

When Treatment Appears “Medically Futile”: Communication, Values, Limits, and Policy

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What do we mean by “Medical Futility”

- Or “Non-beneficial Treatment”
- Or “Medically Inappropriate Treatment”

- A treatment that cannot provide therapeutic benefit
 - Relative to the patient’s values?




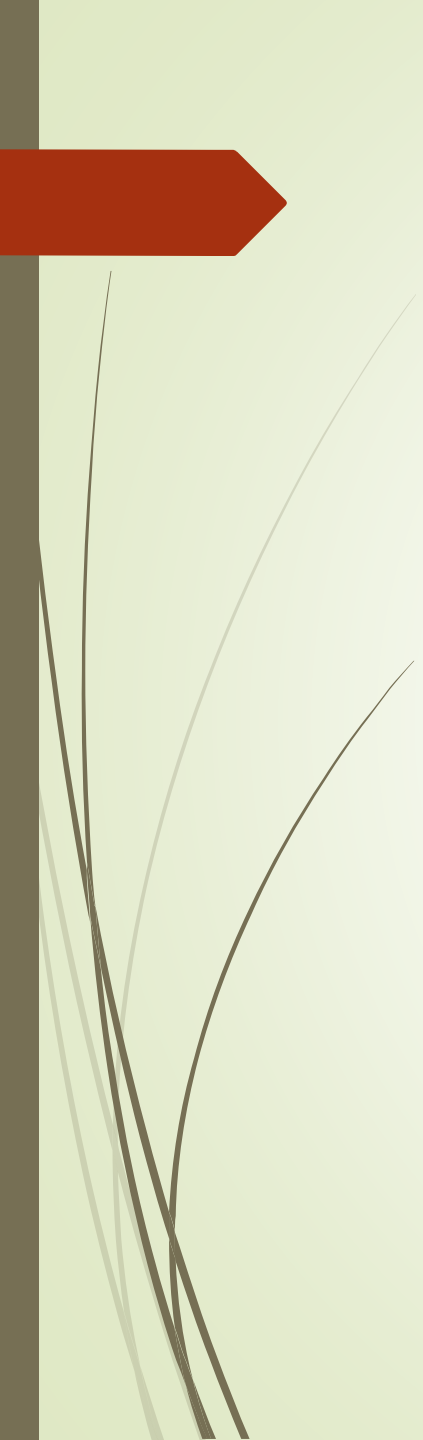
Patient Narrative # 1


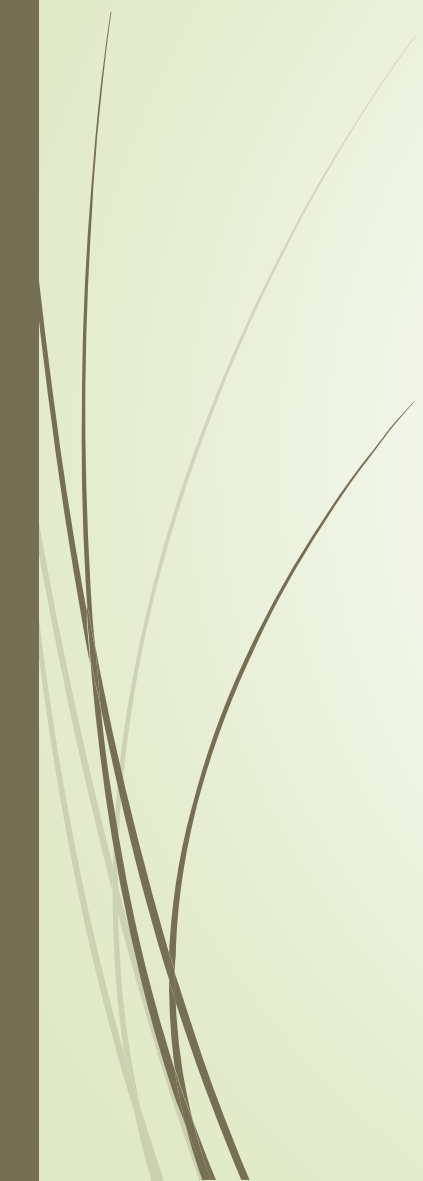
A 16-year-old female presented to an emergency department (ED) for CC: fatigue and general malaise. The day prior she had been seen in a clinic for presumed influenza.


