Responding to Requests for Potentially Inappropriate Treatment

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Disclosures

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- Beckwith Foundation

Royalties
- UpToDate
What to do?

- 81 year old man with severe 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 and pressure ulcers requiring serial debridement.

- Family requests ongoing treatment, saying “Please do everything to keep him alive. We can’t let him go ...and life is sacred...and he’d want to live.”
An Official ATS/AACN/ACCP/ESICM/SCCM Policy Statement:
Responding to Requests for Potentially Inappropriate Treatments in Intensive Care Units


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

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the Clinical Research, Investigation, and Systems Modeling of Acute illness
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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<tr>
<th>Medicine</th>
<th>Nursing</th>
<th>Public/patients</th>
<th>Law</th>
<th>Bioethics</th>
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<td>Gabriel Bosslet</td>
<td>Cynda Rushton</td>
<td>Jill Raleigh</td>
<td>Thaddeus Pope</td>
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<td>David Au</td>
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the Clinical Research, Investigation, and Systems Modeling of Acute illness
The Gist

Intensive communication

Expert consultation

Fair process of dispute resolution
Intensive communication

Expert consultation

Fair process of dispute resolution
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Recommendation 1
Institutions should implement strategies to prevent intractable treatment conflicts, including proactive communication and early involvement of expert consultation.
The Old (Flawed) Mental Model

“My job is to make sure the family has the information they need to make good decisions.”
A Better Mental Model

My job is to support the family in the ways needed for us to make good decisions.

- Have I moved them from a hot state to a cool(er) state?
- Have I given them the information they need?
- Have I helped them think about what decision is most respectful of the patient as a person?
- Have I given them a recommendation and advocated for it?
Shared Decision Making in ICUs: An American College of Critical Care Medicine and American Thoracic Society Policy Statement

Alexander A. Kon, MD, FCCM\textsuperscript{1,2}; Judy E. Davidson, DNP, RN, FCCM\textsuperscript{3}; Wynne Morrison, MD, MBE, FCCM\textsuperscript{4}; Marion Danis, MD, FCCM\textsuperscript{5}; Douglas B. White, MD, MAS\textsuperscript{6}

Table 2. Recommended Practices for Improving Communication and Support for Surrogates in the Intensive Care Unit

<table>
<thead>
<tr>
<th>Systems-level interventions</th>
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<tbody>
<tr>
<td>Conduct regular, structured interprofessional family meetings (63–68)</td>
</tr>
<tr>
<td>Integrate palliative care and/or ethics teams into ICU care for difficult cases (11, 14, 66–71)</td>
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<tr>
<td>Provide printed educational materials to family (66, 67, 72, 73)</td>
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<tr>
<td>Maintain dedicated meeting space for ICU family meetings</td>
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<table>
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<tr>
<th>Clinician-level skills</th>
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<tbody>
<tr>
<td>Coordinate an effective ICU family meeting</td>
</tr>
<tr>
<td>Establish consensus among treating clinicians before the meeting (68, 74)</td>
</tr>
<tr>
<td>Use a private, quiet space for family meetings (68, 74)</td>
</tr>
<tr>
<td>Introduce all participants</td>
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<tr>
<td>Use patient/family-centered communication strategies (see below)</td>
</tr>
<tr>
<td>Affirm nonabandonment and support family decisions (12, 75)</td>
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<tr>
<td>Provide family-centered communication</td>
</tr>
<tr>
<td>Elicit surrogates’ perceptions first (76)</td>
</tr>
<tr>
<td>Use active listening skills and deliver information in small chunks (77, 78)</td>
</tr>
<tr>
<td>Respond to questions and check for understanding of key facts (12, 76, 79)</td>
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<tr>
<td>Acknowledge and address emotion (13, 68, 75, 79, 80)</td>
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<tr>
<td>Support religious/spiritual needs and concerns (68, 81)</td>
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<tr>
<td>Foster shared decision making (15–17, 68, 82)</td>
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<tr>
<td>Assess clinical prognosis and degree of certainty</td>
</tr>
<tr>
<td>Evaluate surrogate preferences for decision-making responsibility (18, 19, 21, 22)</td>
</tr>
<tr>
<td>Elicit the patient’s treatment preferences and health-related values (83)</td>
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High Quality Communication Leads to Consensus In the Vast Majority of Cases
Garros et al. (2003); Prendergast (1998)

