The Ethical Dilemma of Medical Futility: The Case of Mr. X

JoAnn Mick, RN, MSN, MBA, AOCN®, CNAA

Case Study

Mr. X is a 52-year-old Hispanic man who was admitted to the intensive care unit (ICU) for congestive heart failure. He had mitral valve disease with repair in 1999 and underwent a heart valve replacement in February 2001. Mr. X has a history of renal disease that was diagnosed in 1999 and was treated for a gastric ulcer in 2000. He also has chronic gout. He was diagnosed with multiple myeloma in 2003 and received melphalan and prednisone chemotherapy, resulting in a partial response. His medical record indicates that he had been considered for a clinical trial prior to his current illness.

Several months ago, he developed a partial paraplegia secondary to compression fracture of T5 and underwent surgery to reduce the tumor burden on his spinal cord. For the past two months, he has been treated for acute renal failure secondary to the myeloma and respiratory insufficiency related to pulmonary disease. Mr. X is currently in multiple organ failure with the following diagnoses listed in his medical record: respiratory failure, congestive heart failure secondary to chronic atrial fibrillation with recent cardiac arrest, history of mitral valve regurgitation following mitral valve replacement, cardiomyopathy, positive fluid balance, renal insufficiency, liver insufficiency, chronic anemia, superimposed pneumonia, pulmonary hypertension, underlying parenchymal pulmonary disease, gout, and gastric ulcers. Consultants from oncology, neurology, pulmonology, cardiovascular services, gastroenterology, nephrology, endocrine medicine, infectious disease, and nutrition are managing his current care.

A cardiologist at a neighboring hospital cared for Mr. X for approximately nine years prior to transferring services to the current medical facility after he was diagnosed with cancer.

Mr. X’s wife works at a nearby hospital. She has used all of her available leave time and has negotiated her work schedule with her employer to be able to briefly visit Mr. X in the ICU each morning, and then she returns to the hospital after work. Mr. X has two sons who both work and have no paid leave time. Their visits to the hospital are infrequent and brief. The nurses have been flexible with the family regarding visiting hours because of their difficulties managing work and family responsibilities.

Mr. X’s wife has commented repeatedly on her complete faith in the cardiologist who cared for her husband for many years at what she refers to as “the heart institute.” She has hinted continually that she would like his primary cardiologist to be consulted or believes that her husband should be transferred to the heart institute. She believes that his cancer is not the cause of his decline and that his problems are related to his heart condition; therefore, the cardiologist might be able to intervene as he has in the past. She acknowledges that prior to this admission, Mr. X “had not been doing well” since his discharge earlier in the year following treatment for pneumonia. She said that his activity level had decreased until he was mostly either in bed or in a chair, and he was not able to independently manage activities of daily living. She has not called the cardiologist herself to inquire about a transfer. The nurses and physicians explained to Mrs. X that her husband is currently too ill to transfer to another facility, even if the cardiologist would agree to accept his case.

The ICU physician has not disclosed that terminal weaning was mentioned, Mrs. X that he does not seem to be responding to current treatment. When the subject of withdrawing mechanical ventilation (terminal weaning) was mentioned, Mrs. X and confidence in the prior cardiologist, so the ICU physician felt uncomfortable telling her that the cardiologist refused to visit her husband and was not willing to speak about a transfer. The physician stated that he did not want to undermine a long-standing physician-family relationship; he rather would just let the cardiologist discuss his reasons for declining the case if the wife should decide to call him.

During the past week, Mr. X has been intubated and repeatedly failed attempts to be weaned from the ventilator. His condition has never stabilized, and his health status is declining rapidly. Although the physicians and nurses have kept Mrs. X completely informed of his declining health, she expresses that she “knows he would want everything done to keep him alive.” The sons defer to their mother regarding medical decisions. Mr. X did not have an advance directive. His wife acknowledges that Mr. X never directly discussed his healthcare wishes with his family or his physician, but she knows that he has “fought hard against the cancer” and that “he would not ever just give up.”

Mr. X currently is unresponsive and has towels positioned around his face to absorb the continual bleeding from his mouth. The nurses are making efforts to keep Mr. X comfortable and also have reinforced to Mrs. X that he does not seem to be responding to current treatment. When the subject of withdrawing mechanical ventilation (terminal weaning) was mentioned, Mrs. X...
pletely opposed “doing anything that might hasten his death.”

