Ethics and Policies Regarding “Medically Inappropriate Care”

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Overview

• Review the meaning of “medically inappropriate care”

• Assess a process for addressing medically inappropriate care

• Consider policy needs and implications of medically inappropriate care.
“Natural Death”

“Try to get some rest. I’ll be in every few minutes to make sure you don’t.”

“Hey! I think he just moved! Add one more!”
“Medically Inappropriate Care”

Not medically indicated

Ineffective

Non-beneficial

Hopeless

Futile

- ...we propose that when physicians conclude (either through personal experience, experiences shared with colleagues, or consideration of published empiric data) that **in the last 100 cases a medical treatment has been useless**
- If a treatment merely **preserves permanent unconsciousness or cannot end dependence on intensive medical care**, the treatment should be considered futile.
- ...treat probability and utility as independent thresholds....physicians must distinguish between an **effect**, which is limited to some part of the patient's body, and a **benefit**, which appreciably improves the person as a whole. Treatment that fails to provide the latter, whether or not it achieves the former, is "futile".
- ...physicians can **judge a treatment to be futile** and are entitled to withhold a procedure on this basis. In these cases, physicians should act in concert with other health care professionals, but need not obtain consent from patients or family members.
The Elusive “F” Word

• Quantitative Futility
  • Likelihood that intervention will benefit pt is exceedingly poor (reasonable probability of success).

• Qualitative Futility
  • Quality of the benefit an intervention will produce is exceedingly poor, i.e. result will be poor quality of life.
The Futility of Futility
O! be some other name:
What’s in a name? that which we call a rose
By any other name would smell as sweet;

Shakespeare
Romeo and Juliet
Other names...

- California Medical Association: “Non-Beneficial Treatment”
  - “NBT generally not indicated for irreversible medical conditions where imminent death is expected.”
  - “CMA Model Policy: Responding to Requests for Non-Beneficial Treatment.” July 2011

- Critical Care organizations: “Potentially Inappropriate Treatment”
  - 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.
Definitions/Descriptions

• Any treatment a physician determines in the exercise of their professional judgment would:
  • Be ineffective for producing desired physiological effect that the pt/agent desires or expects; or
  • Produce no effects that can reasonably be expected to be experienced by pt as furthering their expressed and medically obtainable goals; or
  • Cause harm to the pt significantly disproportionate to the benefit;
  • Has no realistic chance of returning pt to a level of health that permits survival outside of acute care hospital; or
  • Would serve only to maintain pt’s life in a permanently unconscious state, unless there is evidence that the patient would value remaining alive in that state.
Competing Ethical Obligations

- Patient Autonomy
- Physician Duties
- Relationship & Trust
Treatment Requests → Moral Distress

- Different interpretations of goods and harms.
- Perceived breakdown of fiduciary relationship.
- Decision-making reduced to struggle between patient autonomy vs. clinician autonomy.
- Treatment goals often not clarified.
- Subjective perceptions of quality of this life.
- No established transparent process to resolve disputes.

Helft PR, Siegler M, Lantos J. The Rise and Fall of the Futility Movement. NEJM 343;2000;293-296
From definition to process
### Why policy?

<table>
<thead>
<tr>
<th></th>
<th>Institutional Policy</th>
<th>Case-by-Case Basis</th>
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<tbody>
<tr>
<td><strong>Advantages</strong></td>
<td>- Clear guidelines.</td>
<td>- More flexibility and room for professional judgment.</td>
</tr>
<tr>
<td></td>
<td>- Decreases potential discrimination.</td>
<td>- Less cumbersome process.</td>
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<tr>
<td></td>
<td>- Increased consistency.</td>
<td></td>
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<tr>
<td><strong>Disadvantages</strong></td>
<td>- Process may be cumbersome leading to lack of utilization.</td>
<td>- Inconsistency and risk of discrimination.</td>
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<td>- Cases will inevitably fall outside the definitions.</td>
<td>- Lack of official administrative support.</td>
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Shared Decision Making

**Patient’s Role**
- Determine values/goals including QoL
- Weigh risks/benefits

**Physician’s Role**
- Explain clinical options
- Foster understanding
- Set limits

**Relationship/Trust/Communication**
Legal Support
California Law

- California Probate Code 4735:
  - “A healthcare provider ..... may decline to comply with an individual healthcare instruction or healthcare decision that requires medically ineffective healthcare...”