Number of Family Meetings:
- 1st
- 2nd
- 3+
- Eventual

Proportion of Cases:
- Unresolved
- Resolved

The diagram illustrates the proportion of cases that reach consensus after various numbers of family meetings, showing that high quality communication leads to consensus in the vast majority of cases.
Intensive communication

↓

Expert consultation

↓

Fair process of dispute resolution
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Recommendation 1
Institutions should implement strategies to prevent intractable treatment conflicts, including proactive communication and early involvement of expert consultation.
**Intervention**: ethics consult vs. usual care

**Setting**: adult ICUs in 7 hospitals

**Patients**: 551 patients “in whom value-related treatment conflicts arose”
- Identified by nurses; reviewed by PI
- Cross-over: 67/278 in intervention and 77/273 in usual care

Schneiderman, JAMA 2003; 290:1166
### Outcome of Ethics Consult

<table>
<thead>
<tr>
<th></th>
<th>Intervention</th>
<th>Control</th>
<th>p value</th>
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<tr>
<td><strong>Enroll to death:</strong></td>
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<tr>
<td>Hospital (days)</td>
<td>8.7</td>
<td>11.6</td>
<td>0.01</td>
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<tr>
<td>ICU (days)</td>
<td>6.4</td>
<td>7.7</td>
<td>0.03</td>
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<tr>
<td>Mortality(%)</td>
<td>62.7</td>
<td>57.8</td>
<td>0.20</td>
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No data on bereavement outcomes, patient-centeredness of care, decision quality.

Schneiderman, JAMA 2003; 290:1166
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

Norton S. Crit Care Med 2007

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

Sheldon W. Crit Care Med 2010
Intensive communication

Expert consultation

Fair process of dispute resolution
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 treatment that remain intractable despite intensive communication and negotiation should be managed by a fair process of dispute resolution.

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The Actual Ethical Question in Most Cases

“Are there situations in which the patient’s life could be extended (and doing so is requested by the patient/proxy), but doing so would be ethically wrong?”
Guiding Considerations of the Policy

Neither individual clinicians nor families should be given complete authority to make unilateral decision.

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

In response to intractable conflict, 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

Determination:
- Permissible treatment
- Inappropriate treatment
Recommendation 2
Managing Requests for Potentially Inappropriate Treatment

1. Give notice of the process to surrogates
2. Continue negotiation during the dispute resolution process
3. Obtain a second medical opinion
4. Obtain review by an interdisciplinary hospital committee
5. Offer surrogates the opportunity to transfer the patient to an alternate institution
6. Inform surrogates of the opportunity to pursue extramural appeal
7. Implement the decision of the resolution process
Early Experience with the Texas Advance Directives Act (TADA)
Procedural Approach to Manage Requests “Medically Inappropriate” Treatment

47 consults over 2 years at Baylor U.:
- 37 (78%) resolved with routine ethics counseling
- 10 (22%) proceeded to the more formal ethics committee review following Texas law
  - 4 cases: ethics committee disagreed w/ clinicians that further non-comfort treatments were medically inappropriate.
  - 6 cases: a 10-day letter was issued.
    - 3 cases family agreed to stop treatment before 10 days elapsed.
    - 3 cases patients died during 10-day period.

Policy statement recommends different resolution strategy for:

<table>
<thead>
<tr>
<th>Situation</th>
<th>Recommended Process</th>
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<tbody>
<tr>
<td>Time pressured situations</td>
<td>1. Abbreviated prospective review</td>
</tr>
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<td></td>
<td>2. Prompt retrospective review</td>
</tr>
<tr>
<td>Requests for strictly physiologically futile interventions</td>
<td>1. Refuse to administer intervention</td>
</tr>
<tr>
<td></td>
<td>2. Prompt retrospective review</td>
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Case Resolution

- 81 year old man with severe dementia and severe COPD admitted with respiratory failure, septic shock and multi-organ failure. No advance directive.
  - 6 weeks in ICU
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