The ICU physician met with the medical team to review Mr. X’s case and then called a family conference. Mrs. X’s sons stated they could not be present at the conference because of work obligations. The healthcare team met with Mrs. X and each expressed agreement that Mr. X’s myeloma was progressive. Team members reinforced that even if the patient could be maintained through the current episode, the cancer would continue to progress, he would not physically be able to tolerate any further treatment, and he could not sustain life without the ventilator. When Mrs. X again asked about a transfer to the heart institute, the ICU physician let her know that Mr. X would not survive an attempt to transfer, that his body was basically “giving out,” and although they would continue treatments to keep Mr. X comfortable, “the outlook was just not good.” After careful negotiations, Mrs. X stated that she wanted the current treatment plan maintained but agreed that no other aggressive medication, treatments, or tests needed to be ordered, and she stated that if his body gave out she would accept it. Mr. X remained intubated, and a “do not resuscitate” order was written in his medical record. The ICU physician told Mrs. X that he would monitor Mr. X’s condition over the next 24 hours but reaffirmed that he did not expect any improvement, stating, “At this point, we feel the ventilator is only prolonging the inevitable outcome.” The physician encouraged the nurses to keep Mr. X comfortable and stated that he believed that if Mrs. X was given additional time to observe her husband’s declining condition, she might be more receptive to discussing the option of withdrawing him from the ventilator.

The following morning after being told that Mr. X’s condition had not improved, Mrs. X said that she had prayed about it and that his condition had not improved, she might be more receptive to discussing the issue. She added, “At this point, we feel the ventilator is only prolonging the inevitable outcome.” The physician encouraged the nurses to keep Mr. X comfortable. The ICU physician told Mrs. X that he would monitor Mr. X’s condition over the next 24 hours but reaffirmed that he did not expect any improvement, stating, “At this point, we feel the ventilator is only prolonging the inevitable outcome.” The physician encouraged the nurses to keep Mr. X comfortable. The ICU physician told Mrs. X that he would monitor Mr. X’s condition over the next 24 hours but reaffirmed that he did not expect any improvement, stating, “At this point, we feel the ventilator is only prolonging the inevitable outcome.” The physician encouraged the nurses to keep Mr. X comfortable. The ICU physician told Mrs. X that he would monitor Mr. X’s condition over the next 24 hours but reaffirmed that he did not expect any improvement, stating, “At this point, we feel the ventilator is only prolonging the inevitable outcome.” The physician encouraged the nurses to keep Mr. X comfortable. The ICU physician told Mrs. X that he would monitor Mr. X’s condition over the next 24 hours but reaffirmed that he did not expect any improvement, stating, “At this point, we feel the ventilator is only prolonging the inevitable outcome.” The physician encouraged the nurses to keep Mr. X comfortable.

Questions

1. An ethical conflict about medical futility occurs when
   a. A treatment is withheld because it is harmful or because the disadvantages outweigh the benefits.
   b. A physician is asked to “do everything” but believes that withdrawal of treatment would be the most appropriate measure because reasonable physiologic or qualitative goals cannot be met.
   c. A patient’s condition may deteriorate suddenly to the point of possible cardiac arrest, either as a result of disease progression or as a complication of current treatment.
   d. Awareness of patient or consumer rights and the public’s expectation of greater involvement in medical, social, and scientific affairs are increased.

2. In medical futility cases, the ethical principles that must be balanced are
   a. Nonmaleficence (do no harm) and reciprocal autonomy (cooperation in a decision or action).
   b. Utilitarianism (the greatest good for the greatest number) and principles of justice.
   c. Respect for autonomy (patient’s wishes) and beneficence (physician’s judgment of what is best for the patient).
   d. Reciprocal autonomy (cooperation in a decision or action) and principles of justice.

3. A living will advance directive is
   a. A document that allows individuals to give instructions about the medical care they want to receive in the event that they become unable to speak for themselves because of serious illness or incapacity.
   b. A document that names a person who will make healthcare decisions on behalf of the patient in the event that the patient becomes unable to speak for himself or herself because of serious illness or incapacity.
   c. A law that does not create new rights for patients but reaffirms the common-law right of self-determination as guaranteed by the Fourteenth Amendment.
   d. A law that identifies that treatments with no therapeutic or palliative purposes are medically and ethically inappropriate.

