

AMERICAN THORACIC SOCIETY DOCUMENTS

An Official ATS/AACN/ACCP/ESICM/SCCM Policy Statement: Responding to Requests for Potentially Inappropriate Treatments in Intensive Care Units

Gabriel T. Bosslet, Thaddeus M. Pope, Gordon D. Rubenfeld, Bernard Lo, Robert D. Truog, Cynda H. Rushton, J. Randall Curtis, Dee W. Ford, Molly Osborne, Cheryl Misak, David H. Au, Elie Azoulay, Baruch Brody, Brenda G. Fahy, Jesse B. Hall, Jozef Kesecioglu, Alexander A. Kon, Kathleen O. Lindell, and Douglas B. White; on behalf of The American Thoracic Society *ad hoc* Committee on Futile and Potentially Inappropriate Care

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Background: There is controversy about how to manage requests by patients or surrogates for treatments that clinicians believe should not be administered.

Purpose: This multisociety statement provides recommendations to prevent and manage intractable disagreements about the use of such treatments in intensive care units.

Methods: The recommendations were developed using an **iterative consensus process**, including expert committee development and peer review by designated committees of each of the participating professional societies (American Thoracic Society, American Association for Critical Care Nurses, American College of Chest Physicians, **European** Society for Intensive Care Medicine, and Society of Critical Care).

Main Results: The committee recommends: (1) Institutions should implement strategies to prevent intractable treatment conflicts, including proactive communication and early involvement of expert consultants. (2) 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. Clinicians should explain and advocate for the treatment plan they believe is appropriate. Conflicts regarding

potentially inappropriate treatments that remain intractable despite intensive communication and negotiation should be managed by a fair process of conflict resolution; this process should include hospital review, **attempts to find a willing provider at another institution**, and opportunity for **external review** of decisions. When time pressures make it infeasible to complete all steps of the conflict-resolution process and clinicians have a high degree of certainty that the requested treatment is outside accepted practice, they should seek procedural oversight to the extent allowed by the clinical situation and need not provide the requested treatment. (3) Use of the term “**futile**” should be restricted to the rare situations in which surrogates request interventions that simply **cannot** accomplish their intended physiologic goal. **Clinicians should not provide futile interventions.** (4) The medical profession should lead public engagement efforts and advocate for policies and legislation about when life-prolonging technologies should not be used.

Conclusions: The multisociety statement on responding to requests for potentially inappropriate treatments in intensive care units provides guidance for clinicians to prevent and manage disputes in patients with advanced critical illness.

Keywords: futility; conflict resolution; ethics committees; shared decision making; end-of-life care

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Correspondence and requests for reprints should be addressed to Gabriel T. Bosslet, M.D., M.A., Division of Pulmonary, Allergy, Critical Care, Occupational, and Sleep Medicine, Indiana University School of Medicine, 541 Clinical Drive, C285, Indianapolis, IN 46202. E-mail: gbosslet@iu.edu

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Recommendation 4**Overview**

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.

One reason these cases are difficult is that they bring into conflict important interests of patients, clinicians, and society. Patients have an interest in receiving care consistent with their values and preferences. Clinicians have an interest in not being compelled to act against their best understanding of their professional obligations. Society has important interests in protecting individual rights, fostering clinician professionalism, and ensuring the fair allocation of medical resources. These cases are also difficult because there are generally not clear substantive rules to

which to appeal. Additionally, affected patients are generally vulnerable by virtue of incapacity, have little choice regarding their treating clinicians, and have limited ability to seek treatment elsewhere.

This multisociety statement recommends strategies to prevent treatment disputes in ICUs, provides a framework to characterize disputes, and outlines processes to manage intractable treatment disputes with an emphasis on procedural fairness. It is grounded on the premise that it is ethically untenable to give complete authority for treatment decisions to either patients/surrogates or individual clinicians. Instead, clinicians and patients/surrogates should work collaboratively to make treatment decisions and, in the face of disagreement, should first augment efforts to find a negotiated agreement, including involving expert consultants. In the rare cases in which intractable conflict develops, clinicians should pursue a process-based approach to conflict resolution.

Recommendation 1

Institutions should implement strategies to prevent intractable treatment conflicts, including proactive communication and early involvement of expert consultation.

Recommendation 2

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. Clinicians should communicate and advocate for the treatment plan 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.

The committee recommends the following approach to manage such cases:

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 alternate institution
6. Inform surrogates of the opportunity to pursue extramural appeal
7. Implement the decision of the resolution process

When time pressures (such as a rapidly deteriorating clinical condition) make it infeasible to complete all steps of the conflict-resolution process and clinicians have a high degree of certainty that the requested treatment is outside accepted practice, they should refuse to provide the requested treatment and endeavor to achieve as much procedural oversight as the clinical situation allows.

Recommendation 3

There are two less-common situations for which the committee recommends different management strategies.

Requests for strictly futile interventions.

The term “futile” should only be used in the rare circumstance that an intervention simply cannot accomplish the intended physiologic goal. Clinicians should not provide futile interventions and should carefully explain the rationale for the refusal. If disagreement persists, clinicians should generally obtain expert consultation to assist in conflict resolution and communication.

Requests for legally proscribed or legally discretionary treatments. “Legally proscribed” treatments are those that are prohibited by applicable laws, judicial precedent, or widely accepted public policies (e.g., organ allocation strategies). “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 either legally proscribed or legally discretionary treatments, clinicians should carefully explain the rationale for treatment refusal and, if there is uncertainty regarding the interpretation and application of the relevant rule, should generally seek expert consultation to confirm accurate interpretation of the rule.

Recommendation 4

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

Introduction

One of the most ethically controversial issues in intensive care units (ICUs) is how to respond to requests from patients or surrogates to administer invasive, burdensome interventions when clinicians believe those interventions should not be administered. Conflicts about such cases are not uncommon. In a recent single-day cross-sectional study of European ICUs, more than a quarter of physicians reported providing treatment they perceived to be inappropriate (1). A study in U.S. ICUs revealed that roughly 20% of ICU patients received at least 1 day of treatment that physicians judged to be futile (2). Although most of these conflicts are resolved with intensive communication and/or expert consultation, a small number remain intractable (3–5).