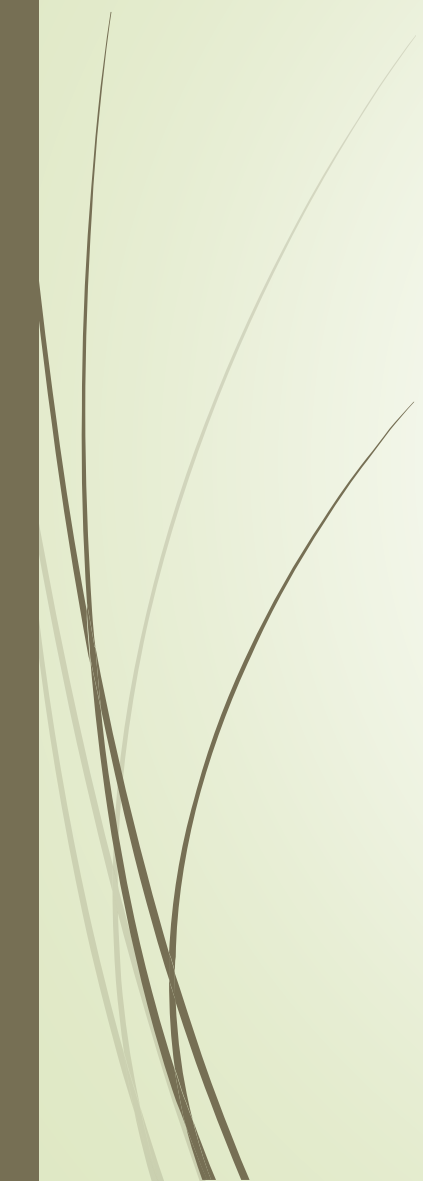
In the ED, her hemoglobin was 4mg/dl and creatinine of 17 mg/dl. She was admitted to the ICU of the outside hospital. During pRBC transfusion, she developed acute dyspnea and sudden cardiovascular collapse. She received chest compressions, was intubated, and given vasoactive medications. She was obtunded (without sedation) and remained on ventilator.


Childrens Hospital St. Louis Case¹

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- **The family was devastated. Their daughter came to the ED for “just a cough and cold.” Brain MRI was consistent with severe hypoxic injury.**
 - **The family requested transfer to the Children’s Hospital. Upon arrival, she remained unresponsive but had spontaneous respiration. She was extubated two weeks after transfer. She was diagnosed as being in a persistent vegetative state secondary to anoxic brain injury. Family requested all available medical care be provided, including resuscitation and dialysis.**

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- **The renal team was concerned that the family's perceptions were unrealistic and dialysis was futile.**
 - **An ethics consult was obtained:**
Would it be ethical to discontinue dialysis for this patient who has irreversible, profound neurological impairment?

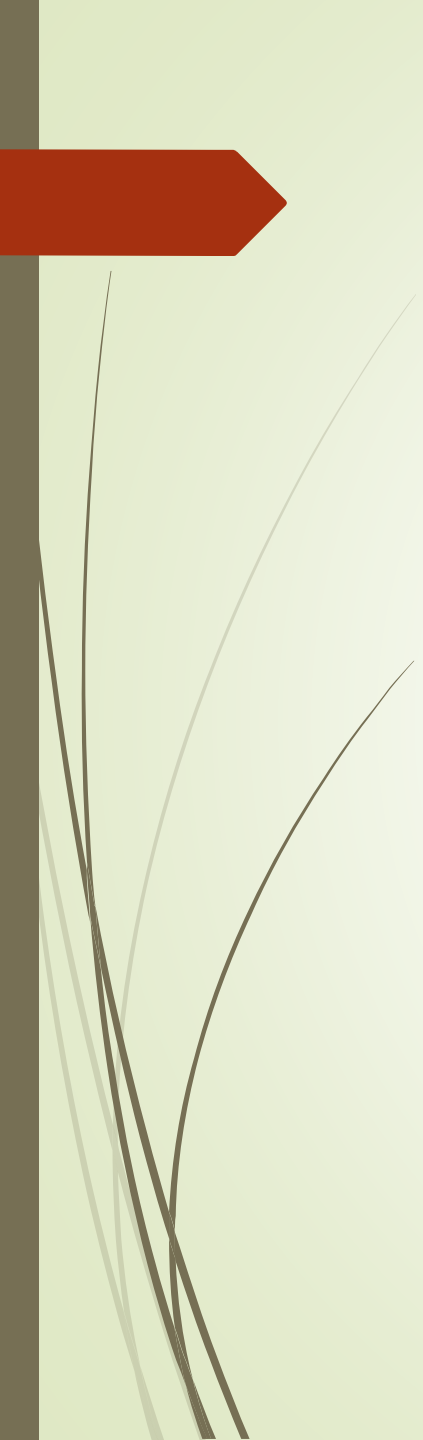
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- ▶ **The family understood the medical situation—their child suffered an irreversible brain injury.**
 - ▶ **However, the family believes that “God is not ready to take her and (the family) remains hopeful that God will perform a miracle.”**

