Retiring the Term *Futility* in Value-Laden Decisions Regarding Potentially Inappropriate Medical Treatment

Alexander A. Kon, MD
Judy E. Davidson, RN, DNP

Downloaded from http://aacnjournals.org/ccnonline/article-pdf/37/1/9/115366/9.pdf by guest on 15 September 2024

We praise Williams and Dahnke[1] for initiating a discussion on the very important subject of ethical issues surrounding the withdrawal of extracorporeal membrane oxygenation (ECMO) in their article published in the October 2016 issue of *Critical Care Nurse.* When the intensive care unit (ICU) staff believe that ongoing ECMO is no longer appropriate, yet the patient's surrogate decision-maker wishes to continue life support, there are often tensions between staff and the patient's family, and indeed among clinicians. Such disagreements can lead to moral distress, distrust, and fractured communication.

When making value-laden treatment decisions, clinicians and patients' families should start by employing a shared decision-making process. The Society of Critical Care Medicine (SCCM) and the American Thoracic Society (ATS) have defined shared decision-making in the ICU:

> Shared decision making is a collaborative process that allows patients, or their surrogates, and clinicians to make healthcare decisions together, taking into account the best scientific evidence available, as well as the patient's values, goals, and preferences.[2,3]

Further, SCCM and ATS state that clinicians should engage in a shared decision-making process to define overall goals of care (including decisions regarding limiting or withdrawing life-prolonging interventions) and when making major treatment decisions that may be affected by personal values, goals, and preferences.[2] When faced with a decision to withdraw ECMO, clinicians and patients' families should share in the decision-making process. Some families may wish to share the responsibility and burden of decision-making relatively equally with clinicians, which can be appropriate. Other families may wish to make such decisions with significant independence, which can also be appropriate.[2] Still other families may choose to cede authority for the decision to the clinicians, and in such cases clinicians may use an informed nondissent model of decision-making, which can also be appropriate.[2,4] Both

Authors

Alexander A. Kon is a past chair of the Society of Critical Care Medicine's Ethics Committee, president-elect of the American Society for Bioethics and Humanities, and clinical professor of pediatrics at the University of California, San Diego School of Medicine, San Diego, California.

Judy E. Davidson is past chair of the Society of Critical Care Medicine's Ethics Committee, chair of the Family-Centered Care Guidelines Writing Task Force for the Society of Critical Care Medicine, and Evidence-based Practice/Research Nurse Liaison for University of California, San Diego Health.

Corresponding author: Alexander A. Kon, MD, FAAP, FCCM, 34800 Bob Wilson Dr, San Diego, CA 92134 (e-mail: alkon@ucsd.edu).

To purchase electronic or print reprints, contact the American Association of Critical-Care Nurses, 101 Columbia, Aliso Viejo, CA 92656. Phone, (800) 899-1712 or (949) 362-2050 (ext 532); fax, (949) 362-2049; e-mail, reprints@aacn.org.

©2017 American Association of Critical-Care Nurses doi: https://doi.org/10.4037/ccn2017234

SCCM and ATS provide significant guidance for facilitating shared decision-making.[2] At times, however, the shared decision-making process breaks down, and clinicians and families cannot find a mutually agreeable course of action. In such cases, questions regarding appropriate treatments and futility may arise.

When discussing such difficult cases, it is imperative that clinicians, ethicists, family members, and others use a common terminology to ensure that we all fully understand one another. Recently, the American Association of Critical-Care Nurses (AACN) in collaboration with SCCM, ATS, the American College of Chest Physicians, and the European Society of Intensive Care Medicine, officially endorsed specific terminology that should be used when discussing such cases.[5] Although some continue to use a variety of terms when considering such conflicts, use of the official multiorganization-approved terminology is important.

The 5 major critical care organizations, including AACN, have agreed that the following terminology should be used[5]:

- The term *futile* should be used only in the rare circumstance that an intervention simply cannot accomplish the intended physiological goal. Clinicians should not provide futile interventions and should carefully explain the rationale for the refusal.
- The term *potentially inappropriate* should be used, rather than "futile" to describe situations in which treatments 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 that 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.
- *Legally proscribed* treatments are those that are prohibited by applicable laws, judicial precedent, or widely accepted public policies (eg, organ allocation strategies). In responding to requests for legally proscribed treatments, clinicians should carefully explain the rationale for treatment refusal.
- *Legally discretionary* treatments are those for which there are specific laws, judicial precedent, or policies that give physicians permission to refuse to administer them. In responding to requests for legally discretionary treatments, clinicians should carefully explain the rationale for treatment refusal.

The 5 major critical care organizations agreed that the term *futile* should be used only in cases of strict physiological futility and that the term *potentially inappropriate* should be used in cases where there are value-based disagreements regarding appropriate interventions.[5] The organizations provided detailed rationale for use of this nomenclature. In brief, the organizations state that most such disagreements stem from different values and/or parties weighing different values differently. For example, Williams and Dahnke[1] state that:

> Clinicians may judge an intervention with no reasonable likelihood of returning a patient to normal functioning or consciousness as a futile therapy that should be stopped, while the patient's family may judge the fact that the intervention keeps the patient alive (even if only in a biological sense) as confirmation that the therapy is not futile.

