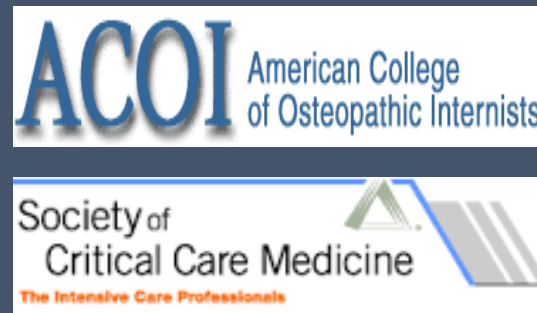
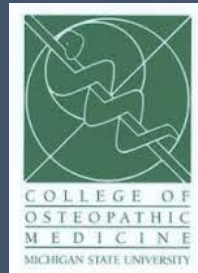


# Responding to Requests for Potentially Inappropriate Treatments in the Intensive Care Unit

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# Disclaimers

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# Objectives

- Review the four (4) recommendations in “An Official ATS/AACN/AACP/ESICM/SCCM Policy Statement: Responding to Requests for Potentially Inappropriate Treatments in the Intensive Care Units” as provided in **Am J Respi Crit Care med Vol 191, Iss 11, pp 1318-1330, Jun 1, 2015**
- Understand the seven features of a program to address conflict resolution in responding to requests for inappropriate care in the ICU
- Discuss “Defining Futile and Potentially Inappropriate Interventions: A Policy Statement From the Society of Critical Care Medicine Ethics Committee” in response to the aforementioned publication.  
**Crit Care Med 2016; 44: 1769-1774**

# ATS/AACN/ACCP/ESICM/SCCM Recommendations

1. Institutions should implement strategies to prevent intractable treatment conflicts, including proactive communication and early involvement of expert consultation
2. 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.

# ATS/AACN/ACCP/ESICM/SCCM Recommendations

## 3. Two less-common situations:

- The term “futile” should only be used in the rare circumstance that an intervention simply cannot accomplish the intended physiologic goal.
- “Legally proscribed” or “legally discretionary” treatments are those for which there are specific laws, judicial precedent, or policies that give physicians permission to refuse to administer them.

## 4. The medical profession should lead public engagement efforts and advocate for policies and legislation about when life-prolonging technologies should not be used.

# Recommendation 1 - Justification

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

1. Collaborative decision making is fundamental to good medical care
2. “Intractable treatment conflicts” usually result in second-best alternatives – usually protracted and burdensome.
3. Most treatment disagreements in ICUs result not from intractable value judgements, but from breakdowns in communications.

# Recommendation 1 - Implementation

- Simple – COMMUNICATE regularly with families, surrogates and provide emotional support and a trusting relationship.
- Clinicians are *not* required to offer treatments that are outside the bounds of normal accepted medical practice.
- When clinicians receive a request s/he believes to be inappropriate, rather than acquiesce to the request, seek to understand the surrogate's perspective and correct misperceptions.
- Advocate for treatments that are good medical practice.
- When these efforts fail, consider an alternate or supportive surrogate – if failing this, seek a court-appointed guardian

# Early Involvement of Expert Consultants

- Hospitals should implement strategies to identify and intervene on ICU conflicts using individuals skilled in negotiation and communication.
  - Ethics or Palliative care consultants
  - Social workers, trained mediators
  - Chaplains or related religious organization representatives

## Recommendation 2

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. Clinicians should communicate and advocate for the treatment plan they believe is appropriate. Requests for potentially inappropriate treatments that remain intractable despite intensive communication and negotiation should be managed by a fair process of conflict resolution.

# Recommendation 2 - Justification

- “Inappropriate” conveys more clearly than “futile” or “ineffective” the assertion that the clinician is applying both a technical and value-laden claim.
- “Potentially” signals that the judgments are preliminary and may be reviewed and can raise ethical concerns such as unlikely success, extreme expense (both financial and physiological), and controversial goals (e.g., long-term severe disability).

# Recommendation 2 - Implementation

- Use a procedure approach to conflict resolution
  - “Sole authority” to either surrogates or clinicians implies a right to unilateral decision-making
  - In surrogates, this may become a disincentive to genuine consideration clinician perspectives.
  - Surrogates may experience strong emotional or psychological barriers to decision making, even despite patient pre-determinations.
  - Well-documented variability in clinician judgements of appropriate ICU care may result in concern of undue variation in treatment considerations.

A institutional process-based approach provides consistency, broader input, and opportunity for continuous learning to mitigate the perception of arbitrariness to conflict resolution.

