Setting Limits:
Demands for Medically Inappropriate Intervention

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Case

An 86 y.o. woman with a history of severe dementia is brought to ER by her daughter/caregiver. She has been bedbound for five months after a fall at home. She is obtunded and breathing rapidly. She has multiple contractures and decubitus ulcers. Evaluation reveals renal failure and severe electrolyte disturbances.

Her family members want “everything” done to prolong her life.

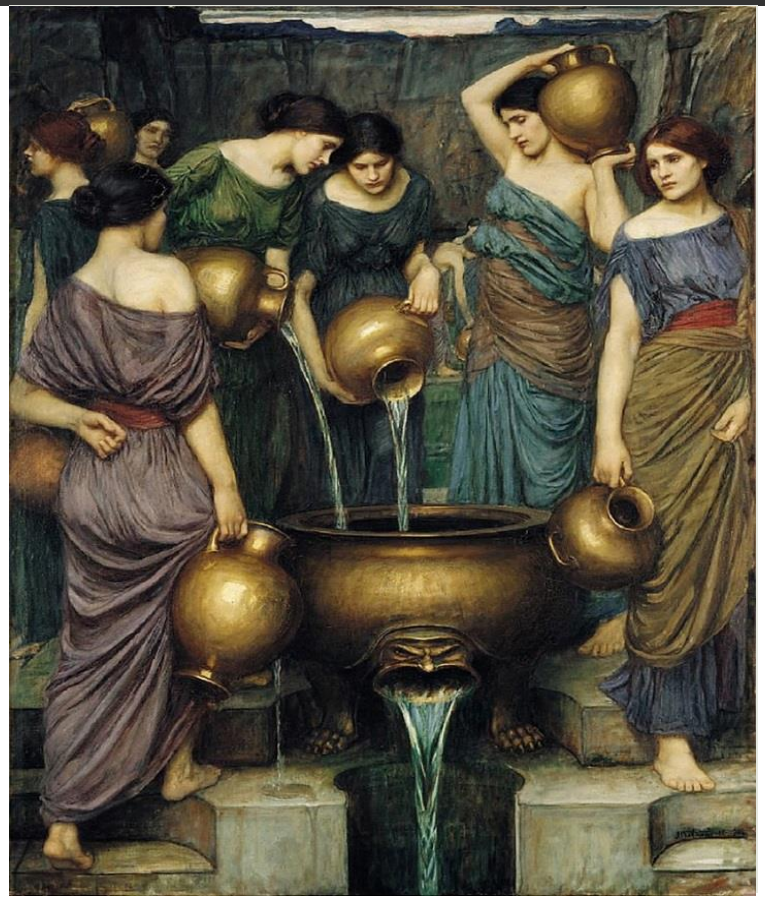
Outline

- The Limits of Patient Autonomy
  - A brief history of medical futility
  - Why invoking futility is futile
- Beyond Futility
  - Medically inappropriate interventions
  - Practical approach to limit setting
- Limit Setting in CPR

Foregoing Life Support
Shifting Emphasis of Medical Profession

- Only decades ago, perception of "over-treatment."
  - Physician training to preserve life at all costs (pre-1980's)
  - Economic disincentive to forego (fee-for-service)
  - Quinlan/Cruzan cases physicians/state rejected family efforts to withdraw support
- Fairly rapid acceptance of limits to care in medicine
  - Physician training shifted to broader goals of medicine
  - Economic incentive to forego (managed care)
  - Family demands for continued support (e.g. Wanglie)

Medical Futility



Daughters of Danaus

- Developed in response to demands for care felt to be unreasonable.
- Defined as treatments with extremely low likelihood of providing benefit (particularly survival).
- Might also provide socially desirable savings of medical resources.

Medical Futility: its meaning and ethical implications. Schneiderman, Jecker, Jonsen. Ann Int Med 1990

Understanding Medical Futility

- Counter to unbridled exercise of patient autonomy:
  - Represents judgment of clinician(s)
  - Is independent of desires of patients or surrogates
- Conceptually useful
  - Defines a limit on patient/family demands for care
- Clinically problematic

Why Futility Fails Us

- Defining benefit
  - Who determines what counts as a valuable outcome?
  - If us, what do we choose? (ICU survival, hospital discharge, return to independent function?)
- Limits of prognostication
  - Below what odds is an intervention futile?
  - Neither clinicians nor disease severity scores are particularly precise at prognostication.

