Ethical issues in palliative care

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INTRODUCTION — Ethical issues in palliative care often arise because of concerns about how much and what kind of care make sense for someone with a limited life expectancy. There is often conflict between clinicians, nurses, other healthcare team members, patients, and family members about what constitutes appropriate care, particularly as patients approach death.

This topic will discuss ethical issues in palliative care. Other issues regarding the legal aspects of end of life care and advance care planning are discussed separately. In addition, issues related to specific symptoms for the patient in palliative care and/or at the end of life are discussed separately.

● (See “Advance care planning and advance directives”.)
● (See "Legal aspects in palliative and end of life care").
● (See “Approach to symptom assessment in palliative care”.)
● (See "Overview of comprehensive patient assessment in palliative care").

FRAMEWORK FOR ETHICAL REASONING — The most common framework for ethical reasoning in the United States (US) is called principalism, after the four guiding principles in medical ethics:

● Respect for autonomy – Respecting autonomy means ensuring the informed patient’s right to participate in medical decision making. It is considered to be the centerpiece of modern American biomedical ethics [1].
● Beneficence – The principle of beneficence mandates that clinicians act in the best interests of their patients.
● Non-maleficence – The principle of non-maleficence is the instruction for doctors to first, do no harm.
● Justice – Justice requires that all people be treated well and fairly, and also that health resources be used equitably.
Applying principalism in palliative care — The four guiding principles above are indispensable, but are often insufficient to guide health decisions in societies and clinical environments, especially in the palliative care setting due to multiple factors including [2]:

- Rapidly evolving medical technology
- An increasingly polarized and scrutinized political and medico-legal environment
- Longer life expectancies, including in patients with a significant burden of illness and/or functional impairment
- Increased awareness of the differing needs of individuals based on cultural, ethnic, economic, educational, religious, and many other kinds of diversity

When two guiding principles seem to be at odds, the clinician may feel that principalism "becomes stuck." For example, a health professional caring for a male patient with an end-stage cancer may have the personal belief that he must be told that his cancer is incurable so that he can make informed decisions and use his remaining time well. However, his family may insist that he not be told because they believe that knowledge will rob him of the will to live. In such a situation, the principles of respect for autonomy and the principle of non-maleficence are at odds. So, who decides what happens with the patient?

Palliative paternalism — In the US, this question of "who decides" has undergone a major transition from paternalism (where the health professional decides) to autonomy (where the patient or his or her surrogate decides). While this transition has many positive aspects, some argue that this is accompanied by a "trend among physicians to avoid making difficult medical decisions by hiding behind a shield of patient autonomy" [3]. That is, the clinician may present the patient or surrogate with their options and invites them to decide, but he or she does not render a recommendation.

Although this may be perfectly acceptable to many patients, it can also impose an undue burden to other patients (and their surrogates), particularly when their own situation places them under tremendous stress at baseline. In addition, patients may be unable to decide because of the burden of having to live (or die) with the consequences of their decisions is palpable. In situations like that, some have advocated for the judicious use of what they call "palliative paternalism," whereby health professionals share the burden of responsibility by seeking a middle ground between paternalism and autonomy [3].

Alternative moral frameworks — As noted, limiting ourselves to one framework to apply to ethical issues encountered in palliative care may heighten the risk of conflict or an impasse between clinicians, their patients, and their loved ones. Therefore, some experts suggest that clinicians consider multiple ethical frameworks rather than adopting a single interpretation of what is in reality a complex clinical situation that gives rise to difficult ethical questions [4]. These include:

- Utilitarian/consequentialist view — These views stress acting in ways that maximize the balance of benefits and burdens [5]. For example, a utilitarian approach (which is not used as routine practice in the US) to deciding whether or not to offer cardiopulmonary resuscitation to a patient would weigh the likelihood of survival and subsequent quality and quantity of life against potential suffering and costs.
- Deontological view — This view holds that some duties transcend calculations of net benefit. A common scenario in palliative care involves clinicians arguing for withholding or withdrawal of treatment based on a utilitarian assessment of futility, whereas family members argue for continued treatment out of a sense of familial duty [6].
Communitarian view – This view emphasizes communal values, the common good, social goals, traditional practices, and cooperative virtues [7]. For example, communitarians would argue in favor of universal access to health care because it improves the quality of life for the entire community.

