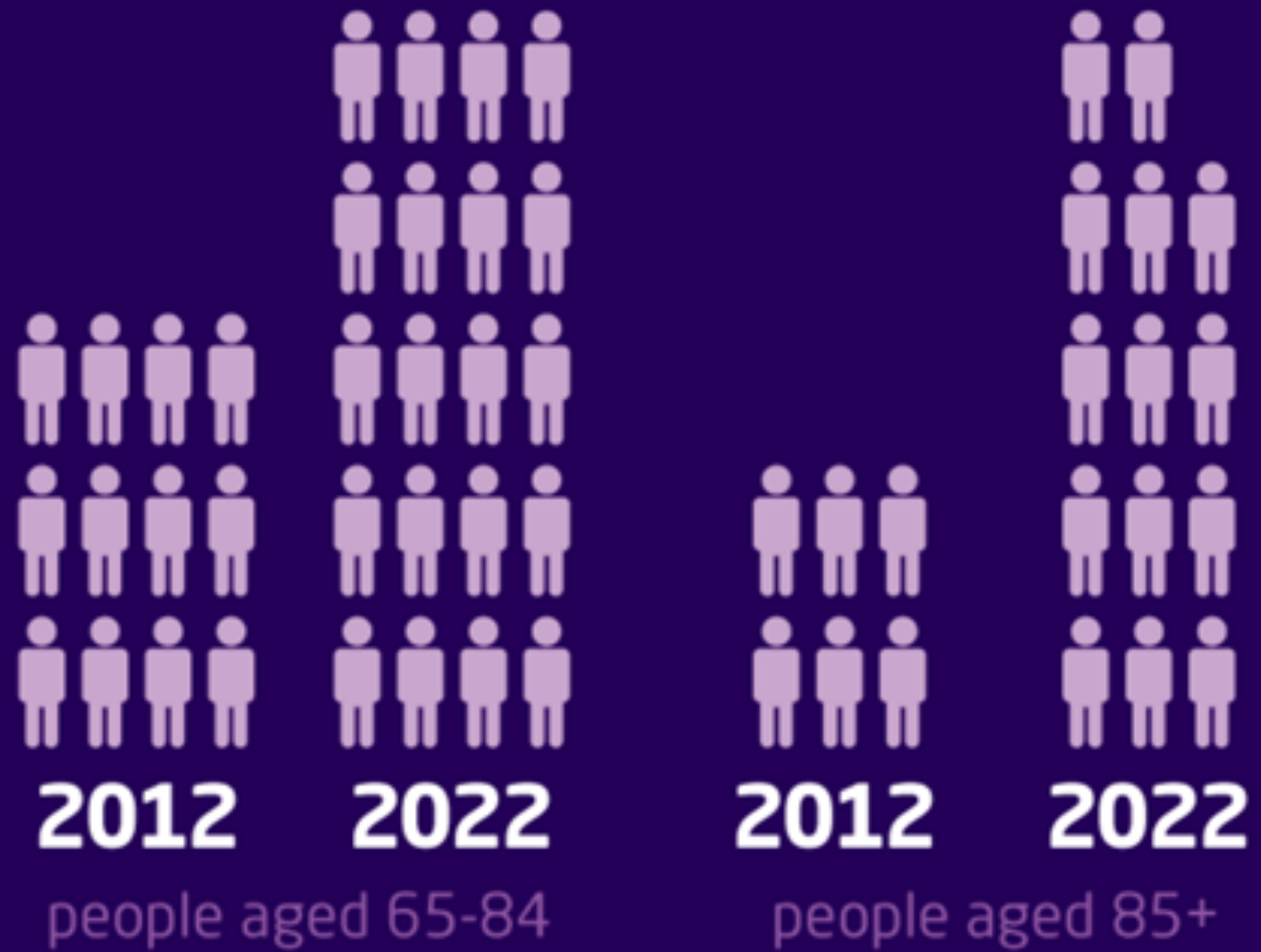
# CO-MORBIDITY

By 2018 it is estimated that there will be 7m older people in the UK who cannot walk up a flight of stairs without resting.



# MORE PATIENTS

Over the next 20 years the number of people in England aged 65-84 will grow by over a third and those over 85 will more than double.





# OBJECTIVES

Help you make good ICU admission decisions

Consider how we might measure the quality of decision making



GOOD ?