Several professional societies have published statements regarding management of such disputes (6–8). These guidelines differ substantially in their definitions of the term “futile” and the recommended management strategies (Table 1). Conflicting guidance from professional societies is problematic because it may exacerbate confusion about this topic among clinicians and policymakers.

There is now widespread agreement that many of these disagreements, previously called futility disputes, do not hinge solely on technical medical determinations and instead also involve contested value judgments about what is appropriate treatment in patients with far advanced illness (9). Such cases bring into conflict important interests of patients, clinicians, and society. Patients have an interest in receiving care consistent with their values. Clinicians have an interest in not being compelled to act against their best understanding of their professional responsibilities. Society has important interests in protecting individual rights, fostering clinician professionalism, and ensuring the fair allocation of medical resources. Because of these complexities and the need for clear guidance for clinicians, the American Thoracic Society (ATS) convened a multisociety working group to (1) provide a framework for understanding different types of disputes that have been loosely referred to as futility disputes (Figure 1), and (2) make

recommendations regarding how to prevent and manage such disputes.

Methods

Methods can be found in the online supplement.

Recommendation 1

Institutions should implement strategies to prevent intractable treatment conflicts, including proactive communication and early involvement of expert consultation.

Justification

Three main reasons justify this recommendation. First, collaborative decision making is a fundamental aspect of good medical care and is therefore a valuable ethical goal to foster (10). Second, once conflicts become intractable, there are only “second best” resolution strategies, which are likely to be protracted and burdensome to all parties involved. Third, most disagreements in ICUs arise not from intractable value conflicts but from breakdowns in communication that are amenable to communication interventions. Studies assessing proactive communication strategies have not specifically evaluated whether they prevent conflict, and there is a paucity of empirical evidence about the effect of such interventions on patient and family outcomes. However, such interventions have been shown to reduce the time needed to make decisions (11) and to improve family satisfaction (12, 13). Existing evidence suggests that most clinician–surrogate disputes can be resolved through ongoing communication (3, 4) or with the help of expert consultants, such as ethics or palliative care consultants (14).

Implement Proactive Communication Strategies

Clinicians and administrators should ensure that reliable systems are in place to achieve timely, effective clinician–surrogate communication. Although the focus of this document is on decision making in ICUs, the committee also strongly endorses efforts to improve advance care planning as a way to prevent disputes in ICUs.

During family meetings, clinicians should listen closely to surrogates; provide

emotional support and establish a trusting relationship; discuss the patient’s prognosis in clear, jargon-free language; elicit the patient’s values and preferences; and explain principles of surrogate decision making. Based on this conversation, clinicians should discuss which treatment options fit with patient’s goals, including the option of a treatment plan focused purely on palliation (Table 2) (15–22). Clinicians need not offer treatments that are outside the boundaries of accepted medical practice.

If surrogates request treatments that clinicians believe are not consistent with a patient’s values or interests, or are outside the boundaries of accepted practice, clinicians should not simply acquiesce to these requests. Instead, clinicians should seek to understand the surrogate’s perspective, correct any misperceptions, and share the clinician’s perspectives with the surrogate. If the surrogate continues to advocate for treatments that the clinician believes are ill advised, the clinician should respectfully advocate for an alternative treatment course. This is important, because clinicians are obligated to advocate for good medical practice as part of their professional role, and their judgments about the boundaries of good medical practice deserve careful consideration in decisions regarding life-prolonging treatments. In rare cases in which the surrogate is clearly not representing the values or interests of the patient, the clinician should identify an alternate surrogate or seek a court-appointed guardian.

The committee recommends increased efforts to teach clinicians end-of-life communication skills, including strategies to achieve shared decision making, conflict-resolution skills, and skills to emotionally support surrogates facing difficult decisions (23).

Consider Early Involvement of Expert Consultants

Hospitals should implement strategies to identify and intervene on nascent conflict in ICUs by encouraging involvement of individuals skilled in negotiation and communication (24). This recommendation is intended to emphasize that conflicts typically develop and worsen over time as communication breaks down and parties become entrenched in their positions. In some hospitals, ethics or palliative care

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Table 1. Existing Conflict-Resolution Processes and Statements

Year	Author/Society	Definition of Futility	Role of Unilateral Decision Making for Disputed Treatments	Conflict-Resolution Mechanism	Appeal Process
1991	American Thoracic Society (8)	"A life-sustaining intervention is futile if reasoning and experience indicate that the intervention would be highly unlikely to result in meaningful survival for that patient."	"A life-sustaining intervention may be withheld or withdrawn from a patient without the consent of the patient or surrogate if the intervention is judged to be futile."	No recommendation given	Not addressed
1997	Society of Critical Care Medicine (7)	"Treatments should be defined as futile only when they will not accomplish their intended goal . . . i.e., treatments that have no beneficial physiologic effect."	"Treatments that offer no physiologic benefit to the patient are futile and should never be offered."	Did not outline specific steps for conflict resolution, but outlined the following criteria for procedural fairness for resolution of conflict: 1. Be on the public record and widely known 2. Represent the set of moral values acceptable to the community served 3. Publicly state the mechanisms by which they were adopted 4. Include appellate and court mechanisms for appeal of a withdrawal decision	Yes, recommends that option for extramural appeal be included in resolution process to achieve procedural fairness
1999	American Medical Association (6)	No substantive definition endorsed	None	1. Joint decision making using outcomes data and values judgments 2. Involvement of consultants and/or patient representative 3. Ethics committee review 4. Attempt transfer of care within institution 5. Transfer to another institution 6. Cease disputed treatment	None
1999	Texas Advance Directives Act (5)	No substantive definition endorsed. The term "medically inappropriate" proposed as alternative. "Rather than attempting to create a fixed legal definition of medically inappropriate treatment (which might be made moot by evolving medical science), the law establishes a process for resolving disputes over such treatment."	None	1. Written information regarding process provided to the surrogates 2. 48-h notice regarding consultation process 3. Ethics consultation committee must provide written report to surrogates 4. Opportunity for transfer facilitated by hospital—10 d 5. If no provider found, provider may withhold/withdraw disputed therapy with legal immunity	May ask state court judge to grant an extension on the 10-d period only; may not ask the judge to rule on the merits of the case