Doctrine of double effect – The doctrine of double effect helps to reconcile that while an action may have more than one result (both an intended and an unintended outcome) it is still ethically justified as long as the intended benefit significantly outweighs the unintended harm. For example, giving pain medication to a dying person is justified, even if a foreseen but unintended consequence is that death is hastened [8].

Social contractarian view – This view balances the responsibilities of society to the individual with the individuals’ responsibilities to society [4]. Conducting pharmaceutical research in poor countries whose citizens won’t be able to afford them violates the social contract by burdening one population so that another may benefit.

Rights-based approaches – Exemplified by the Bill of Rights of the US Constitution, this view emphasizes the rights of individuals [9]. For example, patients who are near the end of their lives, although certainly vulnerable, nevertheless have the right to participate and benefit from appropriate research.

Ethics of caring (or feminist ethics) – This view holds that natural caring for others is the basis for moral behavior, and stresses caring relationships with others not based on “the primacy and universality of individual rights, but rather on... a very strong sense of being responsible” [10]. Hospice and palliative care practice often aligns closely with the ethics of caring, for example by explicitly taking the patient and his or her family as the unit of care.

Virtue ethics – Where utilitarians focus on benefits and burdens, and deontologists focus on duty, virtue ethicists focus on the moral character which informs behavior [11]. The virtues emphasized in hospice and palliative care practice include compassion/empathy, faithfulness, justice/advocacy, and practical wisdom [12].

APPLYING ETHICS IN CLINICAL SETTINGS — For patients in palliative care, ethical issues can arise in many situations related to:

- Medical decision making (including who makes them)
- Issues of futility
- Conflicts of value (between loved ones and/or between clinicians and patients) and professional values

Decision making — As discussed above, the principle of autonomy holds that patients have the right to accept or reject healthcare recommendations made by clinicians [13]. However, this does not mean the patient has the right to demand interventions which are not medically indicated. Respecting autonomy recognizes that medical decisions are complex and are influenced by many factors that go beyond the medical “facts” of the case, and that individuals weigh the risk and benefits of medical interventions through their own set of values, goals, experiences, and social relationships. These other influences may result in different patients making different decisions when faced with the same clinical situation.

The process of decision making can become even more complicated when patients are unable to speak for themselves and decisions must be made jointly by health professionals and family members who bring different personal valuations of quantity versus quality and who are likely to be in various stages of grief.
Jonsen’s “Four Box Model” for clinical ethical decision making provides a practical and potent starting place to help clinicians apply and prioritize ethical principles differently according to the clinical situation. By balancing medical decision making elements important to health professionals with patient-centered elements including preferences, quality of life, and other practical considerations, the Four Box model provides an architecture where professional-patient relationships become central (table 1).

Determining best interest — Decision making often requires recommendations by the clinician or giving voice to what would be in the patient’s best interest. This becomes particularly important when the patient no longer is able to make decisions for him or herself. Criteria frequently used to determine best interest include:

- Determining what the patient’s preexisting description of acceptable or stable quality of life was, or, by contrast, what the patient would have described as a sufficient decrease in quality of life to be characterized as intolerable.
- Reviewing the benefits and risks of each reasonable intervention, including how each would impact recovery in the short- and long-term. This should include some measure of proportionality (ie, characterizing the burden versus benefit of any proposed intervention). For example, treating a leg ulcer with surgical debridement and antibiotics may require proportionately less certainty of success than treating with an above-the-knee amputation because of the latter procedure’s significantly higher burden and permanent functional changes.
- Characterizing the risk and the degree of suffering and pain associated with an intervention, including the clinician’s ability to lessen any suffering encountered.
- Giving the expected prognosis with and without treatment, both in terms of mortality and longer-term consequences (eg, disability).

Working with surrogates — When patients are unable to voice their own decisions, we look to individuals in their life who can provide guidance either based on actual knowledge of the patient’s wishes (substituted judgments) or on their understanding of what is in the patient's best interest. It is the ability of the surrogate to speak from personal knowledge of the patient that provides the reason for clinicians to look to that individual for decisions or guidance in making medical decisions. When evaluated, there does not appear to be a high degree of correlation between what a surrogate decides when compared with the patient [14]. Other data suggest that the expression of trust patients have in their appointed surrogate is important [15-19]. Despite low-quality evidence, surrogate decision making is thought to be more accurate than a clinician acting alone without the benefit of a surrogate. (See "Advance care planning and advance directives", section on ‘Surrogate decision makers’.)