Justifiable

Reduce Stress

Patient & Family Satisfaction

Team Satisfaction

Reduce Fallout



**FALLOUT SHELTER**

# GOOD DECISIONS ?

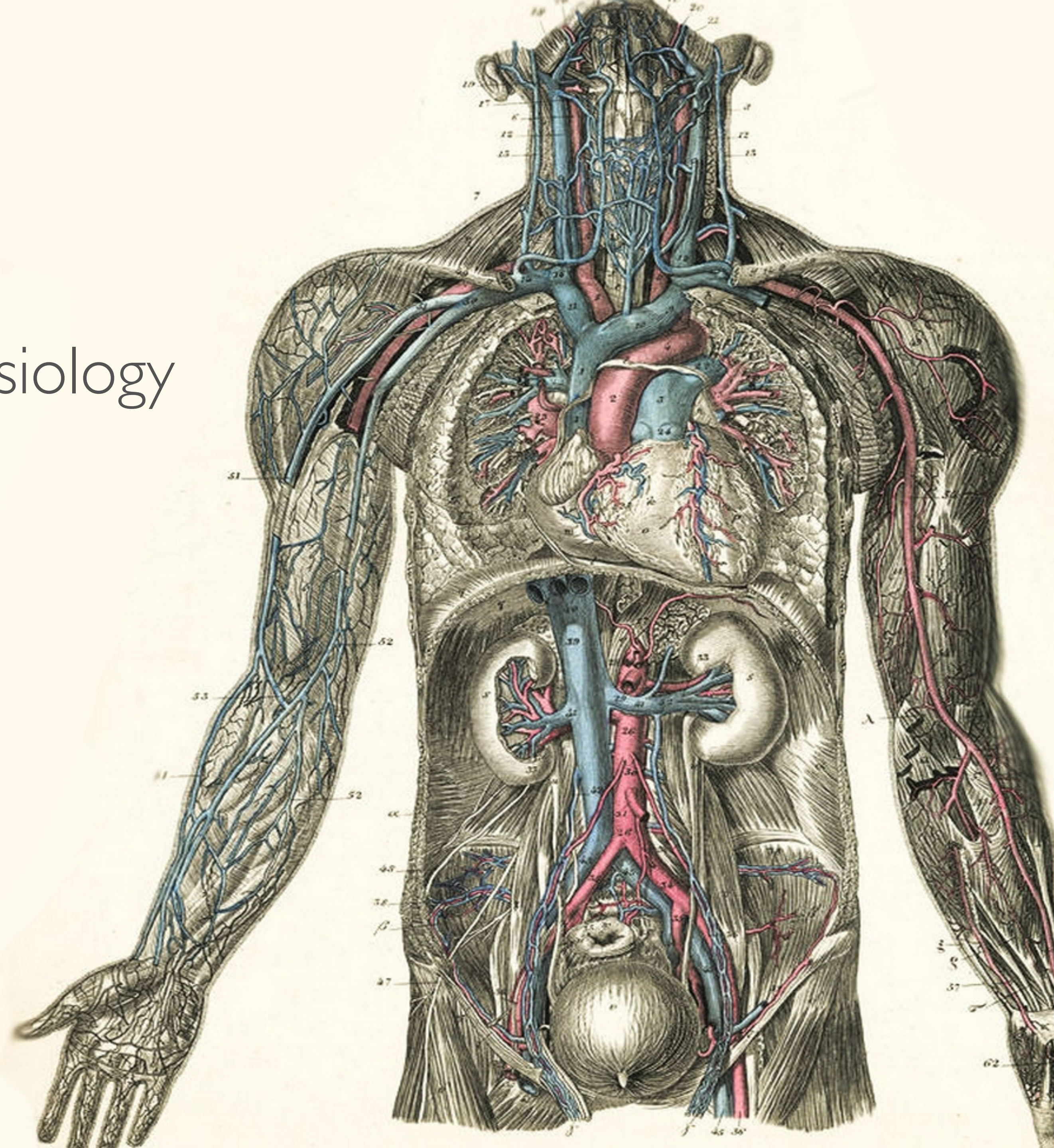
- History
- Examination
- Investigations
- Evidence & Data
- ....Ethics - just a hunch?



**Advanced** Applied Physiology

Vs

**Basic** Applied Ethics





# HEURISTICS & DEFAULTS

- Use pattern recognition or “rules” to make quick decisions
- Numerous bias / prejudices
- Not patient centred / reactive to information
- Individual = Variable =  
**(random)**



Competency

Credibility

Experience

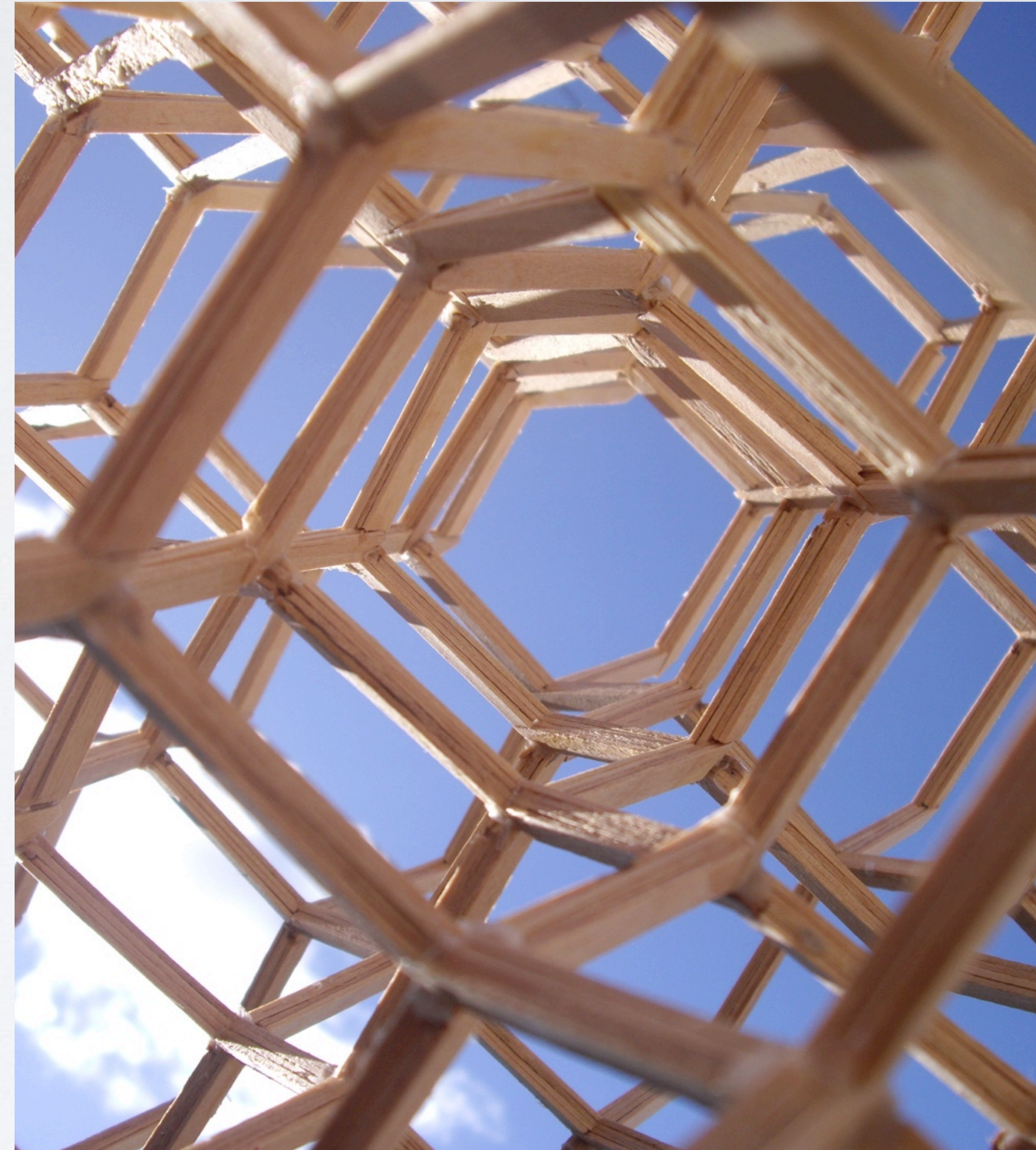
Knowledge

Skill (application)

Safety

# ETHICAL FRAMEWORKS

- Applicable
- Simple / Complex
- Quick
- Robust / Analysable
- Flexible
- Reproducible
- Not Prejudicial





Autonomy

Non-Maleficence

Beneficence

Justice



MORAL BALANCE

M  
O  
R  
A  
L

BALANCE

M

Make Sure of the Facts

O

Outcomes of...

