

# End-Stage Heart Failure: Ethical Considerations

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End-stage heart failure (ESHF) patients deserve end-of-life considerations, according to the ACC/AHA 2005 *Guideline* Update for the Diagnosis and Management of Chronic Heart Failure in the Adult. The Guideline states that all professionals working with heart failure (HF) patients should examine current end-of-life processes and work toward improvement in approaches to palliation and end-of-life care. Professionals caring for patients with ESHF should have realistic expectations for survival and communicate those accurately to patients and families. They should also ensure continuity of medical care between inpatient and outpatient settings.

*Before* the HF patient becomes too ill to participate in decisions, the Guideline recommends educating and informing the patient and family about the prognosis for functional capacity, survival, treatment preferences, resuscitation, option of inactivating implanted cardiac devices, living wills, advance directives, and the role of palliative and hospice care services. Contemplation of resuscitation options, as required by the Patient Self-Determination Act, at the time of hospitalization for worsening HF may heighten patient and family anxiety without revealing true preferences. The ESHF patient should be encouraged to choose in advance a person to assume legal authority (i.e. designated power of attorney or healthcare proxy) for health-care matters when the patient cannot be involved in decisions. Hospitalization and/or resuscitation may no longer be desired by the patient when the limitations imposed by HF alone or in combination with other severe conditions become intolerable.

The Guideline states that it is inappropriate to perform aggressive procedures within the final days of life in patients with NYHA functional class IV symptoms who are not anticipated to experience clinical improvement from available treatments (including intubation and implantation of a cardioverter-defibrillator). Opiates are appropriate and recommended hospice care therapy for relief of suffering and symptom palliation for patients with HF at the end of life; inotropes and intravenous diuretics are optional. Greater attention needs to be devoted to the provision of comfort measures in the final days of life, including relief of pain and dyspnea.

It is important to understand which aspects of further care the ESHF patient wishes to forego. Some patients may want full supportive care while conscious without resuscitation; others may decline hospitalization or any intervention. Furthermore, the decision to forego resuscitation should lead to possible deactivation of the life-saving function of an implanted defibrillation device.

Hospice services, originally developed for patients with end-stage cancer, have recently been extended to provide compassionate care to patients dying of HF. While ESHF patients characteristically suffer from breathlessness, many patients dying of HF do describe pain during the final days. Physicians caring for these patients should, according to the Guideline, not only utilize optionally inotropes and diuretics, but also become familiar with the prescription of anxiolytics, sleeping medications, and narcotics to ease distress during the last days.

The utilization of hospice care, which traditionally required a prediction by the physician of death within 6 months, for patients with ESHF is acceptable even though the health-care providers are generally unable to accurately predict the end of life in patients with HF. Current hospice guidelines and policies are being revised to allow patients with HF to benefit from the type of care that can be provided through hospice services.

Finally, with regard to end-of-life considerations of patients with HF, the ultimate decisions regarding when end-of-life is nearing reflect a complex interaction between objective information and subjective information, emotions, and patient and family readiness. All professionals involved with HF care should make it a priority to improve recognition of end-stage disease and provide care to patients and families approaching this stage. And, as physicians “become more familiar with the steps in progression to end-stage HF in this era, the current abrupt transition from aggressive intervention to comfort and bereavement care will be softened by a gradual and progressive emphasis on palliation until it dominates the final days of care.”

Reference: [www.acc.org/clinical/guidelines/failure/index.pdf](http://www.acc.org/clinical/guidelines/failure/index.pdf)