Exemplary Professional Practice: Accountability, Competence and Autonomy

**EP17** Nurses use available resources to address ethical issues related to clinical practice and organizational ethical situations.

**EP17a:** Provide one example, with supporting evidence, of nurses using available resources to address ethical issues related to clinical practice.

**Introduction:**

At times, patients with significant co-morbidity and diminished functional status have a complex surgery for life-threatening diagnoses. Although the surgical result might be excellent, a patient’s co-morbidities may lead to chronic critical illness (Lamas, 2014) from which recovery ultimately will not be possible. Interprofessional teams can be challenged for many reasons to identify the appropriate time in the patient’s illness trajectory to shift goals of care towards non-escalation of life sustaining treatment or comfort measures.

Clinical nurses assess the patient’s subjective and objective responses as they provide nursing care, perform diagnostic and therapeutic interventions and monitor the patient’s response to both. In this process of assessment, intervention and evaluation towards projected outcomes, clinical nurses learn about a patient’s pain and symptom manifestations as well as the patient’s perceptions of suffering and progress toward or away from recovery. Clinical nurses in the Intensive Care Units (ICUs) are often the first to recognize when a patient is not progressing towards recovery (Gadow, 1983). Other disciplines’ goals of care (i.e. cure) and/or lack of understanding of a patient’s wishes regarding end-of-life care may lead to prolonged attempts to continue treatment (Cooper, Courtwright, Karlage, Gawande, and Block, 2014). Such cases pose challenging dilemmas to clinical nurses as the Code of Ethics (ANA, 2015) directs them to a primary commitment to the patient. At MGH, clinical nurses are guided by the ANA Code of Ethics in their overview of patient care and expert resources support clinical nurses in addressing this commitment through initiation of difficult discussions with care team members and families.

**MGH Ethics Resources:**

There are a significant number of ethics resources available to MGH nurses and other clinicians. These resources are available through direct consultation with content experts, the hospital’s intranet, or the internet. The available resources include:

- **A Nurse Ethicist/Clinical Practice Specialist** in the Institute for Patient Care who is available for consultation around all issues of ethical concerns. Ellen M. Robinson is a graduate of the William F. Connell School of Nursing and received her PhD in Nursing with a focus on nursing ethics, in 1997. In 1997-98, Robinson completed the Harvard Medical School Division of Medical Ethics fellowship, after which she transitioned into the role of Nurse Ethicist at MGH. In
her role as Nurse Ethicist, Ellen provides ethics consultation to health professionals, patients and families at the MGH. She has served on the MGH Optimum Care Committee since 1993 and as Co-Chair of the committee since 2007. In her role as committee co-chair, she has led the way in developing hospital policies designed to protect the patient approaching end-of-life from the harms of cardiopulmonary resuscitation. In addition, she serves on the MGH Hospital for Children Pediatric Ethics Committee and the Harvard Medical School Division of Medical Ethics Leadership Council. Robinson’s curriculum vitae is included in attachment EP17a.a.

- **Interdisciplinary Ethics Committees:**
  - **Optimum Care Committee** which is available to provide consultation to patients, surrogates, nurses and other health care team members regarding end of life care and other concerns related to adult patients
  - **Pediatric Bioethics Committee** which provides similar consultation services for issues related to pediatric patients
  - **Collaborative Governance Ethics in Clinical Practice Committee (EICPC)** which supports ethics educational efforts for all health team members as well as the public.

- **Unit-based Ethics Rounds** which are often facilitated by EICPC Champions under the mentorship of a doctorally-prepared Nurse Ethicist/Clinical Nurse Specialist in the Institute for Patient Care.

- **Policies and procedures** that provide guidance to staff to ensure issues related to ethical concerns are dealt with effectively and that the rights and needs of patients, families and staff are met. Adherence to these policies and procedures ensures compliance with internal and external regulations and practice standards. These policies and procedures are housed in ellucid, an on-line policy and procedure management system, and are accessible at all times. Policies and procedures related to ethics and ethical concerns are contained in OOD 12.