R

Relevance to the...

A

Agents involved.....

L

Level the arguments using the.....

BALANCE BOX

# MAKE SURE OF THE FACTS

- Diagnosis
- Interventions proposed / possible
- Prognosis
- Uncertainty





# OUTCOMES OF RELEVANCE

Mortality / Morbidity

Pain & suffering

Physical & psychological

Grief /Regret

Dignity

Independence

Communication / Cognition

Resource utilisation

Metrics

Complaints & litigation

# HARMS

Communication

Cognition

Mobility

Breathlessness

Powerlessness

Hallucinations & Delirium

Fear

Dignity

Roles



# TRUE GOAL DIRECTED THERAPY

- Pain & Distress
- Communication
- Cognition
- Mobility
- Independence
- Dignity
- Fear
- Social Isolation



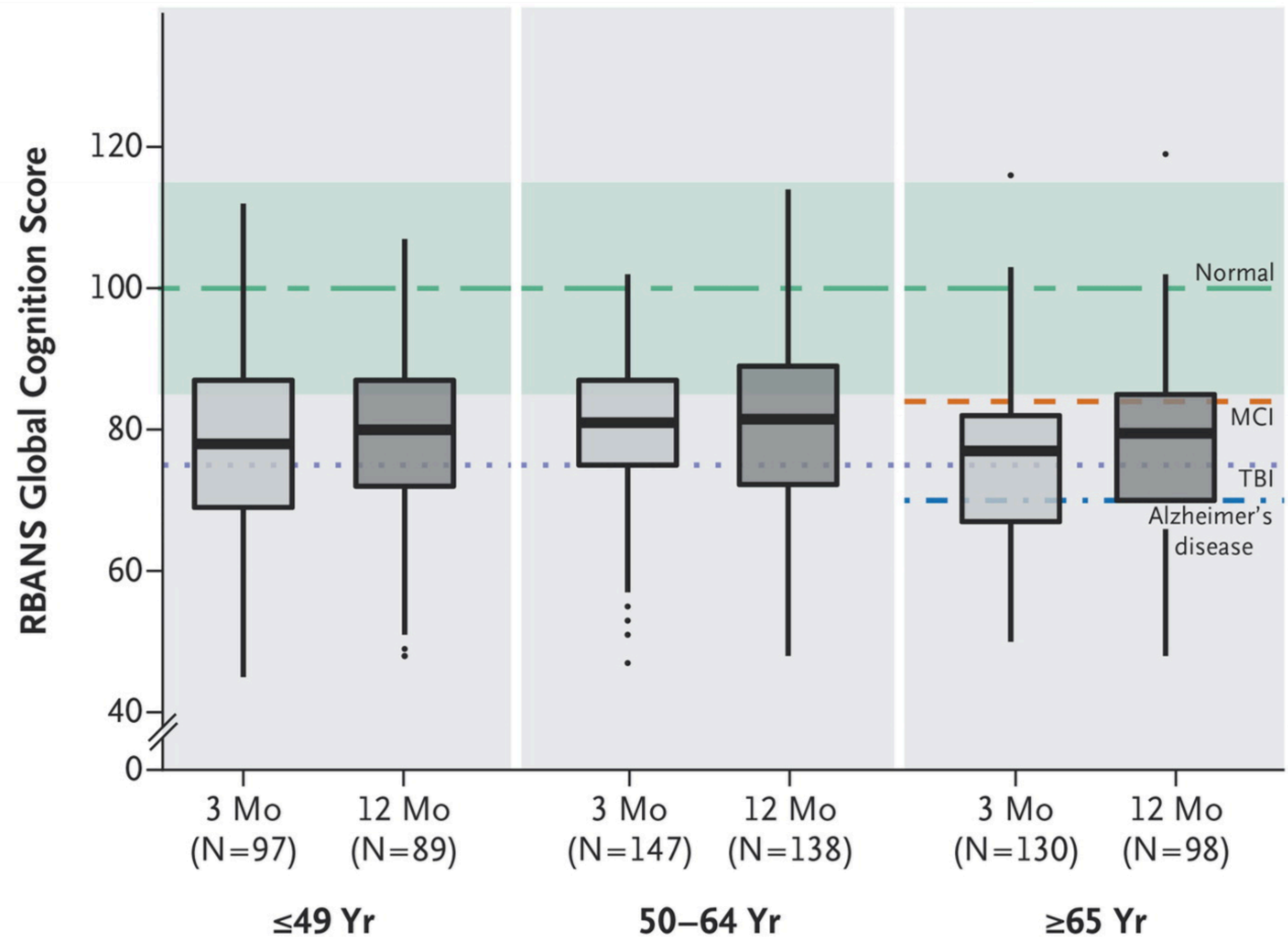




# Long-Term Cognitive Impairment after Critical Illness

P.P. Pandharipande, T.D. Girard, J.C. Jackson, A. Morandi, J.L. Thompson, B.T. Pun, N.E. Brummel, C.G. Hughes, E.E. Vasilevskis, A.K. Shintani, K.G. Moons, S.K. Geevarghese, A. Canonico, R.O. Hopkins, G.R. Bernard, R.S. Dittus, and E.W. Ely, for the BRAIN-ICU Study Investigators\*

N Engl J Med 2013; 369:1306-1316 | [October 3, 2013](#) | DOI: 10.1056/NEJMoa1301372



What can we do to help?

vs

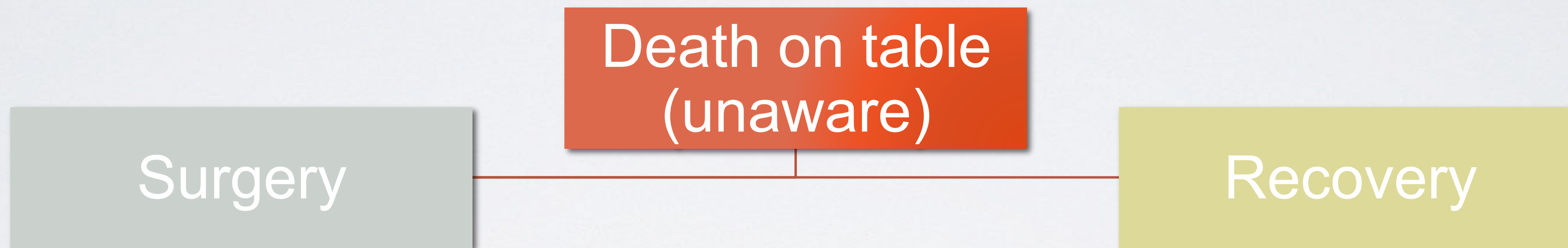
What should we do to help?

