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PRO EDITORIAL

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"No escalation of treatment" as a routine strategy for decision-making in the ICU: pro

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The recent article by Morgan et al. entitled "Defining the practice of 'no escalation of care' in ICU" has engendered some controversy along with the editorial that accompanied it [1, 2]. The correct term should be "no escalation of therapy" (NEOT) as stated in the editorial because we always care about the patient. Almost simultaneously Curtis et al. [3] reported an article entitled "The importance of word choice in the care of critically ill patients and their families." The term "no escalation of treatment" is espoused to be particularly confusing to patients and family and from clinician to clinician and should not be used. The term is not more confusing than many of the other terms used in limitations of therapy. Two of the best examples of confusing terminology are DNR (do not resuscitate) and comfort measures. What is it that we do not resuscitate? Usually we do not resuscitate the patient if they have a cardiac arrest. But do we intubate the patient if they have respiratory failure or do we try to prevent the cardiac arrest with intubation? Do we give antiarrhythmic drugs to prevent cardiac arrest? What if the patient has an MI and simple defibrillation without CPR will reverse the problem and leave no long-term impairment? Curtis also suggests that we should not "break up" the advanced cardiovascular life support (ACLS) into components (chest compressions, drugs, defibrillation, and intubation) [4]. It does not make any sense to be doing chest compression in an unintubated patient or giving drugs but no chest compressions to circulate the drugs. However, these terms mean difference things to different people. Some have suggested do not attempt resuscitation (DNAR) or all but cardiac resuscitation and do not intubate (DNI) as some examples of alternate phrases and abbreviations. Perhaps in some cases we should not use the terms because of the lack of clarity, but we do use these terms.

Is it different from NEOT? Morgan gives a pretty good definition for NEOT that is as intuitive as the definition of DNR: "withholding new therapies while continuing current ones." Admittedly, this still leaves some room for interpretation. MOLST and POLST forms have a series of questions addressing what will not be done and both paper and electronic records could have a checklist to be filled out adding to the clarification of what is entailed. Notes about the meeting during which options and limitations are discussed may also document more specific treatments to be included or excluded in the patient's plan of care. Notes about the meetings were things that Morgan admitted were missing frequently from the chart during their review. Making the parameters more apparent will help the whole team and families understand what is intended by the term.

So why have another level of care in the end-of-life decision-making process? Because one size does not fit all, as Curtis comments in the article in *Virtual Mentor* [5]. At times the step between DNR and comfort measures is too wide for some to come to agreement with. Generally, the concept of shared decision-making is the best way to come to an agreement [6]. At times shared decision-making is difficult to achieve, as we know from practice, and from the literature we also see that not all patients, surrogates, or physicians can agree on the concept of shared decision-making all the time [7–9]. We cannot get to yes. There are differences in how patients, surrogates, and physicians may feel about withholding or withdrawing therapy. While we usually think about this as a personalized issue there is a clear difference on a religious basis on withdrawing or withholding [10, 11]. Sprung's study showed that there was a clear difference between physicians in withholding and withdrawing based on religion and geography and the same is true of patients and surrogates. DNR is about withholding but in comfort measures we usually have at least a component of withdrawal that may not be religiously or culturally acceptable to either party [12, 13]. This was in particular significant for Jewish, Greek orthodox, or Muslim physicians in Sprung's paper and is similar with patients and surrogates. From a religious standpoint patients and families may have difficulties with withdrawing therapy but may be able to accept not adding further therapy. Some other ethnic groups may also have difficulty with withdrawal [14].

So how do we reach an agreement, or get to a yes, in which caregivers and patient and family can concur if both caregivers and patients and families have problems with some aspect of the continuum? The book *Getting to Yes* gives us some guidelines to think about bridging this gap [15]. Fisher and his colleagues suggest several steps that may be useful in this situation: listen to yourself and the other stakeholders; for the patient and family, step to their side and see what they see; focus on interests of what is behind your position and their position; invent options and think out of the box—NEOT is one of those out of the box options; use objective criteria (document), sometimes external pressures will not allow more conventional approaches (religious and personal feelings); develop your "best alternative to a negotiated agreement" (BATNA) which respects the patient and their beliefs and build a golden bridge that meets needs and brings the two groups together. Having only two choices does not always work because of personal opinion, religion, and ethnicity. A compromise between the two ends of the spectrum of therapy may make sense and actually be acceptable to all parties. It clearly is not the only answer but the possibility can be useful in doing what is right for the patient. The definition of limited therapy obviously needs to be clearly documented so that everyone—the patient, all the caregivers, and the family—understands. It is important that the caregivers and family recognize that there can be an escalation of comfort measures at the same time as there are limitations to escalation of other therapy. The use of the term "no escalation of therapy" can be useful in the routine discussion of forgoing life support in the ICU.

Conflicts of interest The author declares that he has no conflict of interest.

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CON EDITORIAL

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Bioethicists have long argued against making a distinction between the ethical acceptability of withholding versus withdrawing treatment [1]. The modern secular consensus was expressed concisely in a landmark 1983 report: "neither law nor public policy should mark a difference in moral seriousness between stopping and not starting treatment" [2]. Nevertheless, it is easier to endorse this principle than to apply it. There is no question that withdrawing feels different to families and clinicians because the temporal link between the decision and death imposes a sense of responsibility that is difficult to allay with intellectual arguments about causality [3, 4]. The concept of a "no escalation of treatment" order relies on this cognitive bias to overcome barriers to implementing a treatment plan that includes withdrawal of life-sustaining treatment. This order is used to declare that there will be "no escalation" of any treatment, neither starting a new life-sustaining treatment nor increasing the intensity of a life-sustaining treatment currently in use. A recent retrospective review of patients who died in a medical ICU found that a stunning 30 % of deaths had a designation of "no escalation of treatment" [5]. However, we believe that routine use of such a "blanket", all-encompassing "no escalation of treatment" order is ethically confusing, if not unethical, and is often difficult to implement in a consistent and coherent way across the many ICU clinicians caring for a critically ill patient. More importantly, in most situations there are more effective alternatives.

