Responding to Requests for Futile or Potentially Inappropriate Treatments

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Royalties

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Would you withdraw life support?

- 71 year old man with moderate dementia, severe PVD and COPD admitted with respiratory failure, septic shock and multi-organ failure. No advance directive.
  - 6 weeks in ICU
  - Minimally responsive after watershed infarcts
  - Ventilator dependent
  - Off pressors; stable vital signs
  - Necrotic digits and pressure ulcers requiring serial debridement.

- The lone adult daughter, who is generally tearful and distraught when in ICU, insists on ongoing treatment, saying, “he would want to live; he’s going to recover; I can’t let him go”.
The Actual Ethical Question in Most Cases is Not ‘Can it Work?’

Surrogates rarely request treatments that stand no chance of achieving the goal of life prolongation.

The actual ethical question:

“Are there situations in which a patient’s life could be extended (and doing so is requested by the patient/proxy), but competing ethical considerations justify refusal of requested treatments?”
The Relevant Competing Ethical Considerations

- Patients’ interest in living according to their values and preferences.
- Clinicians’ interest in acting in accord with professional integrity.
- Society’s interest in just allocation of resources.
Ddx: Causes of Persistent Disagreement

Informational?
- Simple misunderstandings about prognosis
- Lack of awareness about comfort-focused pathway

Emotional/Interpersonal?
- Distrust of physicians’ predictions
- Reluctance to act according to patient’s values
- Conflict within family
- Overwhelming grief → denial or ‘decision paralysis’

Moral?
- Deep moral disagreement about what is best for the patient.
An Official ATS/AACN/ACCP/ESICM/SCCM Policy Statement: Responding to Requests for Potentially Inappropriate Treatments in Intensive Care Units


This Official Policy Statement of the American Thoracic Society (ATS) was approved by the ATS, January 2015, the American Association for Critical Care Nurses (AACN), December 2014, the American College of Chest Physicians (ACCP), October 2014, the European Society for Intensive Care Medicine (ESICM), September 2014, and the Society of Critical Care Medicine (SCCM), December 2014.

http://www.atsjournals.org/journal/ajrccm
# Participants

## Participating Professional Societies
- American Thoracic Society
- Society for Critical Care Medicine
- American Academy of Critical Care Nurses
- American College of Chest Physicians
- European Society of Intensive Care Medicine

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Methods

Iterative consensus process involving a multi-disciplinary committee and representatives from each of the 5 participating professional societies.

- Literature review
- Review of existing professional society guidelines
- Iterative in-person meetings and tele- and web-conferences over 2 years to reach consensus on key recommendations.
- Writing committee drafted policy statement and iteratively revised in response to committee member comments.
- Each professional society’s ethics committee reviewed and approved the document.
- External peer review.
- Final approval by Board of Directors of each society.
Three Main Groups of Recommendations

- Recommendations for:
  - **Terminology** to describe disputes.
  - **Preventing** intractable disputes between clinicians and surrogates.
  - **Resolving** intractable disputes.
**Terminology**

**Recommendation**

The term “potentially inappropriate” should be used, rather than “futile,” to describe treatments that have at least some chance of accomplishing the effect sought by the patient, but clinicians believe that competing ethical considerations justify not providing them.

Bosslet G. AJRCCM 2015
Why Use the Term ‘Potentially Inappropriate Treatment’?
Nudging Clinicians Toward a New Mental Model

Conveys more clearly than the word ‘futile’ that clinicians’ assertions are:

- Value-laden claims rather than a scientific determinations.
- Preliminary rather than final, and in need of some sort of verification.
Potentially Inappropriate Treatment (PIT)

Physician believes that administering the requested treatments would **violate professional integrity**.