# TRAUMA REFERRAL

- 86yr woman. Fall with unstable T-spine. ? ORIF
- BG - COPD, IHD, CKD. Ex tol 20 yrds. Just managing at home with help. Mobility scooter outside home.
- In patient for 4 days. Developing HAP ?
- Capacity - partial

- “unable to mobile without surgery”
- “unable to extubate after surgery”
- “without surgery she’ll very likely die”
- “family & patient keen to give it a go - its not ethical not to give her a chance”

90 %





Recovery



Recovery



Critical illness

Complications



M

Make Sure of the Facts

O

Outcomes of...

R

Relevance to the...

A

Agents involved.....

L

Level the arguments using the.....

BALANCE BOX



# FACTS - DIAGNOSIS & OPTIONS

Have all the options been considered?

AKI

IHD / LV Function

Pneumonia

Muscle Mass

Nutritional State

Exercise tolerance

Cognitive decline?

<b>Physiology Score</b>	<b>Operative Severity Score</b>	<b>Morbidity (%)</b>	<b>Mortality (%)</b>
39	25	99.382	80.358

## Clinical Frailty Scale



**1 Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.



**2 Well** – People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.



**3 Managing Well** – People whose medical problems are well controlled, but are not regularly active beyond routine walking.



**4 Vulnerable** – While not dependent on others for daily help, often symptoms limit activities. A common complaint is being “slowed up”, and/or being tired during the day.



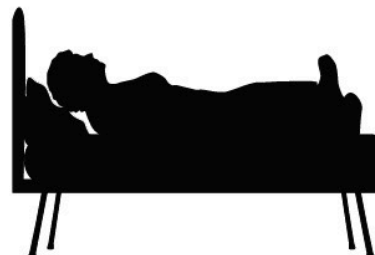
**5 Mildly Frail** – These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.



**6 Moderately Frail** – People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.



**7 Severely Frail** – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).



**8 Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.



**9 Terminally Ill** – Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.

### Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

**Table 3: Clinical outcomes, by frailty status**

Outcome	Group; no. (%) of patients*		Association, OR (95% CI) or difference in medians (p value)†
	Frail n = 138	Not frail n = 283	
Adverse event‡	54 (39.1)	83 (29.3)	1.54 (1.01–2.37)
Death			
In ICU	16 (11.6)	27 (9.5)	1.37 (0.72–2.62)
In hospital	44 (31.9)	45 (15.9)	1.81 (1.09–3.01)
Duration of stay, d, median (IQR)			
In ICU	7 (4–13)	6 (3–10)	1 d (0.02)
In hospital	30 (10–64)	18 (10–40)	12 d (0.02)
Discharge disposition§	n = 91	n = 235	
Home, living independently	20 (22.0)	104 (44.3)	0.35 (0.20–0.61)
Home, living with help	33 (36.3)	58 (24.7)	1.67 (1.00–2.81)
Other¶	38 (41.8)	73 (31.1)	1.51 (0.92–2.48)
Discharged newly dependent**	24 (70.6)	96 (51.6)	2.25 (1.03–4.89)
Hospital readmission§	51 (56.0)	92 (39.1)	1.98 (1.22–3.23)

Note: CI = confidence interval, ICU = intensive care unit, OR = odds ratio.

\*Unless stated otherwise.

†Mann–Whitney test.

‡Composite of medication errors, self-extubation/reintubation, nosocomial infection, death.

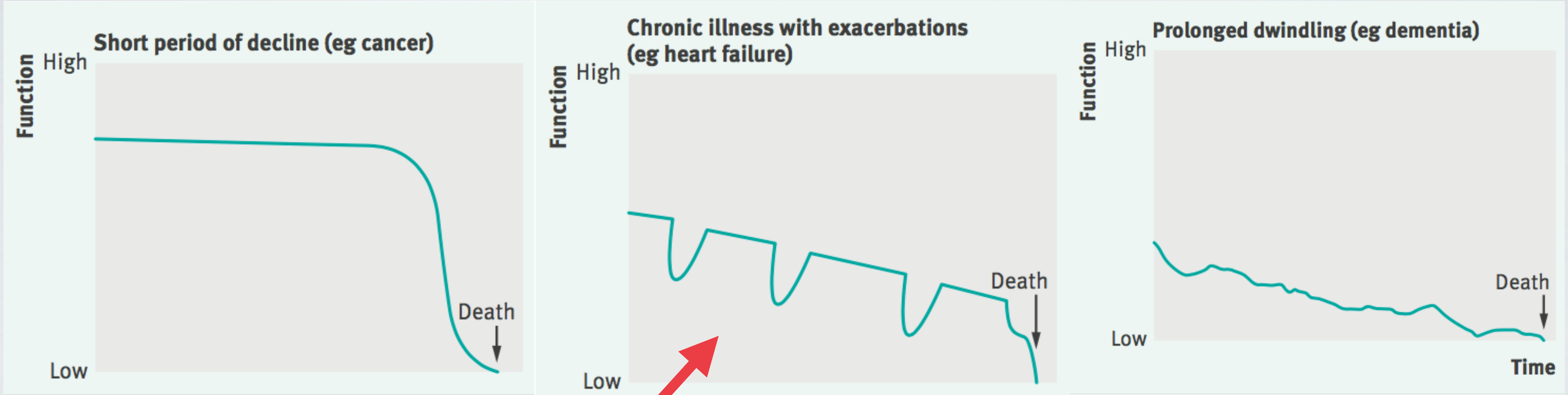
§Among 91 frail and 235 nonfrail patients for whom data on discharge disposition and on hospital readmission within 12 mo after discharge could be ascertained (data missing, n = 1 per group; in hospital at end of follow-up, n = 2 per group).