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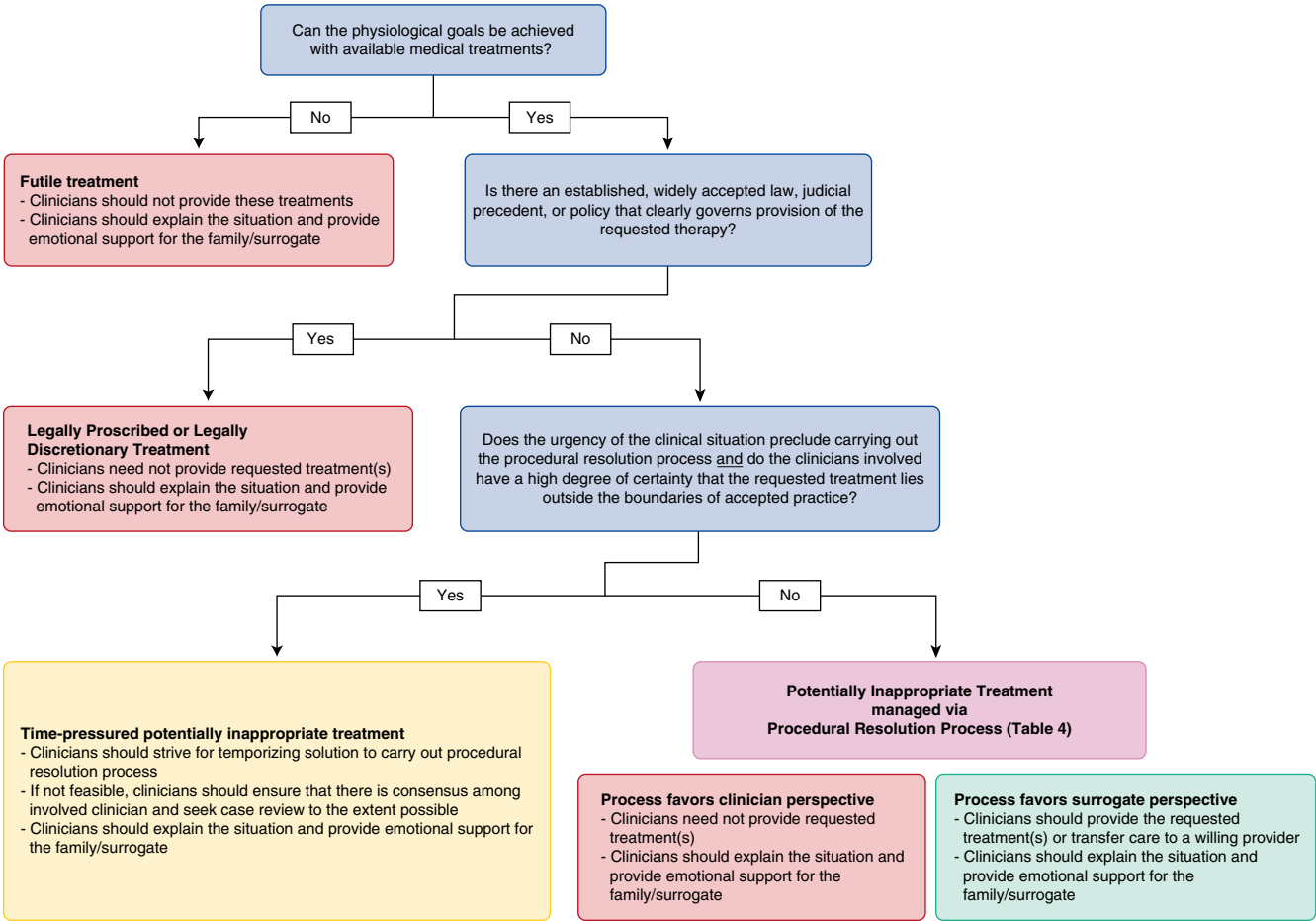


Figure 1. Recommended approach for management of disputed treatment requests in intensive care units.

consultants may be most skilled in mediation and conflict resolution. Other individuals may also be especially skillful in this role, such as expert clinicians, social workers, chaplains, and trained mediators. Hospitals should foster an organizational culture that encourages the early involvement of expert consultants to assist in conflict resolution.

Recommendation 2

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. Clinicians should communicate and advocate for the treatment plan they believe is appropriate. Requests for potentially inappropriate treatments that

remain intractable despite intensive communication and negotiation should be managed by a fair process of conflict resolution.

Justification

The committee recommends use of the term “potentially inappropriate” rather than “futile” to emphasize two important aspects of such judgments. First, the word “inappropriate” conveys more clearly than the word “futile” or “ineffective” that the assertion being made by clinicians depends both on technical medical expertise and a value-laden claim, rather than strictly a technical judgment. Second, the word “potentially” signals that the judgments are preliminary, rather than final, and require review before being acted on. The ethical concerns that may be raised to justify the refusals include concerns that the treatment is highly unlikely to be successful, is extremely expensive, or is

intended to achieve a goal of controversial value (Table 3). Several considerations justify a procedural approach to conflict resolution, rather than giving all decision-making authority to either surrogates or individual clinicians. Giving sole authority to surrogates is problematic because, although it is generally accepted that patients/surrogates should be allowed to choose from accepted, available treatment options, there is no positive right to interventions that are outside the boundaries of accepted practice. In addition, surrogates sometimes experience strong emotional and psychological barriers to authorizing decisions to forego life support, even when those decisions are clearly consistent with the patient’s values and preferences (25, 26). Giving unilateral authority to surrogates may create a disincentive for them to genuinely consider clinicians’ perspectives and to move through the emotional challenges of foregoing treatment when doing so is consistent with a patient’s values and preferences (27).