- California Probate Code 4740:
  - “A healthcare provider ..... acting in good faith and in accordance with generally accepted healthcare standards ..... is not subject to civil or criminal liability for any action in compliance with this division, including, but to limited to, any of the following conduct:
    - Declining to comply with a healthcare decision of a person based on a belief that the person lacked authority.
    - Declining to comply with individual healthcare instruction... in accordance with Sections 4734 to 4736.”
Policy Development

• Based on CMA Model policy and California state law
• Developed by Regional Bioethics Committee over 2 year period
• Vetted by numerous stakeholder groups
• Reviewed and approved by legal and risk management.
• Reviewed and approved by regional leadership.
• Reviewed and approved by service area leadership
• Annual review
Steps

- Enlist expert consultation for negotiation / conflict resolution
- Inform patient / surrogates
- 2nd medical opinion
- Interdisciplinary hospital committee review
- Opportunity to transfer the patient to an alternate institution
- Opportunity to pursue extramural appeal
- Decision implementation
- Ongoing support
Policy Process

• Step 1: Identify NBT
• Step 2: Communication among Medical Team
• Step 3: Communication with patient/decision makers
• Step 4: Second Opinion by Reviewing Physician
• Step 5: Ethics Review
  • Supports Initiation/Continuation of Treatment—transfer to another MD
  • Supports Forgoing Treatment—opportunity for transfer, than treatment stops
**Workflow**

**Responding to Requests for Non-Beneficial Treatment (NBT)**

**Physician Workflow**

The complete policy can be found on Docushare and should be reviewed at onset.

* Indicates an ideal time for an ethics consultation

However, Ethics may be consulted at anytime

No health care professional has an ethical obligation to provide or participate in the provision of a Non-Beneficial Treatment.

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**Criteria**

“Non-Beneficial Treatment” (NBT) is any Treatment that a Physician determines, in the exercise of his or her professional judgment:

1. Will be ineffective for producing the physiological effect that the Patient/LRHCMD desires or expects of the medical Treatment; or

2. Will produce no effects that can reasonably be expected to be experienced by the Patient as furthering the Patient’s expressed and medically obtainable goals; or

3. Will cause harm to the Patient significantly disproportionate to the benefit; or

4. Has no realistic chance of returning the Patient to a level of health that permits survival outside of a general acute care hospital as defined in Health and Safety Code section 1250(a); or

5. Would serve only to maintain the Patient’s life in a permanently unconscious state, unless there is evidence that the patient would value remaining alive in that state.

No health care professional has an ethical obligation to provide or participate in the provision of a Non-Beneficial Treatment.
"There's just so far you can go with ethics, and then the real world kicks in."
Policy Outcomes

• 1 KP service area (South Bay)
• Retrospective evaluation of all bioethics consultations 11/6/09 (policy adoption) – 8/6/12.
• Case-specific data for conflict involving withholding or withdrawing of nonbeneficial treatment.
• Main Outcome Measures: Conflict resolution
• Results:
  • 146 (39.4%) cases
    • 54 (37.0%) of the cases, resolution occurred.
    • 92 (63.0%) NBT eventually withheld or withdrawn.
      • 87 (94.6%) where treatment was withheld or withdrawn, consensus reached through policy process
    • 5 conflicts remained
• CM Nelson, BA Nazareth, Nonbeneficial Treatment and Conflict Resolution: Building Consensus, Perm J 2013 Summer; 17(3):23-27
## 5 cases of persistent conflict