¶Continuing care facility, subacute care facility or other.

\*\*Among 34 frail and 186 nonfrail patients who were living independently at baseline.

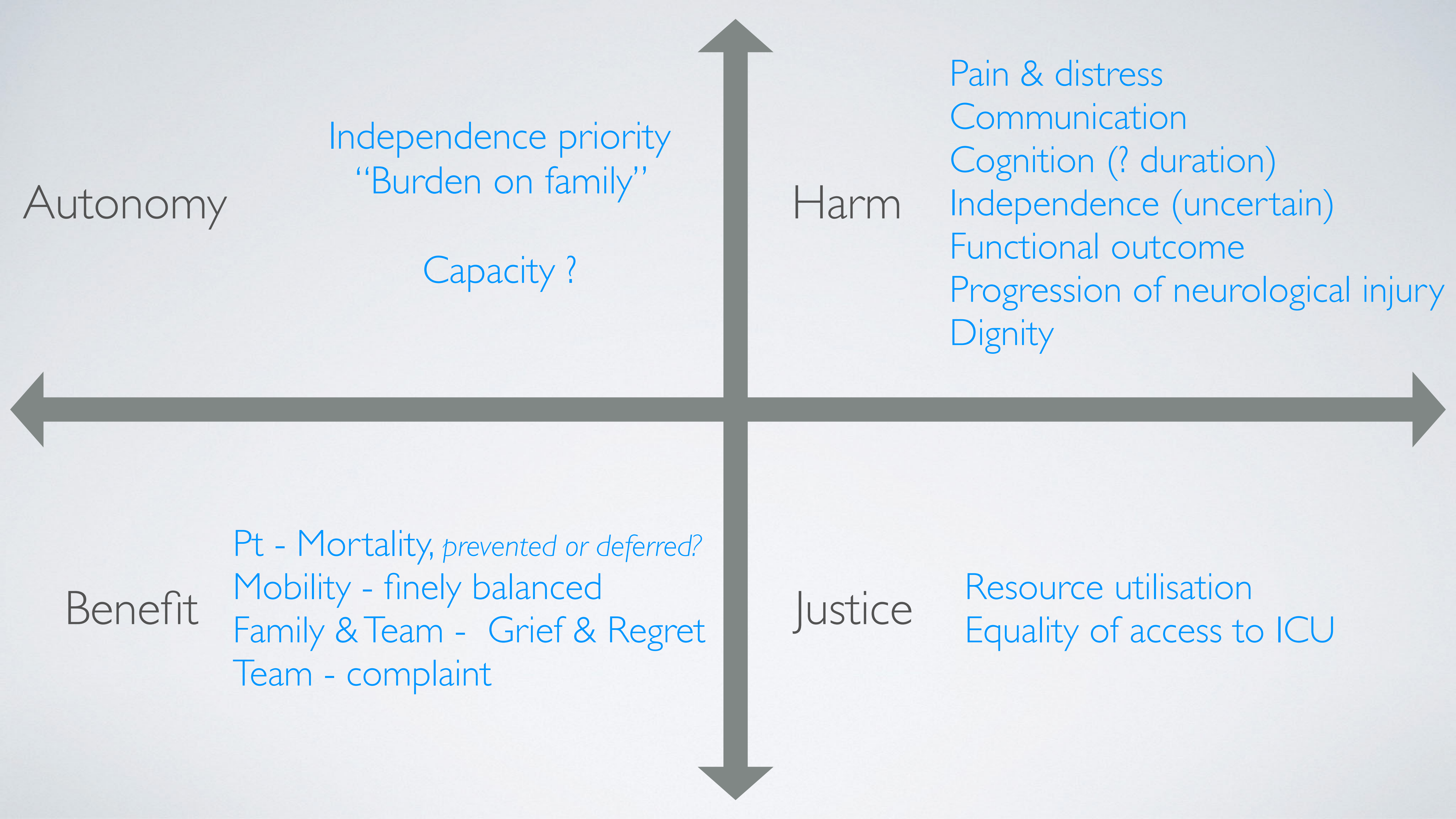
**Association between frailty and short- and long-term outcomes among critically ill patients: a multicentre prospective cohort study**

# TRAJECTORIES



# OUTCOMES OF RELEVANCE

Mortality / Morbidity  
Pain & suffering  
Physical & psychological  
Grief /Regret  
Dignity  
Independence  
Communication / Cognition  
Resource utilisation  
Metrics  
Complaints & litigation



Autonomy

Independence priority  
"Burden on family"

Capacity ?

Harm

Pain & distress  
Communication  
Cognition (? duration)  
Independence (uncertain)  
Functional outcome  
Progression of neurological injury  
Dignity

Benefit

Pt - Mortality, *prevented or deferred?*  
Mobility - finely balanced  
Family & Team - Grief & Regret  
Team - complaint

