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How should clinicians respond to requests for potentially inappropriate treatment?

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there is considerable methodological heterogeneity among these studies, it appears that conflicts regarding treatment requests in ICUs are not infrequent.

Previous guidelines from professional societies differed considerably in both their terminology and recommended management strategies for handling treatment disputes in ICUs [3–5]. Conflicting recommendations are problematic because they may confuse an already nebulous topic for clinicians and policymakers. Recently the American Thoracic Society, the European Society for Intensive Care Medicine, the American College of Chest Physicians, the American Association of Critical Care Nurses, and the Society for Critical Care Medicine published a collaborative statement to present a unified guideline on how to handle disputed requests for treatment in ICUs [6]. This statement creates a framework for categorizing such requests, suggests strategies to prevent intractable conflict, and delineates a fair process of conflict resolution to be used in response to intractable clinician–family conflict.

Introduction

One of the most ethically controversial issues in intensive care units (ICUs) is how to respond to requests from surrogates to administer life-prolonging interventions when clinicians believe those interventions should not be administered. This article will outline the framework provided by a new multi-society consensus statement regarding such requests.

Several recent studies suggest that disputed requests for treatment in ICUs in North America and Europe are common. One survey of European ICUs demonstrated that 27 % of practitioners believed they provided inappropriate care to a patient on the day of the study [1]. Recently, a single-center study demonstrated that up to 20 % of ICU patients were perceived by physicians as receiving at least “probably futile” treatment [2]. While

Preventing conflict: communication as cornerstone

The multi-society consensus statement places a strong emphasis on early and proactive strategies to prevent conflict from becoming intractable. This is because empirical data suggest that the vast majority of treatment conflicts in ICUs can be resolved through negotiation and communication, even when clinicians believe they have exhausted all avenues for collaborative solutions [7]. For example, Fine and Mayo found that in cases in which clinicians were pursuing unilateral withdrawal of life-prolonging treatment because of a perceived intractable conflict, involvement of consultants with expertise in conflict resolution yielded a collaborative solution approximately 80 % of the time [8]. Rather than treating a conflict as unresolvable, clinicians should

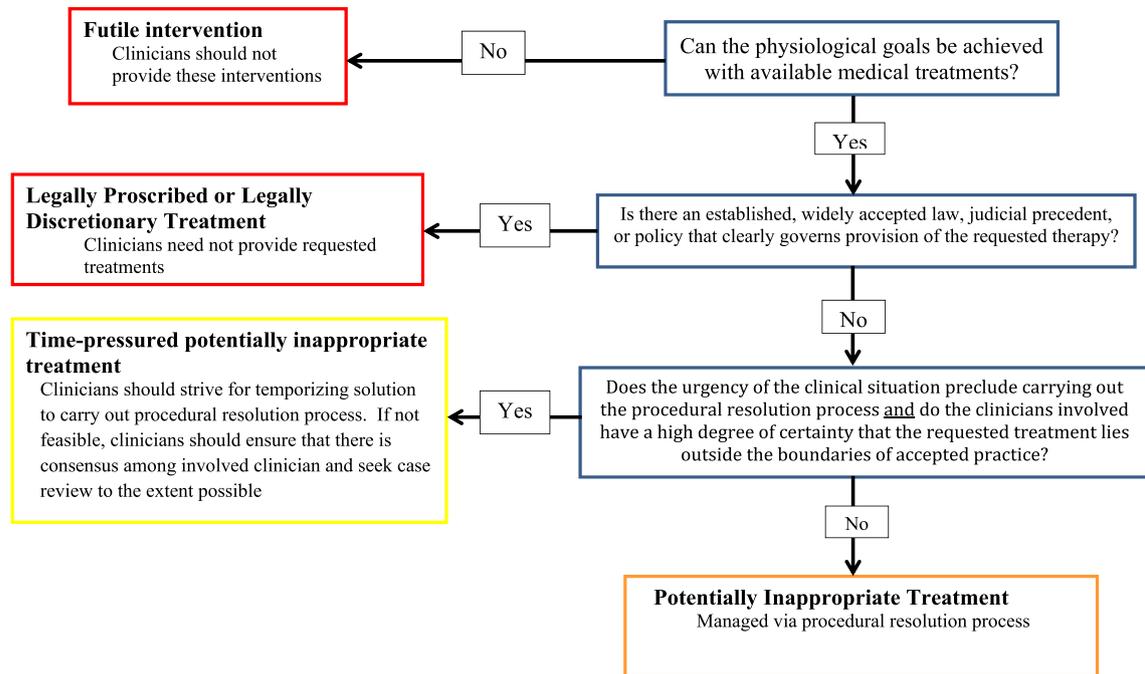


Fig. 1 Recommended approach for management of disputed treatment requests in intensive care units [7]

redouble efforts at engagement and support, and should enlist the assistance of consultants with expertise in communication and negotiation to move toward resolution [9]. The statement recommends best practices for both clinician- and system-level interventions to improve communication and support to prevent conflict.