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- **Opportunity to engage the family & explore beliefs**
 - **Has the patient ever discussed?**
 - **Does the family need time to adjust?**
 - **Given adequate explanation and time to consider, many families agree to withdrawal of LST.**
 - **Have we adequately communicated?**



Other ethical issues in the case

- ▶ **Some providers are reluctant to provide CPR & are concerned they are harming the patient (non-maleficence)**
- ▶ **Some team members conscientiously object to participating in CPR or provision of hemodialysis (Professional integrity)**
- ▶ **Though dialysis is federally funded, is this a just use of resources for a patient in PVS? Where will patient be cared for post hospital?**

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- ▶ **A number of guidelines/consensus statement, even state laws, indicate that it is appropriate to withdraw or withhold LST for patient in PVS.**
 - ▶ **Such withdrawal also requires that a legal surrogate (or person authorized to make decisions under state law) consent to withdrawal**

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- **In the patient's case, dialysis continues**
 - **Along with efforts to communicate the ineffectiveness of the treatment in terms of patient improvement**
 - **Continued communication re DNR/DNAR**




Recent Guidelines: *Responding to Requests for Potentially Inappropriate Treatments in Intensive Care Units*


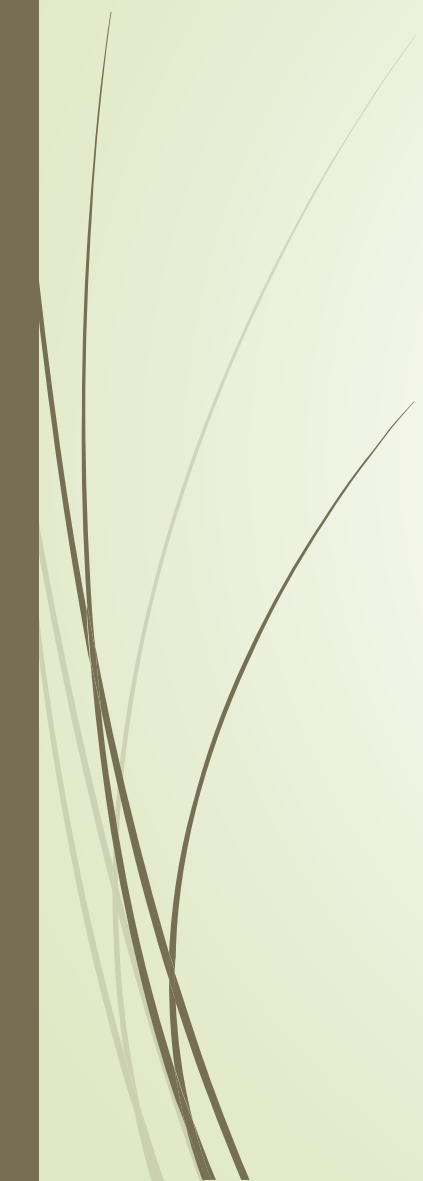
- **ATS/AACN/ACCP/ESICM/SCCM Policy Statement ²**
- **Includes traditional arguments re “futility”**
- **recommends a move away from the language of “futility”**
- **supports a focus on communication strategies to prevent intractable conflict.**

ATS/AACN/ACCP/ESICM/SCCM Policy Statement – Potentially Inappropriate Tx in ICU

- June 2015
- (1) Institutions should implement strategies to prevent intractable treatment conflicts
 - proactive communication and
 - early involvement of expert consultants.
- (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.