Justice

Resource utilisation  
Equality of access to ICU

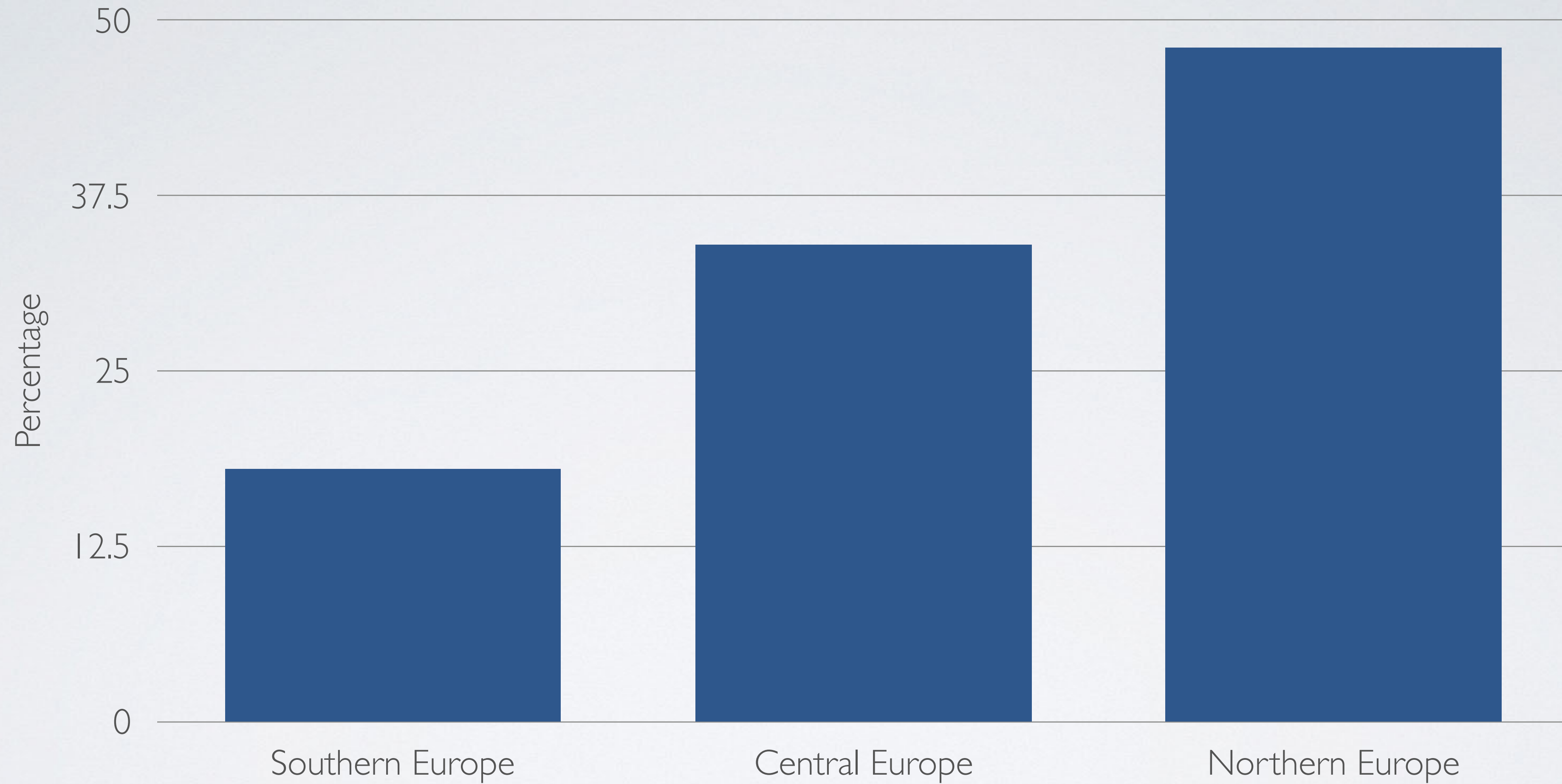
# OUTCOME

- Clarity of thought facilitates discussion with patient, family & team
- Interventions & priority of outcomes & care clarified
- Expectations & understanding set at outset

## Agreed

- Surgery will prevent attributable loss of mobility from progression of neurological injury - but loss of mobility likely to come from functional loss instead
- Mortality “benefit” finely balanced and difficult to predict
- Conservative brace offers some benefits with reduction in harms
- Progression of HAP to respiratory failure represents failure to achieve holistic goals - ICU will worsen not improve these
- DNAR at patients request