In this case, there is a value-based disagreement between the clinicians and the family. Specifically, the clinicians believe that it is inappropriate to keep the patient alive with no reasonable expectation that the patient's neurological function will improve sufficiently to allow the patient to perceive the benefits of treatment. In contrast, the family believes that keeping the patient alive is a good unto itself, regardless of the expected neurological outcome.

Based on the multiorganization statement and the SCCM definition, the case described by Williams and Dahnke[1] would be considered a disagreement over potentially inappropriate treatment (not futility). Further, unless there is imminent risk of the ECMO circuit clotting or other emergent reasons to discontinue ECMO, the clinicians should redouble efforts to improve communication and work toward a mutually agreeable course of action while initiating the 7-step process for dispute resolution described in the following paragraphs.

The organizations emphasize the significant difference between disagreements over futile interventions and disagreements over potentially inappropriate treatments, specifically because there are important ethical differences between such disagreements and because such disagreements should be handled differently.

Downloaded from http://aacnjournals.org/ccnonline/article-pdf/37/1/9/115366/9.pdf by guest on 15 September 2024

When families request interventions that are futile, the organizations agree that clinicians ought to decline to provide such interventions. Clinicians should work to improve communication and help patients' families understand why such interventions will not be provided; however, because such interventions are futile, there is no requirement for a fair-process approach to conflict resolution (because this is a medical determination).

In contrast, value-based disagreements over potentially inappropriate treatments require a fair-process approach for conflict resolution. Because such decisions rely on both technical medical expertise and a value-laden claim, rather than strictly a technical judgment, such decisions must be considered preliminary (hence the term *potentially* inappropriate) until reviewed under an appropriate mechanism.[5] The organizations agreed that under such circumstances, the following 7-step process should be followed: (1) enlist expert consultation to continue negotiation during the dispute-resolution process, (2) give notice of the process to surrogates, (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 alternative institution, (6) inform surrogates of the opportunity to pursue extramural appeal, and (7) implement the decision of the resolution process. Only when time pressures make it infeasible to complete all steps of the process and clinicians have a high degree of certainty that the requested treatment is outside accepted practice may clinicians refuse to provide the requested treatment, and they should still complete as much of the 7-step process as they can.[5]

The organizations felt strongly that such value-based disagreements require a process-based approach to ensure wide agreement with the clinician's decision. However, the organizations noted that in some cases time pressures make such a process impossible. The SCCM therefore published a definition of inappropriate treatment for use in such time-pressured cases. The SCCM definition states:

> 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 when there is no reasonable expectation that the patient's neurological function will improve sufficiently to allow the patient to perceive the benefits of treatment.

Further, SCCM states that this definition should not be considered exhaustive or obligatory, noting that there will be cases in which life-prolonging interventions may reasonably be considered inappropriate even when this definition is not met and that even when the definition is met, clinicians may choose to provide ongoing life-prolonging interventions. SCCM notes that decisions regarding whether specific interventions are inappropriate should be made on a case-by-case basis.[6]

We welcome ongoing discussion of the ethical aspects of limiting and withdrawing life-prolonging interventions. When clinicians and patients' families disagree about the best course of action, clinicians are obligated to work diligently to find common ground and a mutually acceptable approach. When discussing such cases, use of standard terminology approved by all major critical care organizations is now indicated. Use of the term *futility* in its past broad context can lead to confusion, mistrust, and suboptimal communication. It is time to retire use of term *futility* in situations of value-laden disagreements regarding potentially inappropriate treatments. CCN

Acknowledgments
The views expressed do not necessarily reflect the official policy or position of the US government, Department of Defense, Department of the Navy, or the US Food and Drug Administration.

Financial Disclosures
None reported.

References
1. Williams SB, Dahnke MD. Clarification and mitigation of ethical problems surrounding withdrawal of extracorporeal membrane oxygenation. *Crit Care Nurse.* 2016;36(5):56-65.
2. Kon AA, Davidson JE, Morrison W, Danis M, White DB. Shared decision making in ICUs: an American College of Critical Care Medicine and American Thoracic Society policy statement. *Crit Care Med.* 2016;44(1):188-201.
3. Kon AA, Davidson JE, Morrison W, Danis M, White DB. Shared decision-making in intensive care units. Executive summary of the American College of Critical Care Medicine and American Thoracic Society policy statement. *Am J Respir Crit Care Med.* 2016;193(12):1334-1336.
4. Kon AA. Informed non-dissent: a better option than slow codes when families cannot bear to say "let her die." *Am J Bioethics.* 2011;11(11):22-23.
5. Bosslet GT, Pope TM, Rubenfeld GD, et al. 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;191(11):1318-1330.
6. Kon AA, Shepard EK, Sederstrom NO, 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(9):1769-1774.

Downloaded from http://aacnjournals.org/ccnonline/article-pdf/37/1/9/115366/9.pdf by guest on 15 September 2024