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Clinical Ethics Grande Rounds

The Ethics of Withdrawing Life-Sustaining Treatment: When Is It Permissible, Recommended or Obligatory?

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Cases

- Mrs. R is an 81yr old who is admitted to medicine from long term care with a diagnosis of aspiration pneumonia. She has a 3yr diagnosis of advanced dementia and has become non-verbal. This is the third admission in 9 months for a total of 129 bed days. Her GOC is R1 and a third feeding assessment confirms an unsafe swallow. Family is insisting on NG feeds after GI has refused PEG placement.

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Cases

- Mr. Bell is a 65yr old who suffered a cardiac arrest in his garage. He was undiscovered for an unknown period of time and was transported to GNH emerg where he was intubated without sedation. EMS recovered pulse 15 minutes into transport. After transport to MAHI and emergency catheterization, Mr. Bell transferred to CCU fully intubated, ventilated, and unconscious. His GCS has not improved from single digits in 26 days and his CT and MRI are consistent with diagnosis of massive global ischemic injury.

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Cases

- Jim K is a 14yr old male who has an aggressive glioblastoma that has been resected twice and is further inoperable. After the second recurrence, his family is devastated. Jim has limited verbal capacity and his cognition is severely impaired. He has been given 6 months to live. His parents request further chemotherapy which team is reluctant to provide as there is not evidence that it will cure his cancer and will have severe side-effects particularly nausea and vomiting.

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The continuum of clinical decisions

Unacceptable to Refuse Reasonable to Accept or Refuse Unacceptable to Demand/Offer

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Withholding and Withdrawing

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Withholding and Withdrawing

Current issues:

- Lack of clarity surrounding ultimate decision-making powers

Alberta Health Services logo and "7" in a red circle.

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Withholding and Withdrawing

Current issues:

- Lack of clarity surrounding ultimate decision-making powers
- Variability in clinical practice

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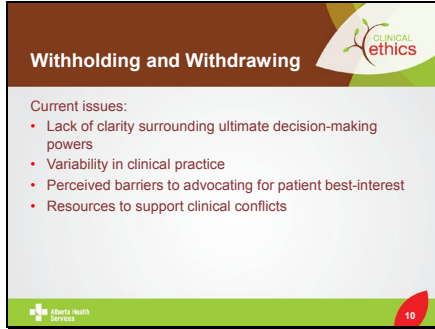
Withholding and Withdrawing

Current issues:

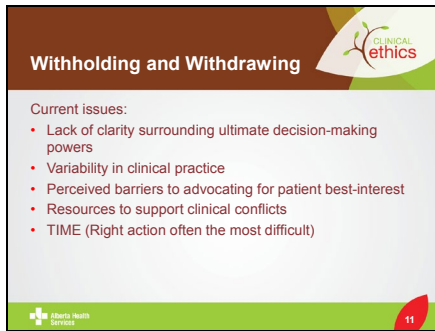
- Lack of clarity surrounding ultimate decision-making powers
- Variability in clinical practice
- Perceived barriers to advocating for patient best-interest

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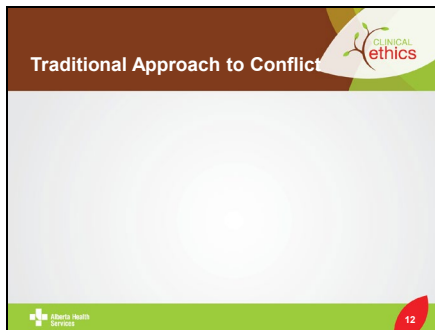
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Traditional Approach to Conflict

Medical Futility
Quality of Life

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Traditional Approach to Conflict

Medical Futility

- term lacks clarity

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Traditional Approach to Conflict