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- **Conflicts that remain intractable despite intensive communication and negotiation should be managed by a fair process of conflict resolution**
 - **hospital review,**
 - **attempts to find a willing provider at another institution, and**
 - **opportunity for external review of decisions.**

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- **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 ...**
 - **seek procedural oversight to the extent allowed by the clinical situation**
 - **and need not provide the requested treatment. *****

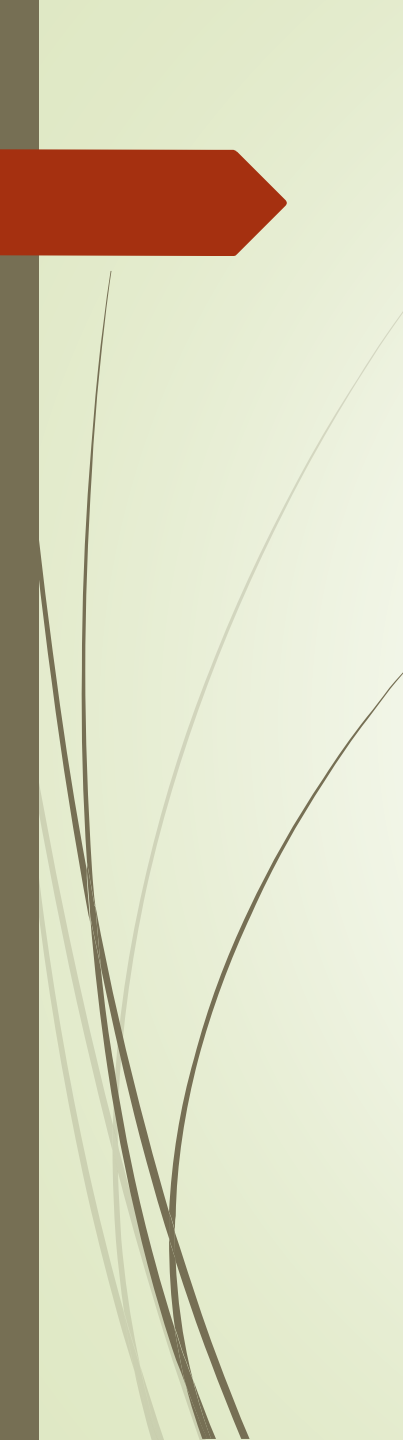



Language of ‘Futility’

- Use of the term “futile” should be restricted to the rare situations in which surrogates request interventions that simply cannot accomplish their intended physiologic goal.
- Clinicians should not provide futile interventions
- the medical profession should lead public engagement efforts
 - Develop societal policies & legislation

Defining Futile and Potentially Inappropriate Interventions: A Policy Statement from SCCM Ethics Committee ³

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

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- **The SCCM Ethics Committee believes that patients, families, and clinicians will benefit from a more consistent understanding of what generally constitutes inappropriate treatment, particularly in cases that involve time pressures that make it infeasible to complete all conflict resolution steps.**
 - **Hopes to decrease unwanted variability in patient care**
 - **Goal – policy statement based on empirical data and consensus opinion**



Systematic review of publications in PubMed presenting data on futility or inappropriate interventions/treatments was performed


- **categories of potentially inappropriate interventions were developed.**
- **either cardiopulmonary resuscitation (CPR) or ICU interventions* as inappropriate or futile, and similar situations in which respondents would not personally want CPR or ICU interventions**

***often reported as mechanical ventilation**




Results

- ▶ **physicians, nurses, and other healthcare staff appear to agree that life-prolonging interventions (or in some cases, interventions that merely prolong the dying process) are inappropriate:**
 - ▶ **when the patient will not survive outside the acute care setting or**
 - ▶ **when the patient has irreversible severe neurologic injury**