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Table 2. Recommended Practices for Improving Communication and Support for Surrogates in the Intensive Care Unit

Systems-level interventions

- Conduct regular, structured interprofessional family meetings (63–68)
- Integrate palliative care and/or ethics teams into ICU care for difficult cases (11, 14, 68–71)
- Provide printed educational materials to family (66, 67, 72, 73)
- Maintain dedicated meeting space for ICU family meetings

Clinician-level skills

- Coordinate an effective ICU family meeting
 - Establish consensus among treating clinicians before the meeting (68, 74)
 - Use a private, quiet space for family meetings (68, 74)
 - Introduce all participants
 - Use patient/family-centered communication strategies (*see below*)
 - Affirm nonabandonment and support family decisions (12, 75)
- Provide family-centered communication
 - Elicit surrogates' perceptions first (76)
 - Use active listening skills and deliver information in small chunks (77, 78)
 - Respond to questions and check for understanding of key facts (12, 76, 79)
 - Acknowledge and address emotion (13, 68, 75, 79, 80)
 - Support religious/spiritual needs and concerns (68, 81)
- Foster shared decision making (15–17, 68, 82)
 - Assess clinical prognosis and degree of certainty
 - Evaluate surrogate preferences for decision-making responsibility (18, 19, 21, 22)
 - Elicit the patient's treatment preferences and health-related values (83)

Definition of abbreviation: ICU = intensive care unit.

Giving sole authority to individual clinicians is problematic because there is well-documented variability between clinicians in their judgments about what is appropriate care in such cases, raising the concern of undue variability in treatment decisions (1, 28–32). In addition, the perspectives of ICU clinicians about preferences for end-of-life care often differ significantly from the perspectives of patients and their family members (33–35). Giving all authority to clinicians may also create a disincentive for clinicians to fully engage in the time-consuming, challenging conversations often required to support surrogates and achieve mutually agreeable decisions.

A process-based approach to conflict resolution is also recommended because the cases in question are ethically controversial, have important interests at stake, and do not have explicit rules that can be mechanically applied to resolve disputes (36, 37). It is ethically important to incorporate multiple perspectives to minimize the risk that the values of any one individual will carry undue weight. In addition, process-based approaches better fulfill democratic ideals for resolving conflicts involving fundamental interests, such as transparency, legitimacy, accountability, and opportunity for appeal (38, 39).

Procedural fairness is especially important because these cases generally involve patients who are vulnerable by virtue of incapacity, who have little choice regarding their treating clinicians, and who, because of their overwhelming illness, have severely limited ability to seek out other caregivers. Practically speaking, process-based approaches may allow mutually agreeable solutions to emerge as the conflict-resolution process unfolds over time (5). Within institutions, a process-based approach to conflict resolution may lessen arbitrariness by ensuring broader input, consistency, and the possibility for continuous institutional learning about how to manage future cases (39).

Recommended Conflict-Resolution Process

Hospitals should develop and adopt conflict-resolution processes that contain the seven characteristics detailed below, which are broadly informed by the conflict-resolution literature, philosophical conceptions of procedural justice, and prior professional society guidelines (Table 4) (5, 6, 8, 40–43). This process should be an option of last resort for the relatively rare cases in which conflicts remain intractable despite intensive communication and

negotiation. In general terms, clinicians should conceptualize their judgments that requested treatments are inappropriate as preliminary claims in need of confirmation, rather than conclusions to be immediately acted on. The committee recognizes that some state laws or statutes may not currently permit this approach to resolving intractable clinician-surrogate conflicts and recommends that clinicians advocate to amend such laws (44).

1. Enlist expert consultation to aid in achieving a negotiated agreement. First, clinicians should redouble efforts to reach a negotiated agreement with surrogates. Clinicians should generally seek the assistance of consultants skilled in mediation and conflict resolution. These consultants should be separate from the hospital review committee that evaluates whether the requested treatments are inappropriate (*see* characteristic 4). The consultant should ensure frequent, skillful communication between parties; foster negotiation; and provide psychosocial support to the clinicians and surrogates. Both clinicians and surrogates should be encouraged to reconsider their positions as new information becomes available.

2. Give notice of the process to surrogates. Surrogates should be informed in writing and verbally about the procedural conflict-resolution mechanism and invited to participate in the process.

3. Obtain a second medical opinion. Clinicians should obtain a second opinion from another independent clinician with expertise in the patient's condition, addressing both the patient's prognosis and the judgment that requested treatment is inappropriate.

4. Provide review by an interdisciplinary hospital committee. If disagreement persists, the case should be evaluated by an interdisciplinary institutional committee whose members are not directly involved with the patient's care. The committee should be interdisciplinary in nature with community representation if possible, in accord with existing recommendations regarding the composition and competencies of hospital ethics committees (24, 45). The committee should be able to convene and proceed with case review in a timely fashion.

The charge of this committee should be (1) to provide an opportunity for both clinicians and surrogates to explain their

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Table 3. Categories of Disputed Treatments in Intensive Care Units