As clinicians work with surrogate decision makers, there may be an underlying tension regarding questions of whether the surrogate is accurate in their understanding of the patient’s wishes and values. This is strongest when the decisions have grave consequences, may cause additional pain or suffering, or are considered irreversible. Surrogates cannot decide to allow patients to suffer unnecessary pain when it can be safely treated. Other commonly encountered issues faced by clinicians include:

- The patient’s preferences are unknown to the surrogate
- The surrogate may lack decision making capacity themselves
- The clinician knows or believes the surrogate is not acting in accordance with the patient’s wishes
- The surrogate has difficulty or is unable to make an informed decision related to the best interest of the patient
● The surrogate’s decision may be in conflict by others in the patient’s life (eg, other friends and family members) [20,21]

Impact of acting as a surrogate — Clinicians need to be aware there are consequences for the individual who has agreed to act as a surrogate, either appointed or by hierarchy (ie, surrogate determination based on relation of the patient to family members in the following order: spouse, adult children, siblings, then others). Some of these consequences include a heightened sense of burden and stress [22-25]. In one systematic review, performing in the role of surrogate decision maker was associated with a substantial toll (including emotional burden) on at least one-third of surrogates which lasts for months and even years following the decision making process [23].

Common negative experiences surrogates identified included stress associated with participating in the decision making process, guilt associated with the decisions they made, and doubting if they had made the correct decision. Stressors include:

- Being unsure what the patient’s preferences would be
- Uncertainty associated with prognosis
- Stress of being in the unfamiliar environment of the hospital
- Poor communication by clinicians
- Feeling pressured by time to make decisions
- Conflict between clinicians and family
- Sense of being solely responsible for the decision
- The process of decision making logistics
- Sense of uncertainty or guilt over the decisions

Futility — Medical futility can be defined as excessive medical interventions (both in terms of effort required or financial resources utilized) that stands little prospect of changing the ultimate clinical outcome [26]. While it may be tempting for clinicians to refuse to provide potentially futile therapies on the basis that doing so would preserve precious resources for other patients, this kind of bedside “rationing” does nothing to ensure just health care. That is, there is no reason to think that refusing to treat a specific patient will result in better (or more) care for other patients who stand a greater chance of benefit.

Instead, healthcare institutions should have policies that address conflicts in medical decision making procedurally to ensure that clinicians, patients, and families have recourse to the same opportunities and resources. (See "Ethics in the intensive care unit: Responding to requests for potentially inappropriate therapies in adults", section on 'Responding to requests for physiologically futile interventions'.)

Conflicts of value — Conflicts of value typically arise when patients lack decision making capacity. This can give rise to differing interpretations of their preferences by loved ones and their clinicians. As a result, the care team may run into tension in the guiding principles in palliative care.

There is broad consensus that health professionals are not obligated to participate in care that they find morally objectionable. For example, The Hastings Center Guidelines on the Termination of LIFE-Sustaining Treatment and Care of the Dying state: “If a health care professional has serious objections to the decision of the patient or surrogate, so that carrying it out is impossible as a matter of conscience or commitment to principle, the professional is not obligated to do so.” [27]. Health professionals whose practice does not follow professional norms cannot be judged automatically to be acting unethically. The key, according to Wicclair, is respect for health professionals’ moral integrity: “...an appeal to conscience
has significant moral weight only if the core ethical values on which it is based correspond to one or more core values in medicine” [28].

While loved ones may be trying to act in the best interest of the patient (beneficence), and are concerned with not harming him or her (non-maleficence), it is not uncommon that individuals reach different conclusions about what should be done. This may impact care, especially if clinicians feel an obligation to provide care, even though they may believe doing so would be medically futile. This could reflect a desire to respect the patient’s autonomy or the medicolegal climate. In addition, this might mirror the clinician’s belief that refusing treatment would leave them and the hospital open to a lawsuit.

SPECIFIC SCENARIOS — There are numerous clinical scenarios that raise ethical dilemmas when rendering palliative care to patients. What follows are some examples that may be seen in routine clinical practice.