4. The role of the nurse in resolving issues of medical futility includes all of the following except
   a. Developing scientific methods to support the decision-making process and promoting an understanding of the ethical balance that underpins healthcare decisions.
   b. Facilitating a discussion of the events that are likely to occur near death and encouraging patients to make informed choices about what they would wish healthcare providers to do should they become unable to make decisions.
   c. Ensuring that adequate time, resources, and facilities are available for a thorough assessment of the patient or family’s preferences, goal expectations, and self-reported definitions of quality of life.
   d. Addressing psychosocial and spiritual issues and advising the patient and family based on personal beliefs, knowledge, and experiences.

5. The Patient Self-Determination Act
   a. Requires all healthcare agencies receiving Medicare and Medicaid reimbursement to recognize the living will and power of attorney for health care as advance directives.
   b. Is important to respect the cultural and religious backgrounds of the patient and family to maintain an active level of compassion, communication, delivery of information, counseling, and coordination of other services that may be helpful.
   c. Provides specific instructions for healthcare decisions and a medical power of attorney naming a person who will make healthcare decisions on behalf of the patient.
   d. Determines that when a consensus cannot be reached by the healthcare team and the patient or family, a review by the legal system may be pursued as a final resort to resolve conflict in an ethical dilemma.

Answers

Question 1: The correct answer is b, a physician is asked to “do everything” but believes that withdrawal of treatment would be the most appropriate measure because reasonable physiologic or qualitative goals cannot be met.

The concept of medical futility is basic to the provision of ethical medical care (Benrub, 2002). In clinical practice, controversy arises when patients or family members and physicians have differing values or goals of care (Fine & Mayo, 2003). Futility treatments are those that are almost certain to fail. Choice a, a treatment is withheld because it is harmful or because the disadvantages outweigh the benefits, is incorrect. Sometimes families confuse futility with harm. Nurses should clarify whether treatment is withheld because it is harmful, because the disadvantages outweigh the benefits, or because it is futile and simply will not work. Withholding harmful treatment has a straightforward ethical justification using the principle of nonmaleficence, to “do no harm.” Reasons for withholding futile treatments often are less clear; therefore, the decision-making process can become more complex (Kite & Wilkinson, 2002). For example, Mr. X’s prognosis was poor.
even though he was receiving treatment for specific symptoms. Choice c, a patient’s condition may deteriorate suddenly to the point of possible cardiac arrest, either as a result of disease progression or as a complication of current treatment, is incorrect. The healthcare providers were aware that his condition was failing.

Debates about futility often are viewed as an effort to provide a clear and justified borderline between healthcare providers’ and patients’ decision-making authority (Lelie & Verweij, 2003). Choice d, awareness of patient or consumer rights and the public’s expectation of greater involvement in medical, social, and scientific affairs are increased, is incorrect. The principles of beneficence and nonmaleficence sometimes are challenged by the increasing awareness of these rights and expectations. In a healthcare system in which rationing is inevitable, the concepts of utility and distributive justice easily can come into conflict with an individual’s right to autonomy. When a patient’s autonomous wishes are in conflict with the judgment and professional integrity (autonomy) of the physician and when the demand for care involves the use of costly resources, continuing futile treatment does not uphold the principle of justice. Society is not able to sustain every individual’s unlimited demands on its resources. Futile treatment is a matter of justice and accountability and requires consideration of the use of resources, the outcomes of consequences, and appropriate decision-making capabilities. The sense of justice is satisfied when accountability is present, and whenever it is absent an ethical conflict may result (Bursyska, 2001). Determining the balance between beneficence and maleficence requires an understanding of what the intervention can realistically achieve and consideration of the burdens it can impose.