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- **Three (3) studies reported: over 95% physician stated that they would not want CPR or mechanical ventilation if they had severe neurologic injury (PVS, perm coma)**
 - **1 study: 90% of physicians would not want CPR or mechanical ventilation if they were unable to recognize people or to speak understandably**
 - **In 1 study in the case of advanced dementia 95% of physicians would not want mechanical ventilation, 76% of physicians would not want CPR**

Patient/Family Perceptions

- ➔ **One study: 90% of patients with advanced AIDS agreed that physicians need not offer mechanical ventilation if the physician judges it to be futile**

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- **One study with COPD patients:**
 - **pts do not want ventilator (94%) or CPR (91%) if had permanent coma**
 - **If had advanced Dementia - 82% no CPR; 85% no ventilator**
 - **Homeless individuals:**
 - **If in permanent coma -67% no CPR and 58% no ventilator;**
 - **If advanced dementia, 77% no CPR and 68% no vent**

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Guidance not exhaustive or obligatory

- **above definition should not be considered exhaustive. There will be cases in which life-prolonging interventions may reasonably be considered inappropriate even when the above definition is not met.**
- **Decisions regarding whether specific interventions are inappropriate should be made on a case-by-case basis**
- **Providers may support ICU care when definition not met (some never wish to overrule pt/family)**




Healthcare Ethics Consortium (HEC) Roundtable on Potentially Inappropriate Medical Treatment

❖ Met twice in 2016 – end of January & in October

Goals:

- Met twice in 2016 – end of January & in October**
- Reviewing current practice in organizations in region**
- Eliciting current institutional policies/guidelines**
- Interest in a joint project to address this issue across institutions**

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- **Some institutions developed policy
– few have used**
 - **Legal concerns re “unilateral”
nature**
 - **Tennessee (& some other states
nationally) has law supporting
discontinuing treatment**

What's at Stake for Families?

- Families who are afraid or unable to make a decision to limit treatment
- Families who do not trust the medical system
- Families who are opposed and no efforts will change this position




“Medical Futility” – Possible Mechanisms for Resolution?

- Identify clear criteria for “futile treatment” or unnecessary services?
- Accept a procedural approach
 - Does a fair process approach prioritize institutional decision making over the family?
 - In practice, should we allow the surrogate to make the final decision?
- Communication with a goal to consensus, but acknowledging that this will not always occur, then back to a process?


Resolution?

- Is it a matter of medical professionalism?
 - Requiring medical education and leadership?
 - Determining what is “medically inappropriate”
- Is it a value conflict about which we should allow families to make the decision after much education and discussion?
- Is resource use a legitimate consideration?



HEC Discussion of Possible Next Steps

- **Mandate an interdisciplinary meeting and discussion with all specialists in the room?**
- **Combining “right to decide” with responsibilities?**
 - **E.g. some financial charge for family per day if medically inappropriate treatment is continued?**
- **Support for patient advocacy; shared decision making**
- **Physician training**
 - **E.g. surgeons communication; training to “save the patient”**
 - **Encourage palliative care consultation**

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- **Communication – when specific tx is “demanded”; provided guidance about why we are Not willing to provide “x” treatment**
 - **Having a consistent point person re communication**
 - **Adopt a common process?**
 - **Do we need a cross-institutional body for review?**
 - **Gather information across state and region**



Need to Change the Public Conversation

- ▶ **How do we educate/inform the public ...**
 - ▶ **can we do this adequately in advance?**
- ▶ **Reframing/Empowering Person/Patient-Centered Care**
- ▶ **Currently, Choosing Wisely partnership with Consumer Reports and AARP as one step**
- ▶ **Addressing suspicion/mistrust directly**
- ▶ **Informed patients and families prepared to talk about what goals are realistic and the limits of what treatment is desired**



References

1. <http://www.stlouischildrens.org/health-care-professionals/publications/doctors-digest/june-2013/case-study-ethics-301>
 2. **Bosslet, G et al. An Official ATS/AACN/ACCP/ESICM/SCCM Policy Statement: Responding to Requests for Potentially Inappropriate Treatments in Intensive Care Units. American Journal of Respiratory and Critical Care Medicine 191 (11) in June 2015.**
- **Kon, A. et al. Defining Futile and Potentially Inappropriate Interventions: A Policy Statement From the Society of Critical Care Medicine Ethics Committee. Crit Care Med 2016; 44:1769–1774.**