Application of Do Not Resuscitate orders — The American Heart Association recommends that all patients in cardiac arrest should be resuscitated unless they have a valid Do Not Resuscitate (DNR) order, or in cases where resuscitation is physiologically futile (e.g., signs of irreversible death) [29]. For patients with advanced illness, a code status may be inadequate to guide treatment in this situation because, in general, it applies specifically to cardiopulmonary arrest and not to the current health status, even when the patient becomes progressively more ill [30]. Thus, in nonemergent situations, conversations with patients with advanced illness or frailty should not begin with clarifications about his or her code status. Rather, code status decisions should emerge from the context of a fuller conversation about prognosis and goals of care. In addition to writing a resuscitation order, goals of care conversations should be documented in the medical record in a way that is readily accessible and that explains the context of the decision (i.e., why the patient wanted what they wanted). The more information available, the less risk that clinicians who may not be as familiar with the patient will be forced to rely on their own judgement when events occur outside the narrow scope of the DNR.

Cardiopulmonary resuscitation (CPR) is unique in health care because it is the only medical intervention where consent is presumed (based on implied consent for emergency treatment) and that requires a medical order to withhold. There are cases when resuscitation may be physiologically feasible, but medically futile. That is, while a patient’s circulation might be physiologically restored through resuscitation, clinicians believe that the patient is very unlikely to survive to hospital discharge. For patients without a code status, especially those at the end of life, mandating CPR in case of cardiac arrest puts clinicians in the awkward position of having to get permission from patients or surrogates to not provide a treatment even when they believe it is not indicated. In turn, patients and surrogates are put in the unacceptable position of being asked to make a decision which will shorten (even briefly) the patient’s life. Not surprisingly, many patients and surrogates find this position extremely distressing or morally unacceptable. (See ‘Impact of acting as a surrogate’ above.)

The American Heart Association acknowledges that withholding resuscitation is appropriate when the only outcomes are early death or unacceptably high morbidity, but only allows this in cases of extreme prematurity (<23 weeks or birth weight <400 g) and anencephaly. Guidance for clinicians to withhold CPR in adults is lacking, and a common question for clinicians is whether they can ever unilaterally decide to withhold resuscitation in cases where they believe it is medically futile. An extended discussion on the clinical approach to futile treatments is covered in the approach for patients in the ICU and is relevant here as well. (See "Ethics in the intensive care unit: Responding to requests for potentially inappropriate therapies in adults").
Advance care planning — Americans have embraced the right of seriously ill patients to make their own choices about whether they receive life-sustaining treatment. How to actually do this in end of life situations, however, has proved difficult, especially when the patient is too sick to make his or her own decisions [31]. In addition, advance directives have distinct limitations that undermine their usefulness. This includes having a basis on the patients’ attitudes about health conditions that they have not yet experienced, possibly not reflecting changes in attitudes that have occurred since they were completed, and describing conditions that may be hard to match to the patient’s actual condition. Further discussion on advance care planning is covered separately. (See "Advance care planning and advance directives").

Withdrawing versus withholding treatment — While not an ethical issue per se, there is no need to make a distinction between withholding and withdrawing treatments. Instead, decisions regarding treatment should focus on helping clinicians, patients, and families to talk about prognosis openly and clearly. This is a central tenet in palliative care [32]. (See "Withholding and withdrawing ventilatory support in adults in the intensive care unit").

The key ethical principle here is non-maleficence, as the intention in either withholding or withdrawing is to avoid or cease causing harm in situations where the benefits and burdens of treatment are not clearly on the side of treatment. For some clinicians and family members, the emotional weight of withdrawing a treatment is greater than that of withholding a treatment in the first place. This can be particularly difficult when treatment withdrawal is closely followed by death such as cases that occur in the intensive care unit, drawing into fine focus the distinction between allowing death and killing. Others will feel that stopping a treatment that has proved ineffective is more acceptable because it does not rely on a prognostication that further treatment will not be beneficial.

There are situations where withholding would be better than initiating a treatment and then withdrawing it. For example, withholding a treatment is ethically appropriate if a treatment is completely unable to provide benefit as defined by the patient or surrogate. However, there are other scenarios where withdrawing following a trial of treatment is ethically appropriate. For example, initiating a treatment may be allowable when there are differences of opinion about prognosis and potential benefit, followed by withdrawal if expectations are not met.

Time-limited trial — A “time-limited trial” is a utilitarian approach to addressing ethical conflicts. It is a way of moving forward when parties disagree over whether a treatment is going to be beneficial or not or when a clinician’s concerns about futility conflict with a surrogate’s obligation to preserve life. In a time-limited trial, clinicians and patient/family agree to a trial of treatment over a specified period of time to see if the patient improves or deteriorates according to agreed-on clinical outcomes. If the patient improves, the agreed-on treatment continues. If the patient deteriorates, that treatment is withdrawn and usually replaced by more comfort-oriented care. This approach respects the wishes of those who wish to try something while also acknowledging those who fear that treatment will continue indefinitely [33].