<table>
<thead>
<tr>
<th>Cases of unilateral withdrawal</th>
<th>Patient preferences</th>
<th>After ethics committee case review</th>
<th>Treatment withheld or withdrawn</th>
<th>Outcome</th>
<th>Postoutcome litigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Beneficial treatment per advance directive</td>
<td>Family thankful</td>
<td>CPR, increased dose of vasopressors, antiarrhythmics</td>
<td>Comfort measures initiated; patient died in hospital</td>
<td>No</td>
</tr>
<tr>
<td>2</td>
<td>Unknown; family never discussed treatment preferences with patient</td>
<td>Family accepting</td>
<td>CPR, stent, increased dose of vasopressors</td>
<td>Comfort measures initiated; patient died in hospital</td>
<td>No</td>
</tr>
<tr>
<td>3</td>
<td>No advance directive; patient ambivalent with treatment preferences, then lost capacity</td>
<td>Family unaccepting</td>
<td>CPR, dialysis, vasopressors, antiarrhythmics, tracheostomy, antibiotics</td>
<td>Comfort measures initiated; patient died in hospital</td>
<td>No</td>
</tr>
<tr>
<td>4</td>
<td>Family stated that patient requested conservative treatment; no advance directive</td>
<td>Family unaccepting</td>
<td>CPR, dialysis, feeding tube</td>
<td>Comfort measures initiated; patient died in subacute care facility posttransfer</td>
<td>No</td>
</tr>
<tr>
<td>5</td>
<td>Conservative treatment requested per advance directive</td>
<td>Family unaccepting</td>
<td>Nasogastric tube and percutaneous endoscopic gastrostomy tube</td>
<td>Transferred to another hospital by family; no further contact</td>
<td>No</td>
</tr>
</tbody>
</table>
Societal disconnect

No matter what.

Fight On.

TIME

How science is searching for ways to keep us Forever Young

PLAYING GOD

Talking About Ethics in Medicine and Technology
Historically...

“Medical ethics do not allow me to assist in your death. I am, however, permitted to keep you miserable as long as possible.”
Doctors Die Differently

“It’s not a frequent topic of discussion, but doctors die, too. And they don’t die like the rest of us. What’s unusual about them is not how much treatment they get compared to most Americans, but how little. For all the time they spend fending off the deaths of others, they tend to be fairly serene when faced with death themselves. They know exactly what is going to happen, they know the choices, and they generally have access to any sort of medical care they could want. But they go gently.

Of course, doctors don’t want to die; they want to live. But they know enough about modern medicine to know its limits. And they know enough about death to know what all people fear most: dying in pain, and dying alone. They’ve talked about this with their families. They want to be sure, when the time comes, that no heroic measures will happen—that they will never experience, during their last moments on earth, someone breaking their ribs in an attempt to resuscitate them with CPR (that’s what happens if CPR is done right).”
Doctors Die Differently

“...victims of a larger system that encourages excessive treatment”

Ken Murray, Journal of Medicine, August 1, 2013,
https://www.ncnp.org/journal-of-medicine/1240-doctors-die-differently.html
Communication Is Key

“...part of their [physicians’] angst comes not simply from the pressure to provide burdensome treatment, but also from an inability to find the right language and conceptual framework for talking about the problem with patients and families.”

Beyond Communication...

- Family “threats” to go to the media or attorney
- Fair application of policy based on medical indications, while remaining sensitive to cultural and religious differences.
- Institutional support for application in individual cases.
- Societal perspectives
Policy implications

• Physician duties at the bedside
  • Respect for patient/surrogate autonomy
  • Avoid harm (“overmastered by disease”)
  • Steward resources

• Ends of medicine
  • Recognition of limits of medicine
  • Limits of autonomy

• Societal Obligations
  • Unsustainable costs and manpower
  • Opportunity costs
  • Fairness: just distribution of resources
Competing Ethical Obligations and Social Context

- Patient Autonomy
- Physician Duties
- Funding
- Societal Norms
- Relationship & Trust
Public Engagement

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

OFFICIAL POLICY STATEMENT:
American Thoracic Society (ATS), approved 10/15
American Association for Critical Care Nurses (AACN), 12/14
American College of Chest Physicians (ACCP), 10/14
European Society for Intensive Care Medicine (ESICM), 9/14
Society of Critical Care Medicine (SCCM), 12/14
Individual, Physician or Society?

And the winner is…
For questions

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Resuscitative Services Policy
Medically Inappropriate CPR

• Affirms policy to provide medically indicated CPR, in the absence of a DNR order.
• Identifies situations in which CPR is considered ineffective and is not medically indicated:
  1. Terminally ill patient who is imminently dying
  2. Patient experiencing irreversible organ failure not expected to survive current hospitalization
  3. Permanently unconscious patient
• Decision that CPR is not medically indicated and will not be offered must be disclosed to patient/agent and documented in the medical record.
DNR and MIT/NBT

MIT/NBT

CPR