The United States now has clearer guidelines on withholding and withdrawing life-prolonging treatment, resuscitation, and do-not-resuscitate policies that emphasize that the primary goal of treatment is to restore or maintain health. Justification for providing a treatment is lost when the treatment fails or when adverse effects outweigh treatment benefits. A treatment that does not provide a benefit is considered futile and therefore it may be ethically and morally withheld or withdrawn (Simonds, 2003). In considering Mr. X’s case in terms of patient autonomy and healthcare economics, the capability to sustain life created a conflict because the medical benefit was considered futile. Even when a decision has been made to forgo life-sustaining treatment, the process remains complex. Solutions usually are achieved by continued evaluation of a patient’s status and reinforcement of the low probability of being able to achieve the patient’s goals with technology. Establishing an understanding between patients and/or their families and the healthcare team regarding appropriate medical treatment often is dependent on trust (Low & Kaufman, 1999). In Mr. X’s case, the ICU physician was not willing to jeopardize Mrs. X’s trust in the prior cardiologist by informing her that he had refused an offer to visit the patient on consult. Although a member of the healthcare team suggested that informing the family that a trusted provider has nothing more to offer might reinforce the reality of the situation, the ICU physician maintained his position. He believed that creating mistrust with a prior physician might translate to potential issues of trust with the current physicians involved in Mr. X’s care. He also stated his personal belief that the cardiologist had a professional responsibility for a final visit with Mr. and Mrs. X. He acknowledged that he did not want to tell Mrs. X that someone she regarded so highly was unwilling to visit her or her husband to personally deliver this information. Although not everyone on the healthcare team agreed with the ICU physician’s belief, all agreed to support his decision.

The basic principles of medical ethics are embodied in beneficence, nonmaleficence, autonomy, and justice, and these principles can guide primary care physicians as they manage the care of dying patients (Rousseau, 2001). When considering interventions that have limited clinical utility, effective decision making may be accomplished by evaluating the potential medical benefits of the intervention based on scientific evidence in similar cases, any potential nonmedical benefits of the intervention, the patient and family’s preferences, and the avoidance of value judgments about quality of life or consideration of a patient’s worthiness to receive a particular intervention. In addition, the potential risks of the intervention, including adverse or suboptimal outcomes, must be evaluated. Intervention and treatment decisions must be based on the expected risks and benefits to the patient, family, and society (Marco & Larkin, 2000).

In critically ill patient cases, the various subspecialists that are consulting often see a benefit to some organ system with the kind of therapy they can provide. The healthcare team consultation meeting held prior to the family conference regarding Mr. X’s status provided the opportunity for healthcare team members and family members to agree that Mr. X was dying. Even if more treatment was attempted for his individual systems, death was the expected outcome for Mr. X. An important counterbalance in such a complicated case is simply the recognition that at some point every person will die. The tension between the use and nonuse of technology must be serious and equal. Therefore, the aim of good critical care medicine should be to establish a meaningful tension between the aim of preserving life and making a peaceful death possible (Callahan, 2003).

**Question 2:** The correct answer is c, respect for autonomy (patient’s wishes) and beneficence (physician’s judgment of what is best for the patient). In medical futility cases, the ethical principles that must be balanced are patients’ wishes and physicians’ judgment of what is best for patients (Bursyska, 2001). Every U.S. state has developed legal rules to address end-of-life decision making, but the prevailing thought expressed in the literature is that no law to date has effectively dealt with medical futility (Fine & Mayo, 2003). The concept of “medical futility” is present in ancient Hippocratic writings, which identified medical goals of “cure, relief of suffering, and refusal to treat those who are overmastered by their diseases” (Schneiderman, Jecker, & Jonsen, 1996, p. 673). Through the years, the legal debate regarding medical futility has occurred in court. The Baby Doe case (Ascension Health, 2005a) engaged the public and professionals on the issues of what treatment should be provided for seriously ill or disabled newborns and whether their parents should be allowed to decide when treatment should not be provided. The concerns focused on a family’s decision, supported by healthcare providers, to provide too little technologic support for a patient. In the Wanglie case (Ascension Health, 2005c), physicians recommended that life support for a severely brain-injured patient could be discontinued because it was medically futile. In the Baby K case (Ascension Health, 2005b), physicians and ethics committees argued that providing certain treatments such as mechanical ventilation to an anencephalic newborn could serve no therapeutic or palliative purposes and therefore was medically and ethically inappropriate. In these cases, the courts determined that families could judge the appropriateness of continuing or stopping treatment that physicians or ethics committees consider medically futile. In the case of Gilgunn versus Massachusetts General Hospital (Sisters of Charity of Leavenworth Health System, 1995), a court found that providing cardiopulmonary resuscitation to a dying patient with multiple organ system failure was not necessary, even if demanded by the patient’s family.
In 1999, the American Medical Association (AMA) Council on Ethical and Judicial Affairs published guidelines on medical futility, recommending a process-based counseling approach to resolve futility disputes. When disagreements could not be resolved, the council recommended that healthcare providers should attempt to transfer the patient’s care to another physician. The council determined that when no resolution could be achieved and transfer to a willing provider could not be arranged, discontinuing a medically futile treatment was medically ethical. Often, even when ethics committees agree that treatment is futile, treating physicians are unwilling to withdraw life-sustaining treatment because of a potential lawsuit if the family disagrees with the decision (Fine & Mayo, 2003).

