Emergency Management of Acute Ischemic Stroke in Incapacitated Patients Who Have No Surrogate Decision Makers

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ABSTRACT
When hospitalized patients with acute ischemic stroke are unable to make their own medical decisions, clinicians usually turn to advance directives and the patient’s close family members and friends to define the patient’s wishes and expectations regarding treatment and prognosis. In many jurisdictions, if there is no surrogate for an incapacitated patient, an emergency ethics or risk management consultation is advisable and is usually done with a representative of the hospital’s law office. The ethics team can represent the patient’s interests by hearing the recommendations of the treating physicians and then deciding whether their recommended treatment plan is ethically permissible and in the patient’s interests. Depending on the jurisdiction, it is sometimes necessary for the courts to appoint a guardian for incapacitated patients who have no surrogate decision makers available.

Case
A 60-year-old man was admitted to the emergency department at 9:35 AM for sudden onset of right side weakness and mild dysarthria while having breakfast with his best friend at 8:50 AM. At 9:55 AM, the CT scan of the head revealed no hemorrhages and preserved white/gray matter differentiation. At 10:05 AM, he became aphasic and hemiplegic. A diagnosis of acute ischemic stroke (AIS) was made. He was treated with IV tissue plasminogen activator (tPA) on the basis of implied consent for emergency treatment and admitted to the neurointensive care unit where he continued to deteriorate. Over the following 24 hours, head CT showed cerebral edema had developed. Because of his worsening level of consciousness and impaired airway protection, he was intubated. The neurologist recommended a decompressive hemicraniectomy (DHC) to save his life. However, no family member was available to provide consent. His only relative, a nephew, was reached by phone and stated that the patient had never commented on health issues, that he was unaware of any advance directives, and that he did not feel he could make decisions on behalf of his uncle. The patient’s best friend was then contacted. He remembered that during last Christmas season the patient had stated, “If I ever become a burden or incapacitated, please let me die.”
DISCUSSION

In 1995, the treatment of AIS was revolutionized by the results of the National Institute of Neurological Disorders and Stroke trial. The recent European Cooperative Acute Stroke Study (ECASS III) confirmed the safety and efficacy of IV tPA in patients with AIS within 4.5 hours of symptom onset. The American Stroke Association recommends that patients and their families be informed of the potential risks and benefits of IV tPA therapy, as with any other approved medical or surgical intervention, such as DHC. This case illustrates several important ethical and legal issues that may arise during the care of patients with AIS who simultaneously lack decision-making capacity and a surrogate decision maker.

1. Were the administration of IV tPA and the intubation of the patient appropriately based on the application of the principle of implied consent in emergency circumstances?
2. Can the neurologists and neurosurgeons proceed with DHC on the basis of implied consent for emergency circumstances?
3. Because no surrogate decision maker is available, who will represent the patient’s interests in the decision-making process?
4. When should proceedings for a guardian ad litem be initiated?

In emergency or life-threatening and time-critical situations, physicians have the duty to preserve life. In very few life-threatening conditions, such as sepsis or myocardial infarction, patients can be involved in the consent process. However, physicians often use an “implied consent” principle to perform life-saving interventions in those patients who lack decision-making capacity or surrogates. The emergency doctrine of implied consent allows providers to deliver certain interventions that, if not performed in a timely manner, could potentially lead to increased morbidity and mortality. Physicians can use this doctrine if the following conditions are met: (1) the treatment in question represents the usual and customary standard of care for the condition being treated; (2) delaying treatment while awaiting explicit consent would be clearly harmful to the patient; and (3) patients ordinarily would be expected to consent for the treatment in question if they had the capacity to do so. In this case, both the administration of IV rtPA and emergent intubation satisfy these criteria. Specific to AIS management, in 2011 the AAN Ethics and Humanities Subcommittee updated their policy on the applicability of implied consent for the administration of IV tPA. They concluded that the doctrine of implied consent does apply, but physicians should make reasonable efforts to contact proxy decision makers and document the urgent need to proceed with treatment in the absence of consent. The American Heart Association/American Stroke Association also endorses the use of IV tPA for acute stroke management. The preponderance of evidence suggests that IV tPA is both safe and effective, and physicians caring for patients with AIS should not deny the use of this medication when indicated for fear of medicolegal repercussions.