Why Futility Fails Us

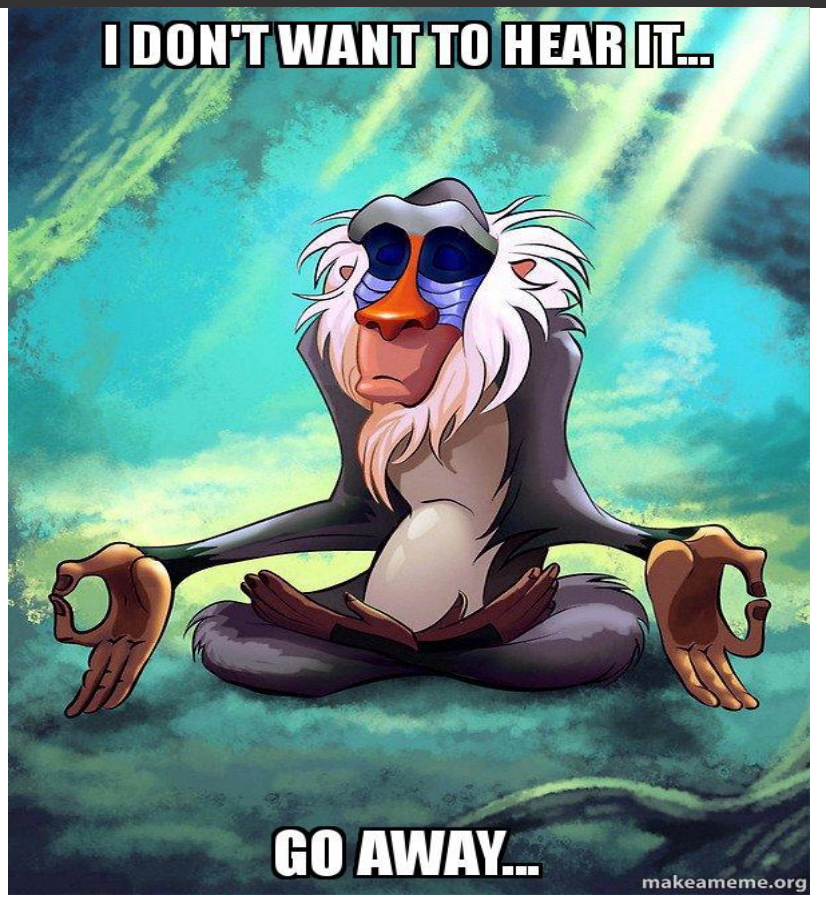
Invoking futility:

tells patients and families that their input is not needed or appreciated.

does not invite questions.

serves as a conversation stopper.

Invoking futility=frustration



Beyond Futility

- Many treatments may be inappropriate (for a variety of reasons) without being futile.
- Determining the appropriateness of care generally requires communication with patients and/or surrogates.
- Even in situations when criteria for medical futility appear to be met, invoking futility may be counterproductive.

An Official ATS/AACN/ACCP/ESICM/SCCM Policy Statement: Responding to Requests for Potentially Inappropriate Treatments in Intensive Care Units. Am J Respir Crit Care Med. 2015 Jun 1;191(11):1318-30.

Medical Inappropriateness

- Interventions/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.*"

- Competing ethical considerations may involve:
  - lack of efficacy
  - resource allocation
  - cost
  - burdens on patients, provider, or system.

- Should represent a clinical consensus rather than individual opinion.

Medically Inappropriate Interventions: Examples

- Antibiotics for viral upper respiratory tract infection
- MRI scan for tension-type headaches

- CPR in patient with widely metastatic cancer
- Dialysis in patient with end-stage liver disease (without option of transplantation)
- Mechanical ventilation for progressive pulmonary fibrosis (without option of transplantation)

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Avoiding Requests for Medically Inappropriate Treatments

- Do **not** lead with limits
  - Establish common goals-**we all want what is best for the patient**
  - "We will do everything medically appropriate.."
  - Later, lay groundwork for future decisions
- Maintain trust
  - Reiterate active/positive efforts
  - Provide a consistent message
- Elicit support and consensus
  - Determination of medically inappropriateness should rely on clinical consensus rather than individual opinion.
  - Consider early ethics/spiritual care/palliative care consultation

Dealing with Requests for Medically Inappropriate Treatments

- Be ready to explain why treatment is inappropriate
  - Negotiating benefit
  - Prognostication beyond survival ("best case scenario")
  - Be clear regarding "not providing" vs. "not recommending"
- Have a system in place for conflict resolution
  - Provide a consistent message
  - Know your hospital process for conflict resolution
- Elicit support and consensus
  - Determination of medically inappropriateness should rely on clinical consensus rather than individual opinion.