# Key features of an institutional program for conflict resolution

1. Expert consultation to aid in achieving a negotiated agreement
2. Notice of the process to surrogates
3. Second medical opinion
4. Review by an interdisciplinary hospital committee
5. Opportunity to transfer patient to an alternate institution
6. Opportunity to pursue extramural appeal
7. Consistent implementation of the resolution process

# Managing Time-pressured Decisions

- If possible, initiate a temporizing treatment plan to allow the conflict resolution process to occur. \*This need not be the surrogate request
- If time cannot be found:
  - Assure facts and assumptions are verified
  - Engage other clinician to the extent possible
  - Explain to surrogates the reasons for refusing to administer the requested tx
- Clinicians should
  - Base judgment on best understanding of professional obligations
  - Have high degree of certainty the request is, indeed, outside medical bounds
  - Only enact this strategy when the conflict resolution process cannot be implemented

# Recommendation 3

## Two less-common situations:

- Requests for “strictly futile” care: The term “futile” should only be used in the rare circumstance that an intervention simply cannot accomplish the intended physiologic goal.
  - Clinicians should NOT provide futile care and should explain the rationale for refusal.
- Requests for legally proscribed or discretionary care: “Legally proscribed” or “legally discretionary” treatments are those for which there are specific laws, judicial precedent, or policies that give physicians permission to refuse to administer them.
  - Clinicians may be obligated to refuse the requested treatment and should explain the rationale to surrogates.
  - If uncertainty exists as to interpretation of the rule, confirm the interpretation by expert consultation.

# Recommendation 3 - Justification

- A very narrow definition exists for “futile” – intervention that *cannot* achieve the desired physiologic goal.
- This distinction separates interventions that *cannot* work versus interventions that have low potential for success and raise countervailing ethical concerns.

# Recommendation 3 - Management

- Futile care:
  - Seek to understand the reasons for the surrogate's request
  - Empathically correct misperceptions, provide emotional support
  - Consider expert psychosocial support for the surrogate.
- Proscribed/Discretionary care:
  - Proscribed rules define treatment that is prohibited.
  - Discretionary rules provide guidance which give physicians permission to refuse to implement the treatment.

These additional options are important, as they highlight that futility is not the only legitimate basis to refuse to provide a treatment.

# Recommendation 4 - Justification

The medical profession should engage in efforts to influence opinion and develop policies and legislation about when life-prolonging technologies should not be used.

- While self-evident as a recommendation, the high level of detail and specificity required to provide a valid guidance is labor-intensive.
- Public engagement should have a goal of informed, considered input from stakeholders.
- Specifically, care plans should include treatments focused on achieving patient comfort.

# Defining Futile and Potentially Inappropriate Interventions: A policy Statement from the Society of Critical Care Medicine Ethics Committee

ICU interventions should be considered inappropriate when there is no reasonable expectation that the patient will improve sufficiently to survive outside the acute care setting, or when there is no reasonable expectation that the patient's neurologic function will improved sufficiently to allow the patient to perceive the benefits of treatment.

SCCM supports the seven-step process presented in the multi-organization statement.

# SCCM: Defining potentially inappropriate interventions

- Specifically, these refer to life-prolonging interventions (or interventions that prolong the dying process) that have no hope of providing the patient survival, to include reversal of severe neurologic injury.
  - Not surprisingly, physicians consistently utilized **severe neurological injury, persistent vegetative state, advanced dementia, low ICU survival scores** in defining “futility” and/or “futile interventions”.
  - ATS (1991): Defined futile as highly unlikely to result in “meaningful survival” for that patient.
  - CMA (1995): No reasonable hope of recovery or permanent benefit
  - SCCM (1997): Process-based approach

# Futility and Inappropriate Intervention: Brief review of articles addressing Surrogate priorities

- Surrogates do not expect offer of MV for futile care
- Agree that treatment solely to keep organs alive is not appropriate
- Some Diagnoses:
  - 91% of COPD patients refused CPR, 94% refused MV
  - Advanced Dementia: 82% and 85%, respectively
- Ethnic variation is low:
  - Refusal statistically higher among Caucasians versus all other ethnic groups
  - All ethnic groups consistently chose to defer inappropriate treatment.

# SCCM Recommendations:

1. Appropriate goals of ICU care include:
  - Treatment that provides a reasonable expectation for survival outside the acute care setting with sufficient cognitive ability to perceive its benefits
  - Palliative care that provides comfort to patients through the dying process may be an appropriate goal of care in some ICUs
2. ICU intervention should be considered inappropriate when there is no reasonable expectation the patient will improve sufficiently to survive outside the acute care setting, or when there is no reasonable expectation that the patient's neurological function will improve sufficiently to perceive the benefits of treatment.

# SCCM Recommendations:

3. These definitions are not exhaustive, in that there will be some cases where life-prolonging treatment is inappropriate even without the above conditions met.
4. Decisions about specific interventions appropriateness should be made on a case-by-case basis.
5. Futile is a specific definition: the proposed treatment *cannot* achieve the desired physiologic goal. Do not provide futile care.
6. A process-based approach, as illustrated above, should be used for conflict resolution regarding treatments

# SCCM Recommendations:

7. When time pressures make it unfeasible to complete the process, and the above definitions of futile or inappropriate care are met, the clinician should *not* provide the treatment; rather, complete as much of the 7-step process as possible.
8. At times, it may be appropriate to provide time-limited ICU care even when the definitions of futility or inappropriate care are met.
9. Treatment to relieve pain and suffering is always appropriate.

# The seven-steps for conflict resolution:

1. Enlist expert consultation to aid in achieving a negotiated agreement
2. Give notice of the process to surrogates
3. Obtain a second medical opinion
4. Provide review by an interdisciplinary hospital committee
5. Offer surrogates the opportunity for transfer to an alternate institution
6. Inform surrogates of the opportunity to pursue extramural appeal
7. Implement the decision of the resolution process.