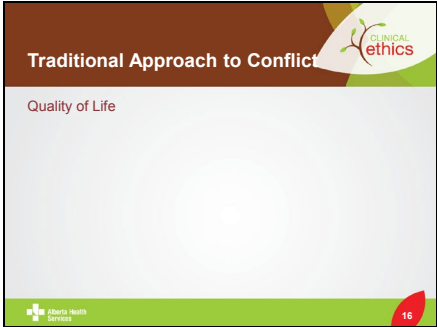
Medical Futility

- concept lacks clarity
- concept implies certainty
- requires messaging to be meaningful
- often misinterpreted as a judgement about patient rather than specific treatment

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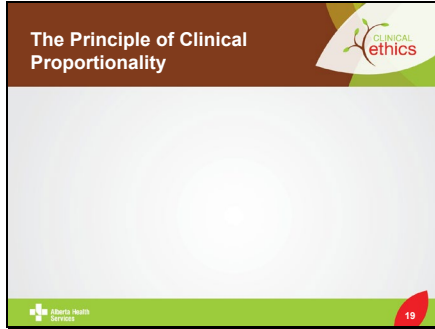
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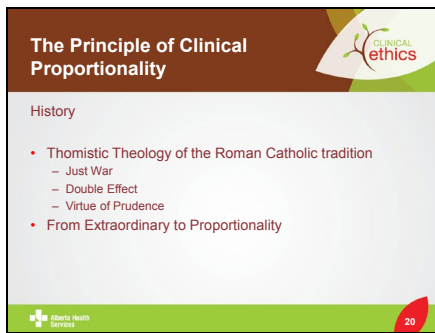
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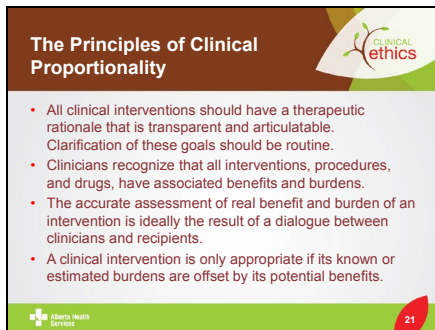
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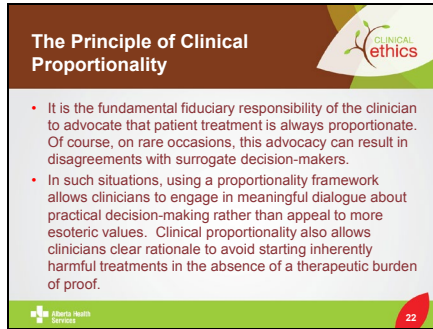
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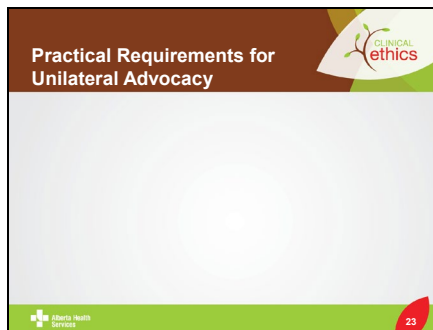
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The Principle of Clinical Proportionality

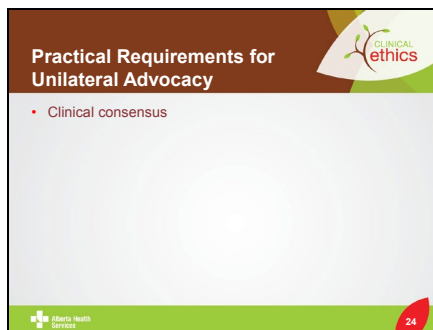
- It is the fundamental fiduciary responsibility of the clinician to advocate that patient treatment is always proportionate. Of course, on rare occasions, this advocacy can result in disagreements with surrogate decision-makers.
- In such situations, using a proportionality framework allows clinicians to engage in meaningful dialogue about practical decision-making rather than appeal to more esoteric values. Clinical proportionality also allows clinicians clear rationale to avoid starting inherently harmful treatments in the absence of a therapeutic burden of proof.

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Practical Requirements for Unilateral Advocacy

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Practical Requirements for Unilateral Advocacy

- Clinical consensus