In contrast, a deontological position may be taken by families that they are duty bound to “do everything,” regardless of the consequences. Ultimately, clinicians’ ability to successfully negotiate with a patient and/or his or her loved ones will depend on their trustworthiness as viewed in their eyes. (See "Communication in the ICU: Holding a family meeting", section on ‘Therapeutic plan’.)

Pain management at the end of life — One of the major concerns of patients facing a terminal illness is that pain will go untreated or poorly treated. Effective pain control is usually achieved through the use of opioids, which may, if titrated aggressively, hasten death. Aggressive pain control at the end of life may
be justified by the doctrine of double effect, which holds that medication intended to achieve pain relief is justified even if a hastened death may result, so long as pain relief, not death, is the intended outcome. (See 'Alternative moral frameworks' above and "Ethical considerations in effective pain management at the end of life", section on 'Principle of double effect'.)

Requests from the family to withhold information — Family requests for clinicians to withhold pertinent information from a patient presents clinicians with an ethical dilemma. How can they respect the autonomy of a patient and meet professional responsibilities of fidelity and veracity while at the same time honoring the family's request to withhold information that they believe will harm the patient? The request by family members not to disclose distressing information is frequently based on their desire to protect the patient or prevent the patient from losing hope, both of which may be culturally based [34].

For the clinician hearing this request, it is important to:

● Take in this information as an important part of the clinical picture
● Maintain a relationship with family and patient by gaining greater understanding of the request
● Determine the patient’s desire for information and how they want communication to occur [35].

This is a time to take into consideration alternative ethical frameworks as described earlier in this article and consider how a variation of the traditional, principle-based medical model may be influencing this request and provide sources for alternative solutions to the dilemma [36].

A proposed strategy to respond to requests for nondisclosure starts before the potentially distressing diagnostic or prognostic information is obtained in order to maintain as neutral an approach as possible [37]:

● Do not overreact. Acknowledge that this might be a difficult conversation and prepare to engage in a dialogue with the family with a goal to reduce any anticipated tension.
● Attempt to understand the family’s viewpoint. Assume the family is coming to you with care and compassion for the patient and try to understand their reasoning, experiences, and goals associated with this request.
● Be flexible. Respecting a patient’s autonomy includes providing the patient with the opportunity to defer decision making to another individual family member or clinician; the key in meeting our professional obligation to respect a patient's autonomy is determining how the patient wishes to express their autonomy. They have no obligation to listen to our clinical information.
● Respond empathetically to the family’s distress. Families are experiencing distress at learning of a terminal diagnosis and helping them to process their own emotions, maintaining a therapeutic relationship, and building trust will help not only in the current situation but also in the future as the clinical picture changes and future conversations and decisions happen.
● Talk to the family about what the patient would want. It is common to assume the patient's wishes are aligned with the family request, but this may not be so. There is also a temptation to extrapolate from earlier life experiences of the patient to guide current decisions. Ways the patient may have acted in protecting a loved one may not reflect their desire when they are the patient.
● State your views as your views, not as universal truths.
● Propose a negotiated approach with the family on how to figure out with the patient how they want clinical information managed, including what they want to know, who they want to be involved in receiving information, and timing of disclosure. It may also be important to clarify with the family
limitations to the negotiated approach, ie, what will your response be if the patient asks directly for information, that you will not lie in that circumstance, but will go slowly with caution, being sure you understand the question being asked.

- Talk with the patient about his or her desire for information: ask for the patient’s view and wishes in as neutral a manner as possible, frequently beginning with asking the patient what they understand.

**Palliative sedation** — Palliative sedation is the use of medications at increasingly higher doses to control pain or other physical symptoms. Some authors distinguish palliative sedation as two concepts: proportionate palliative sedation (PPS) and palliative sedation to unconsciousness (PSU). A more detailed review of this topic is covered separately. (See "Palliative sedation").