There are scenarios when withholding some life-sustaining treatment is justified while continuing or initiating others. The most common example is the DNAR order to withhold cardiopulmonary resuscitation in the event of a cardiac arrest. CPR is the only therapy that is routinely provided without consent and existing evidence provides robust data on the likely outcomes for critically ill patients [6, 7]. Given the poor outcomes of selected critically ill patients after CPR, it often makes good sense to withhold CPR while continuing other life-sustaining treatments. There are also cases where, either because a clinician has decided that it will be ineffective or because the patient has specifically refused it, other treatments will be withheld. Intubation, which precludes communication and can be particularly uncomfortable, is often refused. In these circumstances, it is important to clarify whether intubation is declined because all life-sustaining treatments are being refused in favor of comfort measures only or whether the request is focused on the endotracheal tube. In the latter scenario, a trial of non-invasive ventilation may be indicated [8, 9].

By its very nature a "no escalation of treatment" order is ethically confusing. The primary goal of care for the majority of critically ill patients is to return them to a quality of life they would find acceptable. For some patients, the goal of care changes when it becomes clear that it is either impossible to achieve the primary goal or when the burdens of trying to achieve this goal are unacceptable. In these cases, we shift our focus from life prolongation to dignity, comfort, and support of the family. In this context, all treatments are reconsidered in light of the new goals and treatments that do not support these goals are stopped. Consider a patient who is mechanically ventilated on vasopressors with a rising creatinine and potassium. A “no escalation of treatment” order is written. Obviously, if the patient’s renal failure progresses, metabolic abnormalities will lead to a cardiac arrest. What is the goal of care in this patient? It is neither to return them to a quality of life they would find acceptable nor to focus on comfort. Therefore the order will not accomplish either of these goals well. “No escalation of treatment” orders, like “slow codes”, are unethical if they are used to allow the family to retain the belief that their loved one is receiving effective treatment when, in fact, they are not [10]. Importantly, there are parallels between “no escalation of treatment” orders and a “stuttering withdrawal” approach to ICU palliation. In these cases, withdrawal of life-sustaining treatment is implemented with a series of decisions to withdraw treatments over time. Although an observational study found that stuttering withdrawal was associated with higher family satisfaction compared to situations where life-sustaining treatments were withdrawn all at once, this association does not mean that either this approach or “no escalation of treatment” orders are the best way to improve family satisfaction [11]. Rather, this finding suggests that many families need time to adjust to the realization that their loved one is dying. We believe that there are better ways to give families such time. Instead of “no escalation of treatment”, we advocate the use of a “time-limited trial” [12] of life support coupled with evidence-based family conferences to align the clinical and patient goals of care [13]. This process avoids the goal confusion and, potentially worse, the goal *misrepresentation* that can accompany “no escalation of treatment” orders or stuttering withdrawal. During such a time-limited trial, if new treatments are considered, they should be assessed on an individual basis, considering the benefits and burdens of the treatment for this individual patient. Such consideration might result in a decision not to escalate with the specific treatment under consideration if the burdens outweigh the benefits and, more importantly, provide an opportunity to clarify the goals of care.

“No escalation of treatment” orders are difficult to interpret even when palliative medications are allowed to be escalated. For example, if a current therapy is stopped due a side effect or because it is no longer needed, is restarting this treatment an “escalation”? Are modifications to ventilator settings allowed even if desirable to promote comfort? Is a change in dose of medication an escalation of therapy? Is diagnostic testing or specialist consultation an escalation of therapy? Palliative therapy associated physiologic compromise is tolerated under the principle of double effect in patients whose goal is clearly to maximize comfort. However, for patients cared for under “no escalation of treatment” orders, how should opioid-associated hypotension be handled? The mixed goals for these patients make invoking the principle of double effect problematic. Prolonged survival after a decision to withdraw life-sustaining treatment is a challenging scenario clinicians must prepare for when the goal of care is palliation; it is even more problematic under a “no escalation of treatment” order when the clinical team and family are faced with a patient on prolonged life support where the goal of care is unclear.

We acknowledge that there are rare circumstances where a “no escalation of treatment” order may be justified. There are families who, despite efforts to resolve conflicts over the goals of care, will not consent or assent to the withdrawal of life-sustaining treatments despite the fact that the patient is actively dying. These family decisions may be based on strong religious views about withdrawal of life support. In these cases, a “no escalation of treatment” order may be preferable to providing new ineffective and burdensome treatments. However, we believe that such an approach should be a reluctant, negotiated settlement rather than a frequently used strategy. “No escalation of treatment” orders should never be offered by clinicians because they are easier or less time-consuming to negotiate than a more explicit palliative care plan for dying critically ill patients. This option is not ethically justified because it will needlessly prolong dying and suffering. Finally, clinicians who avail themselves of this strategy should prepare for the challenging implementation issues that will arise, including anticipating a multitude of potential treatment and diagnostic options and accurately conveying the implications of “no escalation of treatment” orders for these complex future decisions across the many hand-offs that occur in the modern ICU.

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