Reasons for this claim might include that the treatment is:

- highly burdensome or painful;
- highly unlikely to be successful;
- is extremely expensive or scarce;
- is intended to achieve a goal of controversial value.
How Should We Prevent Conflict about PIT?
Recommendation 1
Institutions should implement strategies to prevent intractable treatment conflicts, including proactive communication and early involvement of expert consultation.
Table 2. Recommended Practices for Improving Communication and Support for Surrogates in the Intensive Care Unit

Systems-level interventions
- Conduct regular, structured interprofessional family meetings (63–68)
- Integrate palliative care and/or ethics teams into ICU care for difficult cases (11, 14, 68–71)
- Provide printed educational materials to family (66, 67, 72, 73)
- Maintain dedicated meeting space for ICU family meetings

Clinician-level skills
- Coordinate an effective ICU family meeting
  - Establish consensus among treating clinicians before the meeting (68, 74)
  - Use a private, quiet space for family meetings (68, 74)
  - Introduce all participants
  - Use patient/family-centered communication strategies (see below)
  - Affirm nonabandonment and support family decisions (12, 75)
- Provide family-centered communication
  - Elicit surrogates’ perceptions first (76)
  - Use active listening skills and deliver information in small chunks (77, 78)
  - Respond to questions and check for understanding of key facts (12, 76, 79)
  - Acknowledge and address emotion (13, 68, 75, 79, 80)
  - Support religious/spiritual needs and concerns (68, 81)
- Foster shared decision making (15–17, 68, 82)
  - Assess clinical prognosis and degree of certainty
  - Evaluate surrogate preferences for decision-making responsibility (18, 19, 21, 22)
  - Elicit the patient’s treatment preferences and health-related values (83)
Family Support Interventions Improve Care Decisions & Decrease EOL Treatment Intensity

ORIGINAL ARTICLE

Randomized Trial of Communication Facilitators to Reduce Family Distress and Intensity of End-of-Life Care

J. Randall Curtis¹,², Patsy D. Treece¹, Elizabeth L. Nielsen¹, Julia Gold³, Paul S. Ciechanowski⁴, Sarah E. Shannon², Nita Khandelwal⁵, Jessica P. Young¹, and Ruth A. Engelberg¹

¹Cambia Palliative Care Center of Excellence and Division of Pulmonary and Critical Care, ²Department of Biobehavioral Nursing and Health Systems, School of Nursing, ³School of Law, ⁴Department of Psychiatry and Behavioral Sciences, and ⁵Department of Anesthesiology and Pain Medicine, University of Washington, Seattle, Washington

ORIGINAL ARTICLE

A Randomized Trial of a Family-Support Intervention in Intensive Care Units

An Official ATS/AACN/ACCP/ESICM/SCCM Policy Statement: Responding to Requests for Potentially Inappropriate Treatments in Intensive Care Units


Recommendation 1
Institutions should implement strategies to prevent intractable treatment conflicts, including proactive communication and early involvement of expert consultation.

Bosslet G. AJRCCM 2015
Effect of Ethics Consultations on Nonbeneficial Life-Sustaining Treatments in the Intensive Care Setting
A Randomized Controlled Trial

Lawrence J. Schneiderman, MD
Todd Gilmer, PhD

Context: Ethics consultations increasingly are being used to resolve conflicts about life-sustaining interventions, but few studies have reported their outcomes.

Proactive palliative care in the medical intensive care unit: Effects on length of stay for selected high-risk patients

Sally A. Norton, PhD, RN; Laura A. Hogan, MS, RN, ACHPN; Robert G. Holloway, MD, MPH; Helena Temkin-Greener, PhD, MPH; Marcia J. Buckley, MS, RN, BC-PCM; Timothy E. Quill, MD

The effect of a family support intervention on family satisfaction, length-of-stay, and cost of care in the intensive care unit

Wayne Shelton, PhD; Crystal Dea Moore, PhD; Sophia Socaris, MD; Jian Gao, PhD; Jane Dowling, PhD

Schneiderman, JAMA 2003; 290:1166
Norton S. Crit Care Med 2007
Sheldon W. Crit Care Med 2010
Conflict that Seems Intractable Often Is Not

Resolution of Futility by Due Process: Early Experience with the Texas Advance Directives Act