- **The Excellence Every Day (EED) Portal** page is also accessible at all times. The EED Portal houses materials and resources that represent the MGH commitment to providing the highest quality and safest care that meets or exceeds all standards set by the hospital or external organizations. The Ethics EED page is a repository of links to advance care planning resources, various ethics resources at MGH, ethics-related policies, procedures and guidelines, and professional codes of ethics including the American Nurses Association’s Code of Ethics for Nurses with Interpretive Statements (2015), as well as links to the Joint Commission and Magnet Recognition program. Screen shots of the EED Portal page for Ethics are included below.
ADVANCE CARE PLANNING

The Advance Care Planning Process

Advance Care Planning (ACP) is a process that promotes autonomy for individuals so that their treatment preferences will be known and respected should they be in a situation where they are unable to speak for themselves. The Ethics in Clinical Practice Committee supports ACP initiatives.

- Advance Directive & Health Care Proxy Internet Resources
- Know Your Choices: A Guide for Patients with Serious Advancing Illness
  The Massachusetts Department of Public Health created this guide to support patients and their family members with important information about healthcare choices, especially when facing a serious illness.
- Medical Orders for Life-Sustaining Treatment (MOLST) establishes a standardized method of communicating and documenting a patient’s preferences for life-sustaining treatments (i.e. CPR, dialysis treatments, having a breathing tube inserted, etc.) and is completed after advance care planning discussions have occurred between the patient, family, and health care providers (i.e. physician, nurse practitioner). A MOLST form is not to be confused with an advance directive and does not take the place of an advance directive (i.e. Massachusetts Health Care Proxy). MOLST is appropriate for any patient irrespective of age with a serious medical illness that may include but not be limited to conditions such as a life-threatening injury, chronic and progressive disease such as dementia, or medical frailty. See the MOLST website for more information.
The Case:

The case of Mr. X provides an exemplar of how clinical nurses access and use ethics resources in the hospital for both support and strategy in cases where multi-layered factors can contribute to ‘continuing treatment’ at the expense of the patient’s suffering. The ultimate goal is to reach a ‘good end’ for patient and family through professional collaboration with all care team members. Mr. X, a 77 year-old Portuguese-speaking man, was diagnosed with peri-ampullary pancreatic adenocarcinoma in May of 2015 after presenting to the Emergency Department (Ellison 1/Lunder 1) with jaundice, mild abdominal pain and pruritis. His past medical history included diabetes mellitus, alcohol abuse, and hyperlipidemia. The patient was debilitated and dependent in his activities of daily living (ADL), unsteady on his feet, and required assistance in ambulation. Mr. X was married and had three sons and a daughter, who was serving as his health care agent. The surgeon met with Mr. X and his family and Mr. X agreed to have a Whipple procedure which was performed on July 31, 2015. Mr. X was in the ICU from the date of surgery to August 5, 2015 and then transferred to a post-surgical unit, where his recovery was initially progressing. He continued to lack independence in ADLs, needed assistance with ambulation, and received most of his feedings by g-tube, although he was also able to take in a PO diet. Mr. X was awake and alert and able to communicate his needs. He was able to get out of bed to a chair and was working with physical and occupational therapy to improve his ability to function.
On August 17, 2015, the patient experienced an aspiration event on the surgical unit and he was emergently intubated and transferred back to the ICU. During the time between August 17, 2015 until his death on September 24, 2015, the patient was not able to be weaned from the ventilator or vasopressors, nor did his mental status improve from ‘being awake’ to ‘being interactive.’ Mr. X did not manifest any evidence of capacity to understand person, place or time. He experienced renal failure, was on continuous veno-venous hemo-filtration, and was never able to be transitioned to hemodialysis due to his recurrent sepsis and vasopressor dependence. He developed several abdominal abscesses, some of which were drained in interventional radiology. Clinical nurses noted that the patient was awake at times, but would only stare into space. He seemed to have abdominal pain, withdrawing his feet and legs when his abdomen was palpated. During this time, clinical nurses attempted to balance relieving his pain while also providing opportunities to assess his mental status in the hopes that it was improving. Alternating bouts of sepsis seemed to increasingly set him back. The patient’s family showed no sign of wanting to reconsider goals of care. The surgeon’s plan of care in place at that time was on a course of continuing full treatment.