When a patient with AIS is deemed not to have decision-making capacity, the physician must seek an alternate way to obtain consent. The first step is to determine whether the patient has drafted an advance directive, such as a living will or durable power of attorney (for health care decisions). In the absence of an advance directive, the physician must seek the substituted judgment of a proxy or surrogate authorized by the state law. Should the physician be unable to identify an alternative form of
In the case presented above, the neurologists and neurosurgeons are facing a different ethical dilemma: whether to proceed with a DHC in the face of a family member who feels unable to make decisions for the patient. DHC in the setting of malignant middle cerebral artery (MCA) infarction is a life-saving intervention, and about 80% of patients are expected to survive. Among patients who survive, about 40% will have mild to moderate disability (Modified Rankin Scale [mRS] score 1 to 3), and about 60% will face moderately severe to severe disability (mRS score 4 to 5). Thus, for every 10 DHCs performed for malignant MCA infarction, five patients will escape death, and at 6 months one of these patients will have mild disability, one will have moderate disability, and three will have moderately severe to severe disability and remain unable to walk independently. This type of information may be valuable when explaining the risks and benefits to friends, family members, and consultants. Expert opinions supported by clinical trial results suggest that DHC should be performed within 48 to 72 hours of symptom onset. Because DHC is not yet considered the standard of care of emergency management in AIS in the United States, the emergency doctrine of implied consent cannot be applied to this particular intervention, as the conditions necessary to support it are not met. Moreover, according to the patient’s best friend, the patient’s wishes were specific for the scenario of surviving with any disability. Therefore, the relevant question is whether the likely long-term functional outcome is consistent with the patient’s known wishes and the goals of care.

In addressing issues relating to advance directives and withholding or withdrawing life support, several clinical prognostic questions require answers. For example, what is the probability of death during the next month and the next year (and what are the confidence intervals around that probability)? What are the likely causes of death during the first month? If the patient survives, what level of disability will he or she have? What impact will the intervention have on survival or disability? When facing urgent but not emergent time-critical situations, or in the face of withholding or withdrawing medical care such as life support, physicians may use their experience guided by their substantial knowledge of the literature. They should also consider the patient’s known wishes and family member opinions and seek the support of a multidisciplinary team to attain a balanced view of the impact of therapeutic decisions and the expected disability of the patient.

In many jurisdictions, if there is no surrogate for an incapacitated patient, an emergency ethics or risk management consultation is advisable and is usually done with a representative of the hospital’s law office. The ethics team can represent the patient’s interests by hearing the recommendations of the treating physicians and then deciding whether their recommended treatment plan is ethically permissible and in the patient’s interests. Hence, two theoretical outcomes are possible in this case after an ethics consultation.

First, the ethics consultant may find it ethically permissible to allow the treatment team to proceed with the DHC based on the low probability (about 10% to 20%) that the patient will end up with minimal disability, evidenced by the robust pooled data from randomized controlled trials. Studies have
demonstrated a tendency among the nondisabled to view a disabling stroke as equivalent to death, and investigators frequently lump death with the severe disability group. Interestingly, however, quality of life after AIS may be seen as high even in the setting of respiratory failure with ventilator dependency. This may be explained by a phenomenon called “response shift,” where patients redefine their personal values and the sense of reaction when facing disability.

Alternately, the ethics consultant may find a DHC ethically impermissible in this case on the basis of the higher probability of the patient ending up with severe disability and his known wishes expressed to his best friend. Of course, there is no right or wrong answer; therefore, physicians are always encouraged to request ethical/legal counseling when dealing with situations where incapacitated patients require medical care and have no legally authorized surrogate, family member, or friend willing or able to speak on their behalf.

In the absence of surrogate decision makers, physicians must seek the representation of the patient’s interests in the decision-making process through a court-appointed guardian ad litem. Emergency guardianship may be requested through consultation with the hospital’s legal team and the ethics committee. This would be advisable at this point in the management of this patient, as whether or not the patient receives the DHC, decisions regarding additional interventions, such as do not resuscitate orders, tracheostomy, gastrostomy, final placement, and palliative care, may be required. One problem with this system is that court-appointed guardians are often unfamiliar with the patient and have little contact with the treating medical professionals.

CONCLUSION

The principles of autonomy, professional duty, and the common law require physicians to obtain consent before giving treatment, except in emergency circumstances. In the absence of these, physicians must seek the representation of the patient’s interests in the decision-making process through a court-appointed guardian ad litem, particularly when addressing issues relating to urgent interventions and withholding or withdrawing life supportive therapy. Clinical prognostic questions require specific answers, so caregivers should strive to achieve the highest level of certainty regarding the diagnosis and prognosis, with the patient’s wishes in mind.

REFERENCES

Quality of Care Outcomes in Research Interdisciplinary Working Groups: the American Academy of Neurology affirms the value of this guideline as an educational tool for neurologists. Circulation 2007;115(20):e478–e534.