Differential diagnosis of disputed treatments in ICU

The policy statement recommends different approaches to dealing with different types of treatment requests from surrogates (see Fig. 1):

1. Requests for *futile* interventions
2. Requests for *potentially inappropriate* treatments
3. Requests for *legally proscribed* or *legally discretionary* treatments

This framework was designed to accommodate differences across countries in existing norms and laws regarding end-of-life treatment disputes, both due to differences in values and in funding for healthcare. Consequently, it is to be expected that there will be differences between countries in what treatments, for example, are categorized as legally proscribed or potentially inappropriate (see below) [10].

Futile interventions are those that simply cannot accomplish the intended physiologic goal and **should not be provided by clinicians**. This strict definition means that

requests for futile interventions are extremely **rare**, and consequently the notion of **truly futile** treatment is of limited value in actual practice. Nonetheless, requests for truly futile treatments do occasionally arise and the recommendations endorse that clinicians should be permitted to refuse to provide such interventions [11]. An example is a request for cardiopulmonary resuscitation for a patient who has clear signs of irreversible death (i.e., rigor mortis), or requests for administration of antifungal therapies for treatment of an acute myocardial infarction.¹

Potentially inappropriate treatments are those 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. In practice, **most disputes regarding life-prolonging care in ICUs fall into this category** because most conflicts are not about treatments that are strictly ineffective and instead turn on value laden judgments about whether the burdens of treatment outweigh the benefits. An example of a potentially inappropriate treatment is **prolonged use of mechanical ventilation** in a patient who has been discovered to have widely metastatic and incurable cancer.

¹The examples within this manuscript are offered as tangible illustrations of the categories, and the scenarios have been chosen as a “best fit” for the concepts. Because of the variability between countries and jurisdictions regarding how these disputes are handled, (especially for potentially inappropriate and legally proscribed/discretionary treatments) the examples will likely be widely, although not necessarily universally, accurate.

The policy statement recommends a process-based resolution mechanism that emphasizes **fairness and intramural due process**, with the **opportunity for extramural** review. The goals of this approach are to ensure that broad input is obtained to determine whether what is being requested violates current conceptions of good medical practice. Unless specifically granted via societal consensus, as in several European countries, giving unilateral authority to clinicians is problematic in such cases because it raises concerns about arbitrariness and lack of fairness in how deep value disagreements are resolved. In the instances in which time pressures do not allow for completion of the process-based resolution and clinicians have a high degree of certainty that the requested treatment is outside of accepted practice, clinicians may refuse to provide such treatments (see Fig. 1) [12].

Legally proscribed and **legally discretionary** treatments are those which may accomplish an effect desired by the patient, but for which there are laws, applicable judicial precedent, or public policies that govern their provision. An example of a legally proscribed treatment is **a request for an expedited organ transplant outside of the socially sanctioned transplant allocation system**.

This category of treatment requests will vary in size depending on the country and jurisdiction; some have firmly established judicial and legislative precedents that help to guide disputed end-of-life decision making, while others have very little. There are multiple European countries that have, via societal consensus, laws, or judicial precedent, given considerable decisional authority to clinicians in resolving disputes, and within these countries, this category is quite broad [13]. These laws and precedents are likely to change over time, as they are a manifestation of “the continual redefining of the boundaries of decision-making authority between

physicians and patients, involving a variety of professional, cultural, religious, civic, and legal values and mechanisms” [14]. Clinicians need not provide legally discretionary/proscribed treatments.

Moving beyond process-based resolution

The statement calls for clinicians and professional organizations to work with societal stakeholders to develop policies and legislation to guide clinicians and surrogates regarding end-of-life decision-making. Some countries have moved forward with such policies [11], while others have been slower to develop them. Establishing substantive boundaries provides transparent guideposts for both clinicians and surrogates to help avoid treatment disputes.