**Proportionate palliative sedation** — PPS is sedation that commonly occurs near the end of life when medications are administered in increasingly higher doses to achieve maximum relief from physical symptoms which cannot be otherwise controlled. In this scenario, the sedation is a side effect of analgesic and anxiolytic medications that are attempting to control pain or other physical symptoms. PPS is generally well-accepted in the palliative and hospice care community and supported by multiple medical societies and considerable legal precedent. In 1997, the US Supreme Court expressed support for what it called "terminal sedation": "A patient who is suffering from a terminal illness and who is experiencing great pain has no legal barriers to obtaining medication from qualified physicians, even to the point of causing unconsciousness and hastening death" [38].

Despite its legality, it is worth noting that PPS may be perceived as euthanasia by observers, including family members or even some members of the healthcare team [39]. However, they differ by intent: PPS is aimed at relieving physical symptoms that cannot be otherwise controlled. Euthanasia, by contrast, is the administration of drugs intended to hasten death as a means of relieving pain and suffering.

**Palliative sedation to unconsciousness** — When suffering cannot be relieved despite vigorous attempts at symptom management, a patient or surrogate may request PSU, effectively sleeping through the end of their life. This practice is more controversial than PPS because sedation is intended as the means to relieve suffering, instead of being an unintended consequence. It also may be harder to view death as an unintended consequence, especially if sedation precludes ingestion of food and fluids. It is more controversial when requested as a treatment for existential (rather than physical symptom-based) suffering, when surrogates request it for patients who lack decision making capacity, and when patients are not clearly imminently dying. In navigating these difficult moral questions, the clinician’s obligation is easy to articulate but not necessarily easy to accomplish: focus intention on relieving pain and suffering and on respecting patient’s rights to decline treatment, not on hastening death.

**Physician assisted suicide** — Physician assisted suicide (PAS) consists of providing medication, a prescription, information, or other interventions to a patient with the understanding that the patient intends to use them to commit suicide. It is similar to euthanasia in that death is the intended consequence, but differs because the patient self-administers the medication, leaving less doubt about whose preference is being enacted. PAS is sometimes referred to as Physician Aid-in-Dying (PAD). In the US, some states legally permit PAS provided patients meet two requirements: that they are determined to be terminally ill patients and deemed mentally competent by two independent clinicians. However, there is nothing in the term PAD itself that assumes either mental competence or that patients are terminally ill. Therefore, we continue to refer to the practice as PAS throughout UpToDate. (See "Euthanasia and physician assisted suicide").
For any clinician whose patient asks about PAS, it is important that this prompt further discussion because the request indicates the presence of a serious concern as well as a level of trust in that clinician. For clinicians faced with a sincere request by a patient for assistance in ending his or her life, the ethical issue remains undecided. At the risk of oversimplification, it is another example of conflict between a utilitarian argument that helping a patient die is justified because the patient requested it (and thus, he or she would be spared an inevitably difficult death) and a deontological argument that clinicians have a duty not to participate in actively ending a patient’s life because such participation is always wrong either by itself or based on a need to avoid a slippery slope.

SUMMARY

● Ethical issues in palliative care often arise because of concerns about how much and what kind of care make sense for someone with a limited life expectancy. (See ‘Introduction’ above.)
● The most common framework for ethical reasoning in the United States is called principalism, after the four guiding principles in medical ethics: respect for autonomy, beneficence, non-maleficence, and justice. (See ‘Framework for ethical reasoning’ above.)
● As clinicians work with surrogate decision makers, there may be an underlying tension regarding questions of whether the surrogate is accurate in their understanding of the patient’s wishes and values. This is strongest when the decisions have grave consequences, may cause additional pain or suffering, or are considered irreversible. (See ‘Working with surrogates’ above.)
● Healthcare institutions should have policies that address conflicts in medical decision making procedurally to ensure that clinicians, patients, and families have recourse to the same opportunities and resources. (See ‘Futility’ above.)
● There is broad consensus that health professionals are not obligated to participate in care that they find morally objectionable. (See ‘Conflicts of value’ above.)
● In nonemergent situations, conversations with patients with advanced illness or frailty should not begin with code status. Rather, code status decisions should emerge from the context of a fuller conversation about prognosis and goals of care. (See ‘Application of Do Not Resuscitate orders’ above.)
● When faced with a situation where the family does not wish to have the patient informed of his or her poor prognosis, a strategy that starts before the potentially distressing diagnostic or prognostic information is obtained should be used in order to maintain as neutral an approach as possible. (See ‘Requests from the family to withhold information’ above.)

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REFERENCES


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