Practical Approaches to Minimizing Conflicts About Ineffective and Inappropriate Interventions

Ryan F Holmes, MA PhD(c)
Assistant Director of Health Care Ethics
Markkula Center for Applied Ethics
Santa Clara University

Outline

* Preamble
* Definitions
* Problems with definitions
* Problem of values
* Communication
* Practical Approaches
* Questions

Preamble

* Ineffective Interventions occur frequently
  * First question I was asked at my first talk as an Ethics Fellow
  * Huynh, et al. (2013)* found nearly 20% of patients in ICU were receiving 'probably futile' or 'futile' treatment over the course of their time in the ICU (UCLA)
  * They are costly and can be harmful
  * Study estimated $4,000 a day, totaling $2.6 million
* They can be stressful to provide

*Huynh TN, Kleerup EC, Wiley JF, et al. The Frequency and Cost of Treatment Perceived to Be Futile in Critical Care. *JAMA Intern Med.* 2013;173(20):1887-1894.

Preamble

* Interventions can be clearly ineffective
  * These are less morally vexing, though still a challenge
* Focus on End Of Life, though they can occur at any time
  * Also focus mainly to address the more challenging cases
* Rules and regulations regarding withholding or withdrawing based on ineffective interventions vary by state
* Start with theoretical and end with practical
* Time at the end for questions and discussion

Some Definitions

* Ineffective Intervention
* Inappropriate Intervention
* Medical Futility

Problem with Definitions

* Criteria can be unclear
* Can include multiple variables
* Lack consensus
* Does not provide the solution

Criteria Unclear

* What counts as good data for determining an intervention is ineffective?
* What kinds of interventions shouldn't be performed and in what circumstances?
* How does Quality Of Life (QOL) or anticipated QOL affect decision-making? How should the provider consider QOL? How should the surrogate consider QOL?

Multiple Variables

* What are acceptable goals for interventions?
* What are acceptable goals for patients/surrogates to request?
* What are acceptable goals for providers to aim towards? What are unacceptable goals? Why are they acceptable or unacceptable?
* How does one determine that there is virtual certainty or that a threshold of inefficiency is met?

Lack of Consensus

* What does the literature show?
  * Physicians (1994)
    * Majority said 5%, significant minority (19%) said 20% or higher chance of success was still ‘futile’
    * One indicated 60% of success might be ‘futile’
  * Residents (1995)
    * Most thought ≤1% chance of success was ‘futile’
    * At least 33% though interventions that were successful 5% - 30% of the time were still ‘futile’

* Patient/Surrogate tolerance for risk

Definition ≠ Solution

* Simply asserting that criteria for a definition are present does not end the conversation or situation
* Disputes can arise over whether criteria has been met, even when there are clear definitions
* Assertions, particularly about high-stakes issues, can be jarring and can disconnect caregivers and patients
* Important to care for the patient, keep open lines of communication and trust

Tests Core Values

* Basis of dispute is often about values
* In EOL setting, these values are being put to ultimate test
* Nature of cases weighted towards physician expertise
  * Can cause physicians/providers to become entrenched
  * Can evoke equally entrenched reaction by patient/surrogate
* In cases of dispute, this can cause a rift
  * Physicians and providers may feel undervalued
  * Patients and surrogates may feel railroaded or even abandoned

Values (cont'd)

* Patients/surrogates may differ from physicians/ providers in choices about interventions
* Misperception is not the only reason for these choices
  * Patient/surrogates do not always understand the ramifications of choices
  * Contradictory choice ≠ lack of understanding
* Recognizing there may be difference of opinion can allow for better communication and understanding

Communication

* Values can clash, but communication matters, too
* Language is important
* Using the word "futile" in regards to patients or care can invoke strong reactions
  * Treatments can be ineffective or even inappropriate
  * Courses of treatment may be ineffective or even inappropriate (requires input from patient/surrogate)
  * A <u>patient</u> or their <u>care</u> is <u>never</u> <u>futile</u>

Communication

* Understanding patient values is essential
* Clarification of values and goals
  * Elicit the patient’s story
* Clarify for surrogate’s the role of representing patient wishes, not their own
  * Substituted Judgment

Virtuous Stewardship

* Limits are important
  * Defines good practice
* Determining limits can be challenging
  * Understanding benefits and harms in particular cases
* Knowing the appropriate action can be difficult
* To withhold/withdraw or provide
  * Prudence is important
  * Ineffective interventions should be avoided
  * Confrontation may not serve all parties

Legal Support: Use with Caution

* According to California law, a healthcare provider or institution "may decline to comply with an individual health care instruction or health care decision that requires medically ineffective care or health care contrary to generally accepted health care standards" (Cal. Probate Code §4735).