The law claims to articulate the societal consensus of what is best for the patient within a broader context of the society by protecting the rights of both the individual and others. Choices a, nonmalefianence (do no harm) and reciprocal autonomy (co-operation in a decision or action), and b, utilitarianism (the greatest good for the greatest number) and principles of justice, are incorrect. In the United States, patient autonomy usually overrides physician beneficence except when the law clearly dictates otherwise.

The AMA Council on Ethical and Judicial Affairs has recognized that the social commitment of the physician is to sustain life and relieve suffering and when the performance of one duty conflicts with the other, the patient’s choice should prevail (Henig, Faul, & Raffin, 2001). In economics, the appropriate allocation of resources is an important consideration when making decisions regarding invasive, costly, or lengthy procedures. Some of the literature supports that, when resources are limited, physicians are ethically justified to limit access to treatments that are expensive and offer minimal benefit and that preventing use of those treatments is socially responsible (Marco & Larkin, 2000).

In the case of Mr. X, physicians, staff, and hospital administration are ethically obliged to engage Mrs. X in a respectful, informed, and candid dialogue. Understanding that Mrs. X’s convictions, decisions, and actions are based on her values and what she perceives as reality in her husband’s medical condition can allow discussion with reasonable examination and evaluation of her decisions. A claim made based on these considerations is worthy of, and subject to, public, reasoned, and respectful discussion. However, acknowledgment of her viewpoint does not mean that her claim is absolute.

Healthcare providers can recognize that Mrs. X’s decision to continue with maximum treatment to “do everything possible” lacks ethical strength because it does not acknowledge any limits to the obligations that society has to Mr. X in view of his poor clinical prognosis (distributive justice). A claim based on exercise of negative rights only is easier to defend than a claim in which positive rights are invoked. Exercise of positive rights often is found in conflict with choice d, a reciprocal autonomy (cooperation in a decision or action) and principles of justice, which is incorrect (Burycka, 2001). In Mr. X’s case, Mrs. X attempted to invoke positive rights that were in conflict with the ICU physician’s decisions. Consideration of the risk and benefit ratio of interventions can be applied in critical care settings, as illustrated in Mr. X’s case, including evaluation of interventions such as advanced airway management, invasive monitoring, cardiopulmonary resuscitation, or other critical care interventions (Marco & Larkin, 2000). The initial primary goal of Mr. X’s critical care interventions was to restore life and health, and the awareness to alter this goal at an appropriate time to balance technology and quality of life was essential.

Question 3: The correct response is a, a document that allows individuals to give instructions about the medical care they want to receive in the event that they become unable to speak for themselves because of serious illness or incapacity.

Discussions about a patient’s wishes should take place during the initial conversations about the treatment plan. Discussion of the diagnosis and proposed treatment options takes place so that patients can make informed decisions about what they want done. Raising the issue of what a patient would like done in the event that treatment is not successful is an appropriate consideration when deciding the treatment plan. For example, when Mr. X was deciding about receiving chemotherapy, treatment of complications, such as neutropenic sepsis, was discussed. Discussion of his wishes if the treatment was unsuccessful would have provided the opportunity to discuss cardiopulmonary resuscitation, advance directive, or durable power of attorney at a time when it was considered an appropriate option. An advance directive is a legal document. The two basic types of advance directives are living wills and medical powers of attorney. An advance directive allows individuals to give instructions about the medical care they want to receive in the event that they become unable to speak for themselves because of serious illness or incapacity. A living will provides specific instructions for healthcare decisions. Choice b, a document that names a person who will make healthcare decisions on behalf of the patient in the event that the patient becomes unable to speak for himself or herself because of serious illness or incapacity, describes a medical power of attorney and is therefore incorrect (Partnership for Caring, 2003). Effective care planning in advance can ensure patient autonomy at the end of life, even when decision-making capacity is lost. As Mr. X’s disease progressed, the opportunity to discuss changing aims of treatment involving quality-of-life issues and future expectations could have been used to facilitate Mr. and Mrs. X’s understanding and acceptance of a do-not-resuscitate order as the time became appropriate.

