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BULLETIN

Surgeons Need Plan for Managing Patients with Difficult EOL Decisions

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One of the most difficult clinical and moral challenges for the patient, surgeon, and the patient's family is determining the correct medical, ethical, and legal decision for a patient who is in a terminal state and unable to communicate his or her wishes.

Modern medicine is now able to resuscitate and stabilize patients who, in a previous era, may not have survived the catastrophic event that caused them to require immediate hospital care. Examples of these kinds of events are major trauma with a prehospital cardiopulmonary arrest, major cerebral hemorrhage, prolonged cardiac arrest with cerebral anoxia, or a postsurgical event resulting in cerebral anoxia. All these scenarios can result in a patient who is being maintained on a ventilator with vasopressor support with no meaningful pathway to recovery. The patient is not brain dead but has no chance of any meaningful functional recovery.

Some of these patients may not have family members or legally appropriate decision-makers who can make end-of-life (EOL) decisions for the patient. It can be very difficult to track down family members or the legally appropriate decision-makers who may be in another state or may not have had any meaningful contact with the patient in recent years. The result is that the legal system may have to designate a conservator to be the legal decision-maker.

The conservator is not a medical person but someone who understands the legal system and can make the decisions to resolve the clinical issues. These are extraordinarily challenging decisions, as they frequently result in termination of life support and the subsequent death of the patient. Conversely, the decision may result in the patient being maintained in the hospital or another facility for a prolonged period without any meaningful recovery.

The family member or potential decision-maker for the patient usually does not have a medical background and does not understand why the patient who is alive and being supported in the intensive care unit will not make a meaningful recovery. It is critical to establish and maintain a trusting relationship based on honest communication with the decision-maker.

Many potential barriers exist to understanding the gravity of the situation. These include cultural, religious, and societal differences, as well as ethical issues. The family and decision-maker may believe that a miracle will happen and favorably resolve the situation.

There is a potential for conflicting information provided by the multiple members of a caregiving team, which in turn, could be poorly perceived and misunderstood by the patient’s family. Unfortunately, this miscommunication could rapidly deteriorate into a contentious situation.

Strategies for Managing a Difficult EOL Situation

The most effective and critically important safeguard in this situation is to have a discussion with a patient about the importance of having wishes relative to EOL decision-making formally recorded and available for decision-makers to access.

In the event the patient does not have written EOL preferences, it is important to establish a relationship of trust and confidence with the family and loved ones immediately following the arrival to the emergency department.

If the catastrophic event is in the surgical domain, the surgeon must identify himself or herself to the family and in simple, understandable terms explain the magnitude of the problem and the potential outcome.

In my experience as a trauma surgeon, one has about 7 to 10 seconds to make an introduction, establish trust, and begin the explanation of the problem. The family is usually extremely upset, which may manifest itself in different ways. For the family, this is an incredibly difficult situation to understand. The use of polysyllabic medical terminology is not helpful and is rarely understood. It is far better to use simple, clear language and be completely truthful about the potential outcome of the catastrophic situation.

In the clinical resuscitative environment, it is very difficult to identify everyone’s role and who is the designated decision-maker. This is compounded by the fact that most of the caregivers are wearing clinical “scrubs.” I have always found it useful to wear my white coat with my name tag and identification easily visible when I speak to the family and the loved ones. They can then identify who communicated with them and what was said to them. This approach leads to continuity of communication and identifies the lead contact person for the family.

As the situation continues over the ensuing hours and days, it is very important that all members of the team, including surgical, intensive care, medical, nursing, social workers, and ethics professionals communicate with each other and have a unified voice and plan to present to the family and decision-makers. It is important to remember that for the medical team, the clinical problem is of paramount importance. For the family, however,

the impact of this event on the patient and their loved ones is as important as the clinical event itself.

The Joint Commission has revised its Rights and Responsibilities of the Individual requirements for accredited ambulatory surgical centers to further clarify who may exercise a patient's rights on their behalf when the patient is unable to make decisions. These new revisions to several requirements align with the US Centers for Medicare & Medicaid Services Conditions for Coverage.

For example, The Joint Commission Standard RI.01.02.01, which mandates that the organization respect the patient's right to participate in decisions about their care, treatment, or services, has been updated with the following verbiage: "If a patient is adjudged incompetent under applicable state laws by a court of proper jurisdiction, the person appointed under state law to act on the patient's behalf exercises the rights of the patient. If a state court has not adjudged a patient incompetent, any legal representative or surrogate decision-maker designated by the patient in accordance with state law may exercise the patient's rights to the extent allowed by state law."

Every surgeon should have a clearly developed plan for effectively managing difficult EOL decisions. It is useful and helpful to communicate this plan to the team as early in the clinical course as is appropriate. It is equally important for the entire team to have a debriefing session following the final outcome for the patient. These discussions go a long way in clarifying difficult decisions and providing a forum for discussion of all elements of the clinical course.

Disclaimer

The thoughts and opinions expressed in this column are solely those of Dr. Jacobs and do not necessarily reflect those of The Joint Commission or the American College of Surgeons.

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