SAFEGUARDING THE UNCONSCIOUS PATIENTS’ OVERALL BENEFIT

TOWARDS A ‘CONSENSUS-BUILDING’ APPROACH

Endcare – An Erasmus+2015 Project

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TWO MODELS OF MORAL REASONING

- ‘Substituted Judgment’ Model
  Decision that the patient would have make if he/she were conscious on the basis of his/her values, religious beliefs and attitudes towards medical care.

- ‘Patient’s Best Interest’ Model
  Weighing of benefits, burdens and risks associated with treatment that are not always limited to clinical considerations.
THIRD MODEL OF MORAL REASONING

- Gives high priority to consensus-building.
- It is a negotiating process among all parties involved which ultimately leads to consensus building.
- Incorporates both the previous two models and at the same time offers a much inclusive and broader perspective.
CONSENSUS-BUILDING APPROACH:
OVERARCHING FUNDAMENTAL ETHICAL PRINCIPLES

- Human Dignity and Fundamental Rights
- Equity and Justice
- Respect for Human Life
- Solidarity
- Subsidiarity and Participation
- Beneficence and Non-maleficence
CONSENSUS-BUILDING APPROACH

Underlying values of consensus-building approach:

- Right to Know and to Choose
- Beneficence as Appropriate Withholding and Withdrawing of Life-Sustaining Treatment
- Proper Assessment of Clinical Futility
- A Collaborative Approach to Care
- Transparency and Accountability
- Non-discriminatory Care
Consensus Building Approach

- Respect for Life and Care of Dying
- Right to Know and to Choose
- Non-Discriminatory Care
- Beneficence as Appropriate Withholding and Withdrawing of Life-sustaining Treatment
- Transparency and Accountability
- Collaborative Approach to Care
- Proper Assessment of Clinical Futility
CONSENSUS-BUILDING APPROACH

Process of consensus-building approach includes the following procedural steps:

- Management Plan of Treatment
- Continuous Assessment of the Clinical Situation
- Spirit of Collaboration among the Treating Team
- Participation of Family Members
CONSENSUS-BUILDING APPROACH: RESOLVING CONFLICTS

Resolving disagreements:

- Disagreement among the Healthcare Team
- Disagreement of Patient’s Family with a Patient’s Decision
- Inappropriate Requests for Continuing or Discontinuing Treatment
Consensus-Building Approach
Process of Decision-Making

Clinical Deterioration/
Non-response to treatment

Management Plan

Continuous Assessment

Team Spirit

Previously Expressed Preferences

Disclosure

Dialogue: Health Care Professionals/Family Members

Consensus

Disagreements:
- among healthcare team
- family members with patient’s decisions
- Inappropriate requests for continuing/discontinuing treatment

Conflict
PALLIATIVE SEDATION

- When any or all aspects of active treatment are to be withheld or withdrawn, appropriate consideration should be given to an alternative care plan (‘comfort care’), focusing on dignity and comfort. This is especially applicable when death is expected.

- The use of medication for control of patient symptoms in this setting is appropriate, even if this may shorten life.
Clinical cases involving PVS patient present particular ethical debate in end-of-life decision-making.

Withholding and withdrawing of hydration and nutrition is permissible in end-of-life decisions depending on the clinical situation.

The crucial issue is whether the administration of food and water, even when medically delivered by feeding tubes, is merely a medical act or a natural means of preserving life.

In principle, artificial hydration and nutrition should be administered since it is basic healthcare.

However, when artificial feeding and nutrition are no longer medically efficacious to achieve their proper goal to nourish the patient and alleviate suffering, then they are no longer morally obligatory.
No ethical problems arise if palliative sedation is administered to a patient in cases when there is a strong **objective medical indication** for such administration.

However, when deep palliative sedation, together with the withdrawing or withholding of artificial nutrition and hydration, is administered **without any objective medical indication**, simply because it is requested by the patient, serious contentious ethical and legal issues arise.
DEEP AND CONTINUOUS PALLIATIVE SEDATION

- In their decision-making process, the healthcare team and family members could decide to withdraw or withhold artificial hydration and nutrition when:

1) it is medically futile (it does not provide effective nutritional support or prevent dehydration, or when the patient is unable to assimilate food and liquids, so that their provision becomes altogether useless, or when the body sometimes starts rejecting artificial feeding)

2) the patient experiences no real benefit
3) the burdens for the patient outweigh the benefits (when artificial nourishment and hydration become excessively burdensome for the patient or may cause significant physical discomfort, for example resulting from complications in the use of the means employed and thus become medically contra-indicated), and

4) the patient is dying.
CONCLUDING REMARKS

The consensus-building approach has a number of advantages when compared to the ‘substituted judgement’ and ‘best interest’ models:

- it takes into account the opinions of all involved;
- the experience and knowledge of everyone involved in taken on board;
- the patient is safeguarded from rushed decisions or hidden agendas;
- family members do not have guilt feelings due to lack of participation or disagreement with the decisions taken as they were not informed and involved;
- the treating team and the patient’s family learn to listen to each other and to understand and respect each other’s views;
- decisions and responsibilities are shared.