Robert L. Fine, MD, and Thomas Wm. Mayo, JD

1. The family must be given written information about hospital policy on the ethics consultation process.
2. The family must be given 48 hours’ notice and be invited to participate in the consultation process.
3. The ethics consultation committee must provide a written report detailing its findings to the family.
4. If the ethics consultation process fails to resolve the dispute, the hospital, working with the family, must try to arrange transfer of the patient to another physician or institution willing to give the treatment requested by the family.
5. If after 10 days (measured from the time the family receives the written summary from the ethics consultation committee) no such provider can be found, the hospital and physician may unilaterally withhold or withdraw therapy that has been determined to be futile.
6. The patient or surrogate may ask a state court judge to grant an extension of time before treatment is withdrawn. This extension is to be granted only if the judge determines that there is a reasonable likelihood of finding a willing provider of the disputed treatment if more time is granted.
7. If the family does not seek an extension or the judge fails to grant one, futile treatment may be unilaterally withdrawn by the treatment team with immunity from civil and criminal prosecution.

47 ethics consults for “intractable” conflict

37 consults (78%) yielded consensus about treatment plan

10 cases to TADA process

How Should We Manage Intractable Disagreements about Potentially Inappropriate Treatment?
Requests for potentially inappropriate treatment that remain intractable despite intensive communication and negotiation should be managed by a fair process of dispute resolution.

Bosslet G. AJRCCM 2015

the Clinical Research, Investigation, and Systems Modeling of Acute illness

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Guiding Considerations of the Dispute Resolution Process

1. Making decisions will necessarily entail value judgments, which should be made explicit.

2. Neither individual clinicians nor families should be given authority to unilaterally decide.

3. Clinicians should not simply acquiesce to requests they believe are harmful to the patient or violate professional integrity.

4. The process of decision making should satisfy basic aspects of procedural fairness.
Last Resort: Process-based Approach to Dispute Resolution

Claim by clinician: potentially inappropriate treatment

Fair process

Determination:
- Permissible treatment
- Inappropriate treatment
Recommended Steps of Conflict Resolution Process*

1. Give notice of the process to surrogates
2. Continue negotiation during the conflict resolution process
3. Obtain a second medical opinion
4. Obtain review by an interdisciplinary hospital committee
5. Offer surrogates the opportunity to seek transfer of the patient to an alternate institution
6. Inform surrogates of their right to appeal (i.e. to seek judicial intervention).
7. Implement the decision of the resolution process

*Abbreviated resolution processes are recommended in time-pressured situations and for requests for physiologically futile treatments.
Case Resolution

Resolution:

- Over several family meetings: clinicians compassionately but firmly expressed their ethical concerns; recommended comfort-focused care plan.

- Informed daughter of conflict resolution process.

- Daughter declined to pursue transfer or judicial intervention.

- 4 days later, daughter agreed to comfort-focused care; patient died with daughter and clinicians at bedside; she thanked the team for excellent care.

CASE: 71 year old man with moderate dementia and severe COPD admitted with respiratory failure, septic shock and multi-organ failure. No advance directive.

- 6 weeks in ICU
- Minimally responsive after watershed infarcts
- Ventilator and dialysis dependent
- Off pressors; stable vital signs
- Necrotic extremities requiring serial debridement
Conclusions

- Managing requests for potentially inappropriate treatment is deceptively complex.

- **Prevention** of intractable conflict is the most promising strategy to improve care.
  - System level interventions to improve communication
  - Early involvement of expert consultants

- For intractable disputes, a stepwise conflict resolution process is the least bad alternative currently available.
Recommendation for Managing Requests for PIT in Time Pressured Situations

- When time pressures make it infeasible to complete all steps of the conflict resolution process and clinicians have a high degree of certainty that the requested treatment is outside accepted practice, they should:
  - Achieve as much procedural oversight as the clinical situation allows and,
  - if there is agreement, should refuse to provide the requested treatment.

- All such cases should be undergo prompt retrospective review by the hospital ethics committee.
Recommendation 3
Managing Requests for Physiologically Futile Interventions

- Clinicians need not provide physiologically futile interventions.
- They should carefully explain the rationale for their refusal.
- If disagreement persists, clinicians should obtain expert consultation to assist in communicating to surrogates the rationale for the decision.
- There should be retrospective hospital review of all cases.