A great deal of consensus exists on the moral principle of autonomy. However, when closely examined in practice, autonomy can be extremely difficult to protect, especially when patients are incompetent or severely compromised in their decision-making capacities. Therefore, we rely on advance directives from the patient, or from a duly informed surrogate (preferably delegated to act as a durable power of attorney or appointed healthcare decision maker), when the patient becomes unable to make decisions.

In practice, however, despite policies and even laws legislating advance directives about resuscitation and end-of-life care, patients can suddenly become incapacitated before obtaining adequate information about their choices in terms of advance directives or patient-appointed surrogate decision makers. There are legal precedents for establishing an order of surrogate decision makers. Closest family members are usually considered the first choice as surrogates because it is assumed that they know the patient best and that they have the wishes and best interests of the patient as a top priority. However, in some situations, the closest family member may not qualify because of estrangement, conflict, or incapacity.1,2 In their book, Principles of Biomedical Ethics, Beauchamp and Childress3 cite the ordering of the Virginia Natural Death Act:

If the patient is incompetent and has not specified standards through an advance directive, a decision to withhold or withdraw life-prolonging treatment must involve consultation and agreement between the attending physician and any of the following individuals in the following order of priority if not individual in a prior class is reasonably available, willing and competent to act: 'judicially appointed guardian (if necessary in the circumstances), patient-designated decision maker, spouse, adult child or a majority of adult chil-

BY PATRICIA BENNER, RN, PhD, FAAN. Thelma Shobe Endowed Chair for Ethical and Spiritual Dimensions of Nursing. From the University of California, San Francisco, Calif, School of Nursing, Department of Social and Behavioral Sciences.
In some cases, documentation may be inadequate, hidden, or even misplaced in the chart. The stage is set for an “ethical emergency,” a situation that offers the patient little protection of her or his right to autonomous decision making about end-of-life care. Doctors must then rely on joint consult with other physicians about the reversibility of the acute episode and about the effectiveness or futility of proposed interventions. In many hospitals, an ethical consult is mandatory in such a circumstance; however, when the crisis is acute and the decision must be made within minutes or hours, it may be difficult if not impossible to get adequate input on the ethical considerations for continued treatment.

Even with clearly written advance directives, ambiguity can exist in terms of a particular illness episode. For example, is a particular episode of pneumonia or respiratory distress reversible, offering the patient months or years of additional life of an acceptable level of quality? In writing the advance directive, the patient usually has the dying phase of life in mind, and this is a notoriously ambiguous phase of life. In the case of chronic long-term illnesses, there is no substitute for ongoing clear communication between patients, family members, surrogates, physicians, nurses, and social workers about each illness episode. In highly fragmented healthcare delivery, discontinuity undermines effective communication with patients, families, and professionals.

Living wills that provide extensive, substantive directions on acceptable medical interventions and durable power of attorney for healthcare, or surrogate decision makers, are standard forms of advance directives. Ambiguity can exist in terms of a particular illness episode. For example, is a particular episode of pneumonia or respiratory distress reversible, offering the patient months or years of additional life of an acceptable level of quality? In writing the advance directive, the patient usually has the dying phase of life in mind, and this is a notoriously ambiguous phase of life. In the case of chronic long-term illnesses, there is no substitute for ongoing clear communication between patients, family members, surrogates, physicians, nurses, and social workers about each illness episode. In highly fragmented healthcare delivery, discontinuity undermines effective communication with patients, families, and professionals.

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Avoiding Ethical Emergencies
Patricia Benner

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