Nurses must inform patients that having an end-of-life conversation with a healthcare provider can be an opportunity for ensuring their wishes are recorded. In that way, information is available in the event physicians or family members need to make medical decisions. Patients should be encouraged to discuss their wishes with their family members and let them know that their wishes have been recorded in their medical record. This will assist with the family members’ understanding that the patient has participated in the end-of-life plan of care. Having the patient’s wishes documented also will allow the physician to confidently assure the family that the agreed-upon plan of care is being administered. Having an end-of-life care discussion while the patient is well may eliminate the stress of last-minute family decision making and other problems that can occur when the subject is avoided.

Choices c, a law that does not create new rights for patients but reaffirms the common-law right of self-determination as guaranteed by the Fourteenth Amendment, and d, a law that identified that treatments with no therapeutic or palliative purposes are medically and ethically inappropriate, are incorrect because they refer to a law. A living will advance directive is a document supported by laws associated with the Patient Self-Determination Act, as guaranteed by the Fourteenth Amendment.

Question 4: The correct response is d, addressing psychosocial and spiritual issues and advising the patient and family based on personal beliefs, knowledge, and experiences.

Advances in medical technology during the past several decades have altered the scenarios of dying by making it possible to prolong life and delay death. Continuing advances in technology, science, and
professional care will raise new ethical, economic, and legislative dilemmas. Choice a, developing scientific methods to support the decision-making process and promoting an understanding of the ethical balance that underpins healthcare decisions, is incorrect because this describes a role of nurses (Stroud, 2002).

During consideration of appropriate limits on life-sustaining technology, healthcare providers must maintain a focus on relief of symptoms, preparation for death, achieving a sense of completion, and ensuring delivery of holistic care (Schneiderman et al., 2003). Choice b, facilitating a discussion of the events that are likely to occur near death and encouraging patients to make informed choices about what they would wish healthcare providers to do should they become unable to make decisions, is incorrect. Nurses have a role in initiating these discussions. Formulating an advance care plan with the patient and healthcare team can explore sensitive issues of withholding and withdrawing life-prolonging treatments (Shah & Lloyd-Williams, 2003). Terminal weaning is one of the procedures limiting life-support therapy and represents an important consideration of discontinuing life-sustaining therapies in terminal, critically ill patients. Sedatives and analgesics are given frequently during this process to allow a humane form of ventilator withdrawal. Employing terminal weaning when a situation is determined to be medically futile has a medical, ethical, and legal basis (Parizkova, Cerny, & Dostal, 2003).

Nurses perform assessments and collect clinically relevant information that can assist with the determination of whether a patient is dying. Nurses communicate with patients and family or caregiver decision makers concerning patients’ diagnoses and prognoses. Nurses can advocate the importance of understanding patient preferences regarding end-of-life decisions and care. Nursing practice provides the opportunity to promote use of available resources, such as advance directives and/or designation of a surrogate decision maker or power of attorney in case of patient incapacity; address psychosocial and spiritual issues; determine the goals of care for the patient, including the possibility of home hospice; review the symptoms experienced by the patient; document nursing interventions and their outcomes; and identify the indications for consultations with palliative care, psychiatric, pastoral care, social work, ethics, patient representative, or other services (Fins et al., 1999).

Healthcare professionals have an ethical obligation to keep up to date with evidence-based practice so that their decisions are supported by the most accurate information available. When expertise and experience are lacking, or when providers disagree with each other or families regarding the plan of care, consultation of peer or committee expertise is advised. When providers have reasonable doubt about the potential for benefit, nurses and physicians can support that a treatment will be provided for a pre-agreed time period and will be reviewed at the end of that period to determine how to proceed. Choice c, ensuring that adequate time, resources, and facilities are available for a thorough assessment of the patient or family’s preferences, goal expectations, and self-reported definitions of quality of life, is incorrect. Nurses need to ensure that this is accomplished before a decision to withdraw or withhold treatment can be made. They also need to maintain an awareness of their individual values and understand the importance of remaining open minded with a goal to reach consensus among healthcare providers, the patient, and the family or caregivers. Patients should not be advised based on nurses’ personal beliefs.