Conclusions

Conflicts regarding end-of-life care are relatively widespread, and it is likely that all ICU clinicians encounter requests for potentially inappropriate treatments. The multi-society statement on potentially inappropriate treatments in ICUs attempts to provide clear guidelines regarding the importance of preventing intractable conflict through intensive communication and managing such conflicts through a fair process of dispute resolution.

Compliance with ethical standards

Conflicts of interest The authors have no conflicts of interest related to this work.

References

1. Piers RD, Azoulay E, Ricou B, Dekeyser Ganz F, Decruyenaere J, Max A, Michalsen A, Maia PA, Owczuk R, Rubulotta F, Depuydt P, Meert AP, Reyners AK, Aquilina A, Bekaert M, Van den Noortgate NJ, Schrauwen WJ, Benoit DD, ESICM ASGotESot (2011) Perceptions of appropriateness of care among European and Israeli intensive care unit nurses and physicians. *JAMA* 306(24):2694–2703. doi: [10.1001/jama.2011.1888](https://doi.org/10.1001/jama.2011.1888)
2. Huynh TN, Kleerup EC, Wiley JF, Savitsky TD, Guse D, Garber BJ, Wenger NS (2013) The frequency and cost of treatment perceived to be futile in critical care. *JAMA Intern Med* 173(20):1887–1894. doi: [10.1001/jamainternmed.2013.10261](https://doi.org/10.1001/jamainternmed.2013.10261)
3. American Medical Association (1999) Medical futility in end-of-life care: report of the Council on Ethical and Judicial Affairs. *JAMA* 281(10):937–941
4. Society of Critical Care Medicine (1997) Consensus statement of the Society of Critical Care Medicine’s Ethics Committee regarding futile and other possibly inadvisable treatments. *Crit Care Med* 25(5):887–891
5. American Thoracic Society (1991) Withholding and withdrawing life-sustaining therapy. *Ann Intern Med* 115(6):478–485
6. Bosslet GT, Pope TM, Rubenfeld GD, Lo B, Truog RD, Rushton CH, Curtis JR, Ford DW, Osborne M, Misak C, Au DH, Azoulay E, Brody B, Fahy BG, Hall JB, Kesecioglu J, Kon AA, Lindell KO, White DB, American Thoracic Society ad hoc Committee on Futile and Potentially Inappropriate Treatment, American Thoracic Society, American Association for Critical Care Nurses, American College of Chest Physicians, European Society for Intensive Care Medicine, Society of Critical Care (2015) 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* 191(11):1318–1330. doi: [10.1164/rccm.201505-0924ST](https://doi.org/10.1164/rccm.201505-0924ST)

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7. Prendergast TJ (1997) Resolving conflicts surrounding end-of-life care. *New Horiz* 5(1):62–71
 8. Fine RL, Mayo TW (2003) Resolution of futility by due process: early experience with the Texas Advance Directives Act. *Ann Intern Med* 138(9):743–746
 9. ASBH (2011) ASBH core competencies for health care ethics consultation, 2nd edn. American Society for Bioethics and Humanities, Glenview
 10. Engelhardt HT Jr (1998) Critical care: why there is no global bioethics. *J Med Philos* 23(6):643–651. doi: [10.1076/jmep.23.6.643.2555](https://doi.org/10.1076/jmep.23.6.643.2555)
 11. General Medical Council (2010) Treatment and care towards the end of life. http://www.gmc-uk.org/static/documents/content/Treatment_and_care_towards_the_end_of_life_-_English_0914.pdf. Accessed 30 Dec 2014
 12. Garland A, Connors AF (2007) Physicians' influence over decisions to forego life support. *J Palliat Med* 10(6):1298–1305. doi: [10.1089/jpm.2007.0061](https://doi.org/10.1089/jpm.2007.0061)
 13. van der Heide A, Deliens L, Faisst K, Nilstun T, Norup M, Paci E, van der Wal G, van der Maas PJ, Consortium E (2003) End-of-life decision-making in six European countries: descriptive study. *Lancet* 362(9381):345–350. doi: [10.1016/S0140-6736\(03\)14019-6](https://doi.org/10.1016/S0140-6736(03)14019-6)
 14. Misak CJ, White DB, Truog RD (2014) Medical futility: a new look at an old problem. *Chest* 146(6):1667–1672. doi: [10.1378/chest.14-0513](https://doi.org/10.1378/chest.14-0513)