# Frequency of 'withdrawal of therapy' in ICU deaths



ETHICUS Study - JAMA. 2003;290(6):790-797



**AT THE HAEMATOLOGY MDT EVERYONE AGREES THAT MR  
JONES IS IN REMISSION, AND THAT HE SHOULD BE FOR FULL  
ESCALATION**



Autonomy

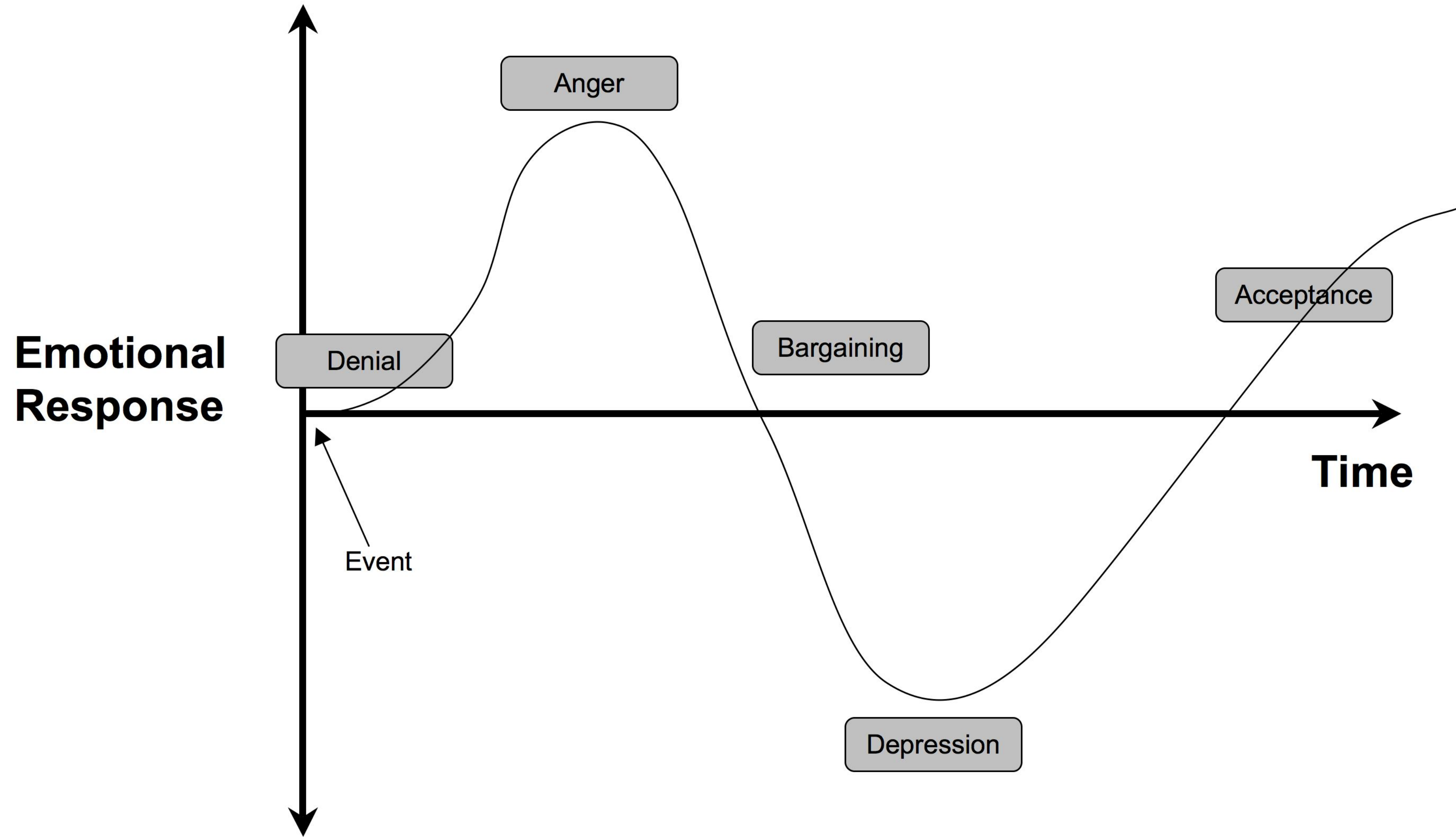
Benefit

Harm

Guilt - we should have done...  
Fear of Complaint  
Fear of Legal Redress  
Coroner  
Concern SMR / Outcome metrics

Justice

# Mr. Kubler - Ross



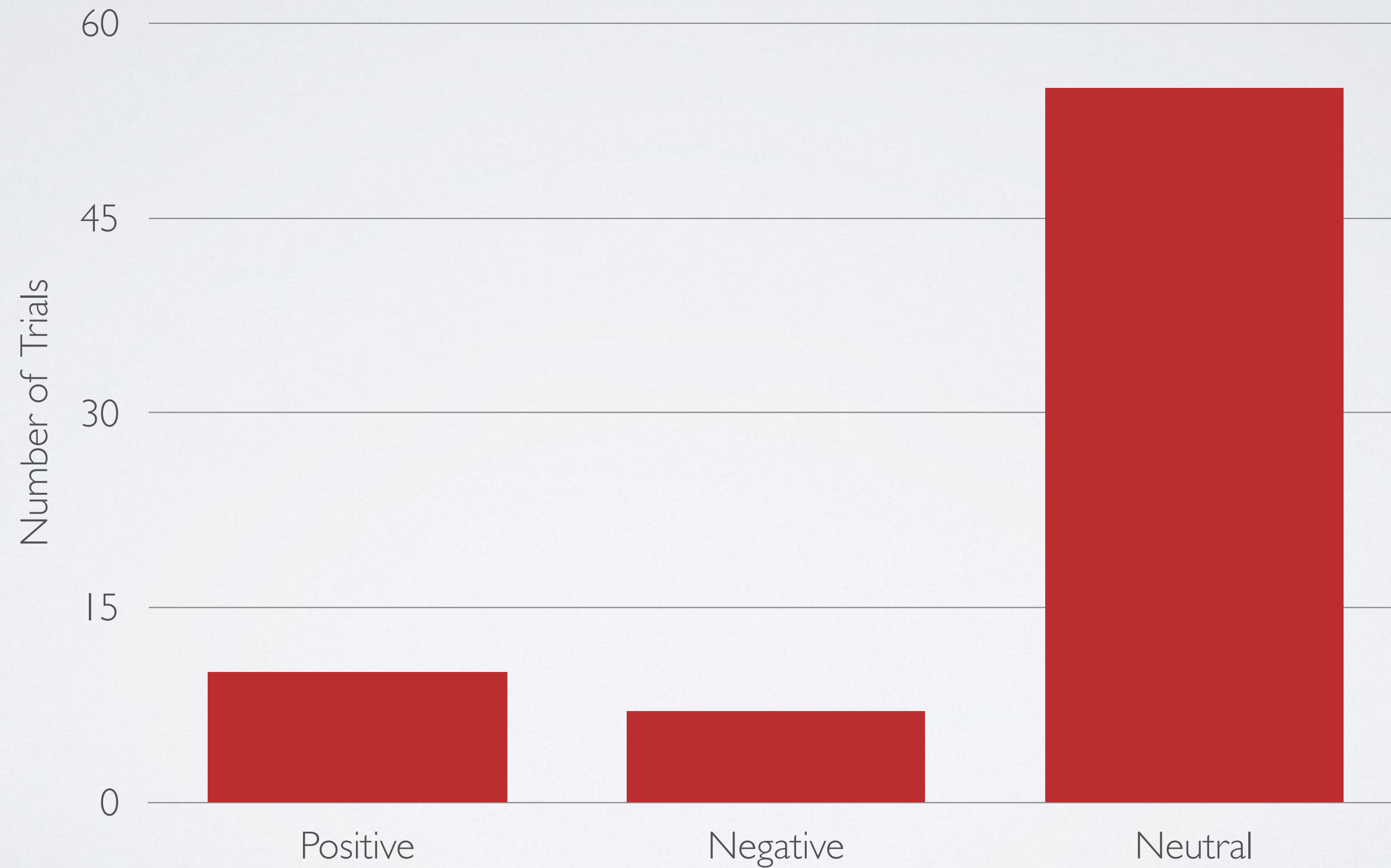


# MORTALITY

is too frequently the primary  
research outcome

# Multicenter, randomized, controlled trials evaluating mortality in intensive care: Doomed to fail?

Gustavo A. Ospina-Tascón, MD; Gustavo Luiz Büchele, MD; Jean-Louis Vincent, MD, PhD