When a nurse’s viewpoint is challenged or a conflict arises, a second opinion or independent ethics consultation is advised. When the healthcare team and the patient and family cannot reach consensus, a review by the legal system may be pursued as a final resort to resolve conflict in an ethical dilemma (Simonds, 2003). Nurses need to acknowledge that some patients are willing to undergo burdensome treatments with a high probability of adverse outcomes in an attempt to restore health. Patients or their family members may benefit from another few days of staying in the ICU to be able to understand the prognosis more clearly (Schneiderman et al., 2003). Less tangible benefits of continued resuscitative efforts should be considered, such as offering time for possible resolution of guilt for family members, acknowledging the comforting significance of the value of technology and the social importance of allowing family members time to arrive and say farewell, as well providing additional time for potential healing through a process of acceptance of bad news regarding the expected outcome (Marco & Larkin, 2000).

The uncertainty of prognosis for acutely ill patients of advanced age with progressive, terminal conditions may involve a mixed management strategy consisting of life-prolonging and palliative measures. Nurses have a role in addressing issues, including a lack of clarity or ambivalence about the goals of care; adherence to established routines of hospital practice that are not logical in an individual case; concerns expressed by the patient, family, or other healthcare providers about “doing nothing”; or inappropriate therapeutic decisions to maintain treatment to preserve life without assessing risk or harm (Fins et al., 1999).

**Question 5:** The correct response is a, requires all healthcare agencies receiving Medicare and Medicaid reimbursement to recognize the living will and power of attorney for healthcare as advance directives. Nurses must understand that patients’ background and biases can influence the nursing care provided to them. Choice b, is important to respect the cultural and religious backgrounds of the patient and family to maintain an active level of compassion, communication, delivery of information, counseling, and coordination of other services that may be helpful, is incorrect (Nyman & Sprung, 2000). Nursing provides the opportunity to practice with compassion and respect, to advocate for patients, to be accountable, and make a contribution to the profession. Nurses can discuss the Patient Self-Determination Act and advance directives. The act, passed in 1990 and instituted on December 1, 1991, encourages patients to make choices and decisions about the types and extent of medical care they want should they become unable to make decisions in the future. The act requires all healthcare agencies receiving Medicare and Medicaid reimbursement to recognize the living will and power of attorney for health care as advance directives. Choice c, provides specific instructions for healthcare decisions and a medical power of attorney naming a person who will make healthcare decisions on behalf of the patient, is incorrect. A power of attorney is a document that allows patients to identify the person who they grant the authority to act on their behalf on specified matters. The power of attorney can be specific to a certain task or broad to cover many duties. It can be authorized to start immediately or after a determined event, such as mental incapacity (Law Depot, 2005). The act reaffirms the common-law right of self-determination as guaranteed by the Fourteenth Amendment. Under the act, healthcare agencies must ask patients if they have advance directives and must provide educational materials about a patient’s right to have one (American Cancer Society, 2003). Advance directives allow for respect of patients’ autonomy by supporting patients’ rights to make decisions about their care. Advance directives for all states can be located on the National Hospice and Palliative Care Organization Web site (www.caringinfo.org). Choice d, determines that when a consensus cannot be reached by the healthcare team and the patient or family, a
review by the legal system may be pursued as a final resort to resolve conflict in an ethical dilemma, is incorrect because it does not refer to the Self-Determination Act. It refers to AMA's guidelines on medical futility.

A medical futility case creates a challenge to resolve opposing views of patients, families, and healthcare providers regarding the plan of care. A process-based approach allows for an opportunity to resolve the dispute and balance the use of technology in promoting life and delaying death. When consensus cannot be reached, a review by the legal system may be pursued to resolve the ethical conflict. In the case of Mr. X, the situation was managed appropriately to allow Mrs. X to reach a stage of acceptance of the futility of continuing medical treatment; therefore, the ethical dilemma in Mr. X's case was resolved effectively.

Author Contact: JoAnn Mick, RN, MSN, MBA, AOCN®, CNAA, can be reached at jmick@mdanderson.org, with copy to editor at CJONeditor@jsobel.com.

References

sitearea=MIT