Over the course of the last weeks in August 2015, Laura Lux, RN, BSN, the Attending Registered Nurse (ARN) for the unit, began to notice that many clinical nurses were expressing concerns about Mr. X. The ARN is a unit-based clinical nurse who, through leadership and coordination, ensures continuity from admission to discharge, by facilitating the plan of care with the nurse caring for the patient, the patient and family, and the interprofessional team.

During daily interprofessional rounds, Lux shared that clinical nurses caring for Mr. X including Brittney Grazio, RN, BSN and Victoria Bennett, RN, BSN were concerned that the patient would not recover enough to return home. Concern was expressed that significant issues were accruing for this man (i.e. skin breakdown, sepsis, infection, inability to wean from ventilator, pain) while potential benefits seemed to be slipping away (i.e. mental clarity, transition to hemodialysis, ability to ambulate, ability to return home with family). Mr. X’s family did visit, but not often. There were times when they did visit, that some of them, including his health care agent, appeared to be under the influence of alcohol. Due to the increasing number of concerns about Mr. X’s care trajectory, Lux called Ellen Robinson, RN, PhD, Nurse Ethicist, and invited her to attend interprofessional rounds on September 7, 2015.

A strategy for resolving the care team’s questions regarding goals of care emerged during the interprofessional rounds. An email was drafted by Robinson in collaboration with Lux, Mary McAuley, RN, MS, NE-BC, Nursing Director and Ronald Hirschberg, MD, Medical Director of the ICU to invite Keith Lillemoe, MD, Mr. X’s surgeon to attend a team meeting on September 8, 2015 with nursing, ethics, physical medicine, physical therapy and social services. Robinson’s email and Lillemoe’s response are included in attachment EP17a.b. At the team meeting, Robinson facilitated the conversation which allowed the clinical nurses to fully express their impressions and concerns regarding Mr. X. Lillemoe identified three potential pathways for the patient, that could be decided
upon within a shared decision-making model with family. Most importantly, Lillemoe shared his impression of the patient’s condition (i.e., chronically critically ill with reservations about a robust recovery) and this was congruent with the nurses' assessment of critical issues of concern. Grazio captured the discussion in the team meeting in her event note (attachment EP17a.c). Despite being informed of the team’s concerns about Mr. X's chances of recovery, the patient’s health care agent requested continued aggressive treatment for her father.

The ICU team continued to communicate with Lillemoe during the next week after all agreed to honor the patient’s daughter/health care agent’s request for continued aggressive treatment. On September 14, 2015, a family meeting was held which was summarized in the patient’s record by Grazio and Lillemoe (attachment EP17a.d). Again, family continued to request that their father/spouse receive full, aggressive life sustaining treatment, even if his chances for recovery were low and his disability would be great. Unfortunately, in the week subsequent to the September 14, 2015 meeting, Mr. X did not manifest recovery to any better state. During a second family meeting held on September 21, 2015, Lux, Grazio, Lillemoe and David King, MD, a physician from the ICU, discussed their impressions with the family and compassionately informed them that it would not be possible for Mr. X to ever be out of the ICU, and that it would be the right thing to withdraw life support and allow him to die. The family reported that they had also reached this conclusion themselves. A Do Not Resuscitate and non-escalation of life sustaining treatment order was established and a plan was made with family such that they could say their final goodbyes and that a chaplain would visit in order to provide spiritual support. Lux requested to de-brief with Robinson (attachment EP17a.e) which occurred in person on September 23, 2015. Mr. X died peacefully with his family at his bedside in the ICU on September 24, 2015. The process of addressing the ethical concerns in this case was initiated by Lux on behalf of her fellow clinical nurses in order to meet their primary commitment to the patient (ANA, 2015). Utilization of ethics resources, in this case, Robinson, led to a positive outcome for Mr. X that all could support, including his family.

References