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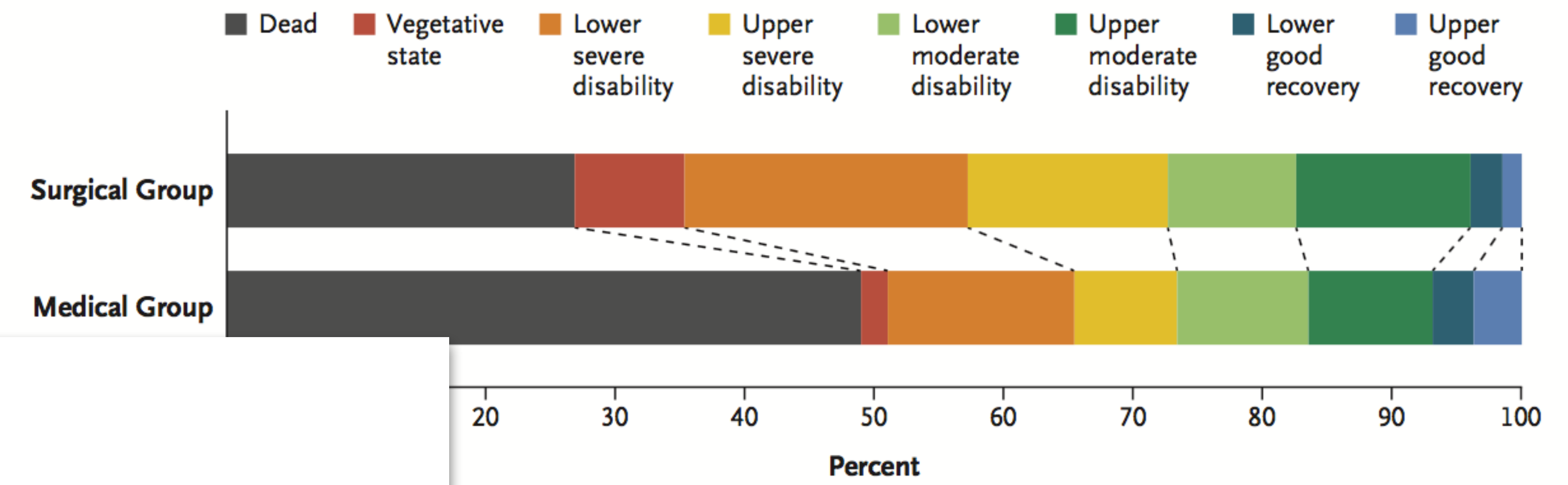
Trial of Decompressive Craniectomy for Traumatic Intracranial  
Hypertension

P.J. Hutchinson, A.G. Kolas, I.S. Timofeev, E.A. Corteen, M. Czosnyka, J. Timothy, I. Anderson, D.O. Bulters, A. Belli, C.A. Eynon, J. Wadley, A.D. Mendelow, P.M. Mitchell, M.H. Wilson, G. Critchley, J. Sahuquillo, A. Unterberg, F. Servadei, G.M. Teasdale, J.D. Pickard, D.K. Menon, G.D. Murray, and P.J. Kirkpatrick, for the RESCUEicp Trial Collaborators\*

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A GOS-E Results at 6 Mo (primary end point)

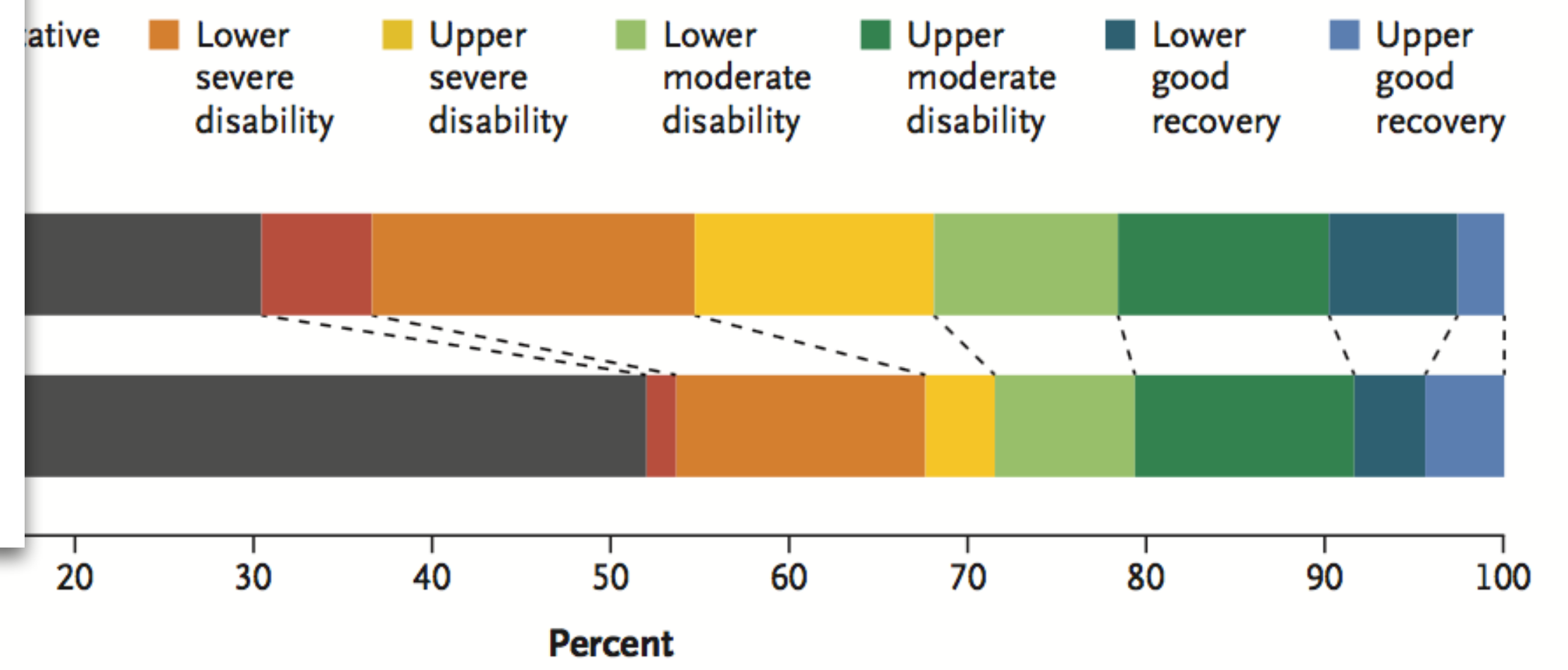


Cochrane Database of Systematic Reviews

Thrombolysis for acute ischaemic stroke (Review)

Wardlaw JM, Murray V, Berge E, del Zoppo GJ

Primary end point)



# MORTALITY

- Doesn't help us make decisions
- Often the wrong ethical outcome
- Poor research & quality outcome
- Not necessarily patient centred



# HOW TO START

- 7 Ps....Proper Planning
- MDT expertise - liaison
- Time & Place & People
- Structure
- *(Training)*





# MORAL BALANCE IN ICU ADMISSION

- Recognise it's hard
- Frameworks
- Recognise ALL the outcomes