Category	Definition	Conflict-Resolution Process	Examples
Requests for potentially inappropriate treatment	Treatments that have at least some chance of accomplishing the effect sought by the patient or surrogate and are not proscribed, but clinicians believe that competing ethical considerations justify refusing to provide the requested treatment	Conflict resolution should be accomplished via the process outlined in recommendation 3 and in Table 4.	<ol style="list-style-type: none">1. A clinician believes ICU admission for a person with end-stage dementia and multiorgan failure is inappropriate.2. A clinician believes it is inappropriate to initiate dialysis in a patient in a persistent vegetative state.3. A clinician believes it is inappropriate to continue mechanical ventilation in a patient with widely metastatic cancer.4. A clinician believes it is inappropriate to place a tracheostomy tube in a child with prolonged respiratory insufficiency and severe irreversible neurological impairment.
Requests for potentially inappropriate treatment in time-pressured situations	Treatments requested in the setting of a rapidly deteriorating clinical condition (which precludes completion of the conflict-resolution process), which clinicians have a high degree of certainty are outside the bounds of accepted practice	<p>As much of the conflict resolution process (Table 4) as possible should be carried out for these requests.</p> <ol style="list-style-type: none">1. Check that facts are clear, assumptions are verified, and moral blind spots are illuminated (Table 5).2. To the extent possible, engage other clinicians to ensure consensus regarding the refusal.3. Empathically explain to surrogates the reasons for the refusal.	<ol style="list-style-type: none">1. A surgeon refuses to perform a laparotomy on a patient on 3 vasopressors with Child C cirrhosis and a bowel perforation.2. A clinician refuses to initiate ECMO on a frail, elderly patient with multiple comorbidities on maximal circulatory support.
Requests for legally proscribed or legally discretionary treatment	Treatments that may accomplish an effect desired by the patient, but for which there are laws, applicable judicial precedent, or public policies that prohibit or permit limitation of their use	<ol style="list-style-type: none">1. Clinicians should work to understand the reason for the request and clearly communicate the rule that governs the request.2. Clinicians should involve individuals with expertise in interpreting existing regulations to ensure the rule is correctly interpreted and applied.3. Clinicians should consider involving communication consultants to assist in clear and accurate communication and psychosocial support for the surrogate.4. Challenges to these rules should be handled by the relevant body that governs the rule.	<ol style="list-style-type: none">1. A clinician refuses to circumvent the organ allocation policy to help a critically ill patient get faster access to an organ for transplantation (proscribed).2. A clinician refuses to prescribe a lethal dose of barbiturates for a patient who seeks physician-assisted suicide in a location in which such actions are illegal (proscribed).3. A clinician refuses to provide ongoing physiologic support for a patient correctly diagnosed as brain dead who is not an organ donor in a state where brain death is recognized as death (proscribed).4. In a state that has a statute governing "medically ineffective treatment," a clinician enters a DNR order for a patient with multiorgan failure and progressive metastatic cancer for whom, to a reasonable degree of medical certainty, CPR would not prevent impending death (discretionary) (56).

(Continued)

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Table 3. (Continued)

Category	Definition	Conflict-Resolution Process	Examples
Requests for futile intervention	Interventions that cannot accomplish the intended physiological goals	<ol style="list-style-type: none"> 1. Clinicians should explain the reasons that the requested intervention is ineffective and explore the surrogates' reasons for the request. 2. If conflict persists, clinicians should consider a second opinion to help clarify the medical facts and enlist communication experts to help empathically communicate the clinical reasoning behind the refusal and provide psychosocial support. 	<ol style="list-style-type: none"> 1. A clinician refuses to perform CPR on a patient with signs of irreversible death (rigor mortis, dependent lividity). 2. A clinician refuses to administer antifungals as treatment for an acute myocardial infarction.

Definition of abbreviations: CPR = cardiopulmonary resuscitation; DNR = do not resuscitate; ECMO = extracorporeal membrane oxygenation; ICU = intensive care unit.

perspectives, (2) to ensure that the conflict resolution process is performed appropriately, and (3) to confirm whether the treating clinicians' claim that the requested treatments are inappropriate represents a broadly held judgment within the institution rather than an idiosyncratic view of a few clinicians. In addition, such review may promote a more thoughtful evaluation by requiring clinicians and surrogates to articulate reasons for their judgments. The committee's conclusions, including their rationale, should be provided in writing to all parties, who should have an opportunity to discuss the decision with the committee.

5. Offer surrogates the opportunity for transfer to an alternate institution. If the hospital committee agrees with the clinicians' judgment that the requested treatments are inappropriate, but the surrogate remains unpersuaded, the surrogate should be informed of their right to seek transfer of care to another institution.

Clinicians and the institution should offer to assist surrogates in seeking an alternate provider because doing so requires expertise that patients and families generally do not have. This includes identifying and contacting alternative providers, explaining the clinical situation to other clinicians, and assisting with the logistics of such a transfer process.

6. Inform surrogates of their opportunity to pursue extramural appeal. Surrogates should be informed of their right to pursue an extramural appeal of the

decision, generally through seeking judicial review. This is because the legitimacy of decisions that arise from a purely procedural conflict-resolution process hinges on adherence to principles of fair process, including legitimacy and freedom from conflict of interest (39), which some have argued cannot be guaranteed given concerns about variable expertise within institutions and financial or relational conflicts of interest (46, 47). The transfer option outlined above may not reliably provide these fair process principles, as clinicians' refusal to accept a patient in transfer may result from financial considerations or a desire to not become

embroiled in another hospital's controversial case rather than the belief that the requested treatments are inappropriate.

7. Implement the decision of the resolution process. If the hospital committee agrees with the surrogate's request for life-prolonging treatment, clinicians should provide such treatments or transfer the patient to a willing provider.

If the hospital committee affirms the treating clinicians' judgment, no alternate providers can be found, and the independent appeal mechanism is either not undertaken by the surrogate or affirms the clinicians' position, clinicians may refuse to provide

Table 4. Recommended Steps for Resolution of Conflict Regarding Potentially Inappropriate Treatments

1. Before initiation of and throughout the formal conflict-resolution procedure, clinicians should enlist expert consultation to aid in achieving a negotiated agreement.
2. Surrogate(s) should be given clear notification in writing regarding the initiation of the formal conflict-resolution procedure and the steps and timeline to be expected in this process.
3. Clinicians should obtain a second medical opinion to verify the prognosis and the judgment that the requested treatment is inappropriate.
4. There should be case review by an interdisciplinary institutional committee.
5. If the committee agrees with the clinicians, then clinicians should offer the option to seek a willing provider at another institution and should facilitate this process.
6. If the committee agrees with the clinicians and no willing provider can be found, surrogate(s) should be informed of their right to seek case review by an independent appeals body.
 - 7a. If the committee or appellate body agrees with the patient or surrogate's request for life-prolonging treatment, clinicians should provide these treatments or transfer the patient to a willing provider.
 - 7b. If the committee agrees with the clinicians' judgment, no willing provider can be found, and the surrogate does not seek independent appeal or the appeal affirms the clinicians' position, clinicians may withhold or withdraw the contested treatments and should provide high-quality palliative care.

or may withdraw the disputed treatments. A care plan should be developed that includes provision of other indicated treatments, including those focused on achieving patient comfort.