Practical Solutions

* Clarify goals of care
* Assess whether all reasonable options have been attempted
* Do no offer options that are not medically effective (or appropriate)
* Establish guidelines and limits of interventions in place
* Seek to address emotional needs of caregiver

Gallagher CM, Holmes RF "Handling Cases of 'Medical Futility'" HEC Forum (2012) 24:91-98

Clarify Goals of Care

* Physician/Provider outline medical possibilities
* Allow patient/surrogate to explain his/her understanding
* Listening to patient/surrogate is paramount
* Any decisions to change goals (e.g. from curative to palliative) should be clearly stated and understood

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Assess Options

* Determine whether all reasonable options have been attempted
* Allows physician/providers to self-evaluate
* Demonstrates a desire to work with the patient/ surrogate
* Demonstrates adherence to standards of care and practice

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Restrict Ineffective Choices

* Advise all options that would be beneficial
* Discuss other possible options
* Do not recommend options you would not wish to provide
  * Difficult when there is uncertainty
* Generally avoid discussing options that are considered extreme and ineffective
  * Informed consent

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Establish Guidelines for Interventions

* Discuss the limits of existing interventions
  * When would the interventions cease to be effective
  * Under what circumstances would you no longer recommend them
* Explain limits of any time trials
  * Why is the intervention being offered
  * What is the goal
  * How will efficacy of the intervention be determined
  * What will happen if it is ineffective

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Address Patient/Caregiver Needs

* EOL situations are particularly emotionally charged
* Discussion of withholding/withdrawing can be particularly draining
* Language such as "futile" or "futility" can be upsetting and confrontational
* Language such as "ineffective" is more neutral, less imposing
* Discussion of limiting treatment can produce raw emotions
* Support from Social Work, Chaplaincy, or others with psychological training can be helpful to patients and providers

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Methods

* Patient Care Conference
* Seek Second Opinion
* Request an Ethics Consult

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Request Ethics Consultation

* Ethics committee consultation can be helpful in:
  * Discerning ethical issue
  * Provide guidance on next steps
  * Facilitating care conferences
  * Assisting in intractable cases

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Best Practice

* Ethics committee review
  * Full committee
  * Invite patient, surrogate decision-maker, family to discuss patient’s hopes and goals
  * Medical review of the case by involved clinicians (including nurses, consulting physicians or other relevant personnel)
  * Deliberate and offer recommendations

Best Practice

* If withholding or withdrawing over objections of surrogate decision-maker
  * Allow time for transfer
    * Texas requires 10 days; Virginia 14 days
    * California gives no direct guidance
  * Ensure treatment in question is continued during this time
* BE CONSISTENT!

Case

* 8 month old baby, suffering from several internal maladies.
* Clear that his condition was not going to be compatible with life
* Parents were young, adamant that they could not withdraw life support from their child
* Refused to defer decision-making to medical staff, could not authorize anything less than continued treatment

Case

* Intensivist felt that continued treatment was both ineffective and inappropriate; called ethics consult
* Intensivist was certain the case would result in a protracted legal battle
* Ethicist met with family – eventually called full committee to review ineffective intervention policy

Resolution

* After committee met, advised that further treatment would be ineffective and inappropriate
* Family sought transfer but was unable to find another institution willing to accept patient
* After 10 days of waiting, intensivist withdrew aggressive interventions
* Family was grateful to staff
* Ended with a reunion with extended family who had otherwise been absent

Lessons

* Not all families will “come around”
* Copious work was done with the family prior to soliciting committee intervention
* Ethics committee process was beneficial to this family, but not all cases end so well
* Reconciliation is not inevitable
* Not everyone was happy; intensivist felt the nature of the reconciliation was inappropriate at the bedside

Other Resources

* Social Work
* Chaplaincy
* Other psychological support services

* Ethics Committee
  * If considering invoking the Ineffective Intervention policy, consult the Ethics Committee

Studies cited

* Curtis JR, Park DR, Krone MR, Pearlman RA. Use of the medical futility rationale in do-not-attempt-resuscitation orders. Jama. 1995;273:124-8
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Questions

Thank you