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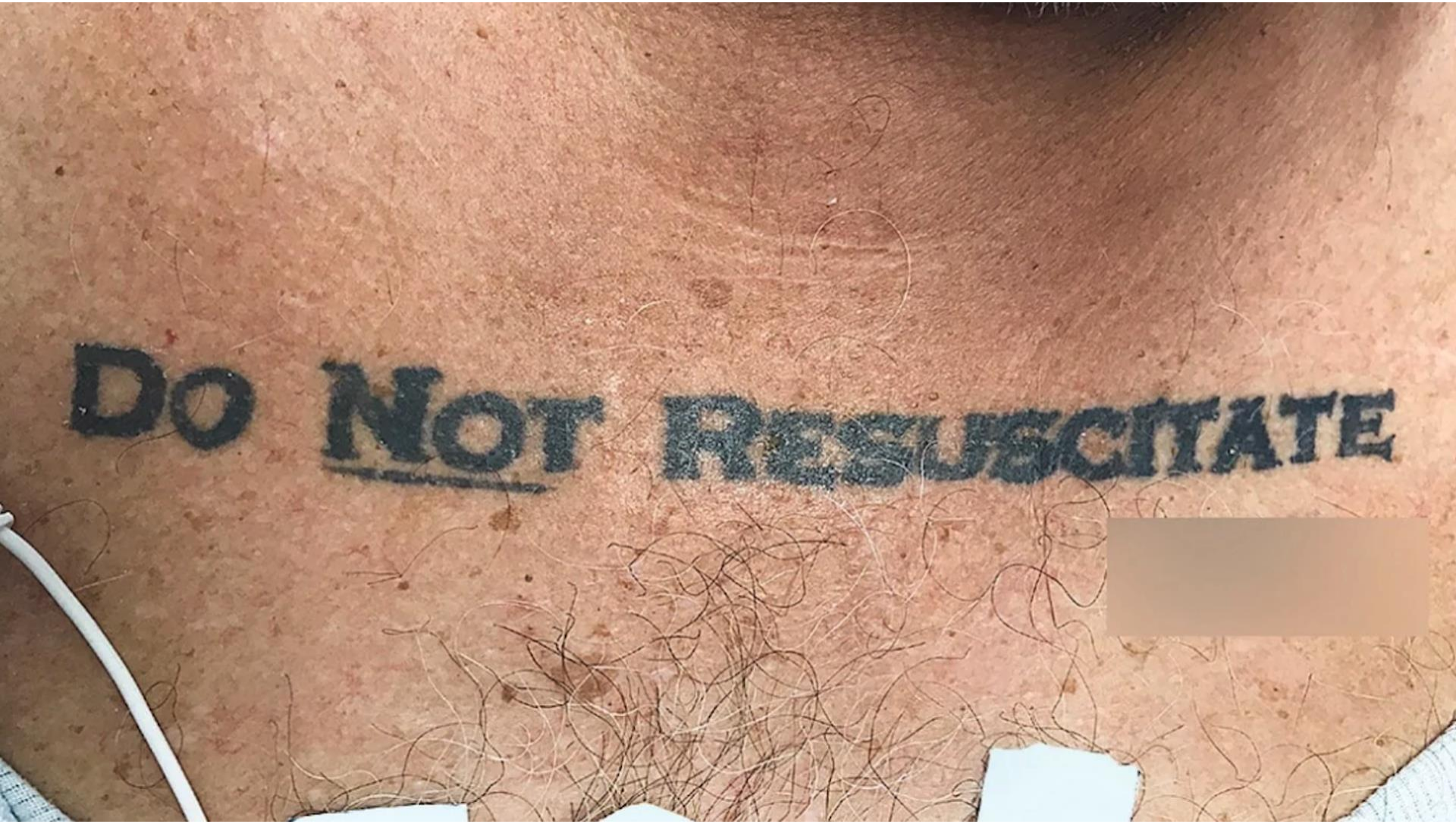
You are worried she may arrest at any time.


DO NOT RESUSCITATE

Limiting CPR

- Success of CPR varies greatly based on indications, underlying co-morbidities, and performance/context.
- CPR is clearly ineffective (and hence medically inappropriate) in certain circumstances. (E.g. exsanguination, refractory shock, advanced malignancy)
- Stopping CPR depends upon clinical judgment, not surrogate decision.
  - 'Stopping' CPR **prior to starting** is an appropriate exercise of clinical judgment

Unilateral DNAR Orders

- Informed Assent
  - Approach that still represents a recommendation, inviting deference to that recommendation rather than consent.
  - Often relieves surrogates of burden of "giving up" on patient.
  - If surrogates do not assent -> conflict resolution policy

JR Curtis; The use of informed assent in withholding cardiopulmonary resuscitation in the ICU. AMA Journal of Ethics/Virtual Mentor 2012

- No Dissent
  - "We will not do CPR"
  - Ethically permissible/Consider hospital policy

Summary of Suggestions

- Dealing with requests for inappropriate medical interventions
  - Maintain trust and open communication
  - Avoid using the f-word
  - Establish professional consensus and support
  - Be prepared to explain why an intervention is inappropriate
  - Have a policy to deal with conflict resolution