Management of Time-pressured Decisions

Very rarely, situations will arise in which surrogates request treatments that clinicians have a high degree of certainty are outside accepted practice, but because of the urgency of the clinical situation, there is insufficient time to complete all steps of the recommended resolution process. For example, in a moribund, frail patient with multiple comorbidities who is on maximal circulatory support, surrogates may request extracorporeal membrane oxygenation when such an intervention is generally regarded as outside of the boundaries of accepted medical practice. Whenever possible, a temporizing treatment plan should be initiated to allow as much of the conflict-resolution process as possible to be completed. Such a plan need not include the requested treatment if the clinicians have a high degree of certainty that it is outside the boundaries of accepted practice.

Before refusing the requested treatment, clinicians should: (1) pause to check that the facts are clear, assumptions are verified, and moral blind spots are illuminated (see Table 5 for questions to assist in this analysis); (2) to the extent possible, engage other clinicians to ensure consensus regarding the refusal; and (3) explain to the surrogates the reasons for refusing to administer the requested treatment, with the goal of reaching a mutually agreeable decision.

The ethically important features of this strategy are that clinicians: (1) base judgments on their best understanding of their professional obligations, (2) have a high degree of certainty that the treatment being requested is outside the boundaries of accepted practice, and (3) only enact this strategy when it is not feasible to carry out the steps of the resolution process. Because decisions made using this approach have fewer procedural safeguards than decisions that carry out the entire process outlined above, they likely come with a higher degree of legal uncertainty for clinicians and health care institutions.

Table 5. Questions to Assist in Illuminating Moral Issues in Time-pressured Situations

Am I certain that this requested treatment is outside of the boundaries of accepted practice?
Would I be willing to have the rationale for my decision publicly reviewed in an appeals board or court?
What are the consequences to the patient, surrogate, team, or institution as a result of implementing this decision?
Am I sure that sex, race, socioeconomic status, ability to pay, or other psychosocial factors are not entering into my decision?

Other Considerations

Reporting and retrospective review.

Institutions should track the incidence and outcomes of cases in which intractable disputes occur. Hospitals should regularly review the cases to identify areas for practice improvement, to ensure that similar cases are managed similarly, and to help develop community standards. If states develop statutes or regulations that govern how these cases should be resolved, such statutes should contain reporting requirements so that necessary statutory changes can be made to improve the process.

Support for providers. Such cases often raise moral distress among clinicians, particularly when clinicians are compelled to provide interventions they judge to be inappropriate during the conflict-resolution process (1, 48). Institutions should offer support services to address clinicians' moral distress. Support services might include peer-to-peer support, debriefing sessions, employee assistance programs, and education aimed at building resilience and ethical decision making (23, 49).

Development of novel extrajudicial appeals processes. In the United States, the courts generally fulfill the appellate function for conflict resolution. Although there are important strengths of the courts as the appeals mechanism (27), there are also serious limitations, such as the time-consuming and adversarial nature of court proceedings. The committee recommends efforts to develop and evaluate novel extrajudicial appeals mechanisms, such as regional ethics committees and quasi-judicial bodies, to resolve conflicts when

surrogates wish to challenge the decision rendered by the intramural resolution process about boundaries of accepted practice (41, 44, 50).

Recommendation 3

There are two less-common situations for which the committee recommends different management strategies.

1. **Requests for "strictly futile" interventions.** The term "futile" should only be used in the rare circumstance that an intervention simply cannot accomplish the intended physiologic goal. Clinicians should not provide futile interventions and should carefully explain the rationale for the refusal. If disagreement persists, clinicians should generally obtain expert consultation to assist in conflict resolution and communication.
2. **Requests for "legally proscribed" or "legally discretionary" treatments.** "Legally proscribed" treatments are those that are prohibited by applicable laws, judicial precedent, or widely accepted public policies (e.g., organ allocation strategies). "Legally discretionary" treatments are those for which there exist specific laws, judicial precedent, or policies that give physicians permission to refuse to administer them. In responding to requests for either legally proscribed or legally discretionary treatments, clinicians should carefully explain the rationale for treatment refusal and, if there is uncertainty regarding the interpretation and application of the relevant rule, should generally seek expert consultation to confirm the rule's correct interpretation.

Futile Interventions

We recommend a narrow definition of the term "futile"—treatments that have no chance of achieving the intended physiologic goal—for two reasons (Table 3). First, using a narrow definition highlights a basic distinction between interventions that cannot work and those that might accomplish the desired physiologic effect but raise countervailing ethical concerns (i.e., potentially inappropriate treatments). This distinction is important because, although there is general agreement that

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clinicians need not provide strictly ineffective interventions, there is controversy regarding how to resolve conflicts about treatments that might produce effects of controversial benefit. For example, there is widespread agreement that clinicians need not administer cardiopulmonary resuscitation (CPR) to a patient who died many hours ago, because it cannot achieve any accepted medical goals (9). In contrast, there is legitimate controversy about whether administering CPR to a critically ill patient with advanced metastatic cancer should be undertaken in light of the small chances and duration of benefit. Additionally, broader definitions of futility (51) are problematic because they often hinge on controversial value judgments about quality of life or require a degree of prognostic certainty that is often not attainable.

Clinicians should not provide futile interventions for several reasons. First, it is widely accepted that administering ineffective interventions goes against the most basic ethical obligations of clinicians to benefit individual patients and to avoid harm (7, 52, 53). Such refusals are also justified by the profession's obligation to steward medical resources responsibly, which preclude administering expensive interventions that cannot accomplish the desired physiological goals (54, 55). Additionally, the medical and nursing professions have a legitimate interest in safeguarding their integrity and trustworthiness, which would be undermined if clinicians administered interventions that they knew could not benefit the patient.

Management of Requests for Futile Interventions

When responding to requests for futile interventions, clinicians should seek to understand the reasons for such requests, empathically correct misperceptions, provide emotional support, and explain why the requested interventions will not be provided. If disagreement persists, clinicians should generally obtain expert consultation to assist with conflict resolution. Clinicians should consider seeking expert consultation to provide intensive psychosocial support to the surrogate. Clinicians should not be required to administer futile interventions during the time period in which communication consultants are being involved. There should be retrospective

institutional review of such cases to foster institutional learning and to identify systems-level strategies to prevent similar occurrences in future cases.

Legally Proscribed/Discretionary Treatments

"Legally proscribed" treatments are those that may accomplish an effect desired by the patient, but for which there are laws, applicable judicial precedent, or public policies that prohibit their use (Table 3). "Legally discretionary" treatments are those for which there exist laws, judicial precedent, or policies that give physicians permission to refuse to administer them. These categories are important because they highlight that futility is not the only legitimate basis for clinicians to refuse to provide a requested intervention.

For example, if the surrogate of a patient with far advanced liver failure requests that clinicians expedite liver transplantation by circumventing existing organ allocation practices, the clinicians are justified in refusing the request (legally proscribed). Even though faster access to liver transplantation might accomplish the patient's medical goal, clinicians' refusal is permitted because there are explicit, well-established rules governing organ allocation. Additionally, some states have statutes that give physicians permission to forego CPR and other procedures in strictly defined circumstances (legally discretionary) (56).

Currently in the United States and most other countries, there are few laws, precedents, or widely accepted policies that can be applied to resolve conflicts in ICUs. We do not attempt to propose individual rules, because such determinations will likely evolve over time and will almost certainly vary within and across countries depending on how certain values are prioritized. Such variability should be permitted in light of moral pluralism (the idea that people often disagree over how to prioritize countervailing fundamental values [57]) and differences in health care resources across countries (58, 59).

Management of Requests for Legally Proscribed or Legally Discretionary Treatments

Clinicians should not provide legally proscribed treatments and need not provide legally discretionary treatments if

they are not indicated. When society has legitimately developed rules to govern controversial aspects of medical practice, clinicians are justified in acting according to those rules as part of their professional role. As a caveat, rules regarding legally proscribed or legally discretionary treatments may vary from state to state, or jurisdiction to jurisdiction.

When responding to requests for a legally proscribed or legally discretionary treatment, clinicians should ensure that they are correctly interpreting the relevant rule, seek to understand the reason for the request, explain why the requested intervention will not be provided, and provide emotional support. In general, clinicians should involve individuals with expertise in interpreting existing regulations (i.e., ethics consultants or legal counsel) to ensure that the rule is correctly interpreted and applied. Involvement of expert consultants should also be considered to help facilitate clear, accurate, and supportive communication with the surrogate.

Recommendation 4

The medical profession should engage in efforts to influence opinion and develop policies and legislation about when life-prolonging technologies should not be used.

Developing clear societal policies and legislation about the appropriate boundaries of medical practice near the end of life would foster transparency in limit setting and may allow more efficient resolution of individual cases. To be clinically useful, such policies/legislation will require a high level of detail and specificity about which

Table 6. Examples of Questions for Public Engagement

What process or factors should drive the allocation of ICU beds when they are scarce?
Should clinicians be required to provide cardiopulmonary resuscitation requested by surrogates for patients with advanced metastatic cancer and multiorgan failure?
Should patients with far advanced dementia or in a persistent vegetative state be admitted to ICUs?

Definition of abbreviation: ICU = intensive care unit.

treatments are proscribed under which circumstances. To be ethically acceptable in pluralistic societies, the development of such policies/legislation will require the input of diverse clinician, patient, and stakeholder groups.

Informed patients must partner in developing substantive policies and legislation because they will experience the effects of such rules and because the

boundaries of acceptable medical practice require value judgments that go beyond the expertise of clinicians (60). Public engagement should have the goal of eliciting informed, considered judgments from key stakeholders to provide input into policy development. There are numerous deliberative democratic techniques to obtain the well-informed views of a representative group of

citizens (43). Such methods have been successfully used to develop difficult policy decisions in both medical and nonmedical matters (61, 62). Table 6 outlines examples of ethical questions regarding life-sustaining therapies for which public engagement may be valuable. Public engagement could happen at the level of geographic communities, health systems, or insurers. ■

This Policy Statement was prepared by an *ad hoc* Committee on Futile and Potentially Inappropriate Care.

Members of the committee:

GABRIEL T. BOSSLET, M.D., M.A. (*Co-Chair*)
DOUGLAS B. WHITE (*Co-Chair*)
THADDEUS M. POPE, J.D., Ph.D.
GORDON D. RUBENFELD, M.D., M.Sc.
BERNARD LO, M.D.
ROBERT D. TRUOG, M.D.
CYNDA H. RUSHTON, M.S.N., Ph.D., R.N.
J. RANDALL CURTIS, M.D., M.P.H.

DEE W. FORD, M.D., M.S.C.R.
MOLLY OSBORNE, M.D., Ph.D.
CHERYL MISAK, D.Phil.
DAVID H. AU, M.D., M.S.
ELIE AZOULAY, M.D., Ph.D.
BARUCH BRODY, Ph.D.
BRENDA G. FAHY, M.D.
JESSE B. HALL, M.D.
JOZEF KESECIOGLU, M.D., Ph.D.

ALEXANDER A. KON, M.D.
KATHLEEN O. LINDELL, Ph.D., R.N.

Author Disclosures: G.T.B., D.B.W., T.M.P., G.D.R., B.L., R.D.T., C.H.R., J.R.C., D.W.F., M.O., C.M., D.H.A., E.A., B.B., B.G.F., J.B.H., J.K., A.A.K., and K.L. reported no financial interests relevant to the document subject matter.

References

- Piers RD, Azoulay E, Ricou B, Dekeyser Ganz F, Decruyenaere J, Max A, Michalsen A, Maia PA, Owczuk R, Rubulotta F, *et al.*: APPROPRIUS Study Group of the Ethics Section of the ESICM. Perceptions of appropriateness of care among European and Israeli intensive care unit nurses and physicians. *JAMA* 2011;306:2694–2703.
- Huynh TN, Kleerup EC, Wiley JF, Savitsky TD, Guse D, Garber BJ, Wenger NS. The frequency and cost of treatment perceived to be futile in critical care. *JAMA Intern Med* 2013;173:1887–1894.
- Prendergast TJ. Resolving conflicts surrounding end-of-life care. *New Horiz* 1997;5:62–71.
- Garros D, Rosychuk RJ, Cox PN. Circumstances surrounding end of life in a pediatric intensive care unit. *Pediatrics* 2003;112:e371.
- Fine RL, Mayo TW. Resolution of futility by due process: early experience with the Texas Advance Directives Act. *Ann Intern Med* 2003;138:743–746.
- Medical futility in end-of-life care: report of the Council on Ethical and Judicial Affairs. *JAMA* 1999;281:937–941.
- Consensus statement of the Society of Critical Care Medicine's Ethics Committee regarding futile and other possibly inadvisable treatments. *Crit Care Med* 1997;25:887–891.
- American Thoracic Society. Withholding and withdrawing life-sustaining therapy. *Ann Intern Med* 1991;115:478–485.
- Rubin SB. If we think it's futile, can't we just say no? *HEC Forum* 2007;19:45–65.
- American Medical Association. Opinion 10.01- Fundamental elements of the patient-physician relationship. 2014 [accessed 2014 Apr 22]. Available from: <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion1001.page?>
- Norton SA, Hogan LA, Holloway RG, Temkin-Greener H, Buckley MJ, Quill TE. Proactive palliative care in the medical intensive care unit: effects on length of stay for selected high-risk patients. *Crit Care Med* 2007;35:1530–1535.
- Stapleton RD, Engelberg RA, Wenrich MD, Goss CH, Curtis JR. Clinician statements and family satisfaction with family conferences in the intensive care unit. *Crit Care Med* 2006;34:1679–1685.
- Selph RB, Shiang J, Engelberg R, Curtis JR, White DB. Empathy and life support decisions in intensive care units. *J Gen Intern Med* 2008;23:1311–1317.
- Schneiderman LJ, Gilmer T, Teetzel HD, Dugan DO, Blustein J, Cranford R, Briggs KB, Komatsu GI, Goodman-Crews P, Cohn F, *et al.* Effect of ethics consultations on nonbeneficial life-sustaining treatments in the intensive care setting: a randomized controlled trial. *JAMA* 2003;290:1166–1172.
- Curtis JR, Vincent J-L. Ethics and end-of-life care for adults in the intensive care unit. *Lancet* 2010;376:1347–1353.
- Curtis JR, White DB. Practical guidance for evidence-based ICU family conferences. *Chest* 2008;134:835–843.
- Thompson BT, Cox PN, Antonelli M, Carlet JM, Cassell J, Hill NS, Hinds CJ, Pimentel JM, Reinhart K, Thijs LG; American Thoracic Society; European Respiratory Society; European Society of Intensive Care Medicine; Society of Critical Care Medicine; Société de Réanimation de Langue Française. Challenges in end-of-life care in the ICU. Statement of the 5th International Consensus Conference in Critical Care: Brussels, Belgium, April 2003: executive summary. *Crit Care Med* 2004;32:1781–1784.
- Evans LR, Boyd EA, Malvar G, Apatira L, Luce JM, Lo B, White DB. Surrogate decision-makers' perspectives on discussing prognosis in the face of uncertainty. *Am J Respir Crit Care Med* 2009;179:48–53.
- Heyland DK, Tranmer J, O'Callaghan CJ, Gafni A. The seriously ill hospitalized patient: preferred role in end-of-life decision making? *J Crit Care* 2003;18:3–10.
- Azoulay E, Chevret S, Leleu G, Pochard F, Barboteu M, Adrie C, Canoui P, Le Gall JR, Schlemmer B. Half the families of intensive care unit patients experience inadequate communication with physicians. *Crit Care Med* 2000;28:3044–3049.
- Azoulay E, Pochard F, Chevret S, Adrie C, Annane D, Bleichner G, Bornstein C, Bouffard Y, Cohen Y, Feissel M, *et al.*; FAMIREA Study Group. Half the family members of intensive care unit patients do not want to share in the decision-making process: a study in 78 French intensive care units. *Crit Care Med* 2004;32:1832–1838.
- White DB, Evans LR, Bautista CA, Luce JM, Lo B. Are physicians' recommendations to limit life support beneficial or burdensome? Bringing empirical data to the debate. *Am J Respir Crit Care Med* 2009;180:320–325.
- Rushton CH. Principled moral outrage: an antidote to moral distress? *AACN Adv Crit Care* 2013;24:82–89.
- American Society for Bioethics and Humanities. Core competencies for health care ethics consultation, 2nd ed. Glenview, IL: American Society for Bioethics and Humanities; 2011.

AMERICAN THORACIC SOCIETY DOCUMENTS

25. Schenker Y, Crowley-Matoka M, Dohan D, Tiver GA, Arnold RM, White DB. I don't want to be the one saying 'we should just let him die': intrapersonal tensions experienced by surrogate decision makers in the ICU. *J Gen Intern Med* 2012;27:1657-1665.
26. Jezewski MA. Do-not-resuscitate status: conflict and culture brokering in critical care units. *Heart Lung* 1994;23:458-465.
27. White DB, Pope TM. The courts, futility, and the ends of medicine. *JAMA* 2012;307:151-152.
28. Sprung CL, Cohen SL, Sjøkvist P, Baras M, Bulow HH, Hovilehto S, Ledoux D, Lippert A, Maia P, Phelan D, *et al.*; Ethicus Study Group. End-of-life practices in European intensive care units: the Ethicus Study. *JAMA* 2003;290:790-797.
29. Wunsch H, Harrison DA, Harvey S, Rowan K. End-of-life decisions: a cohort study of the withdrawal of all active treatment in intensive care units in the United Kingdom. *Intensive Care Med* 2005;31:823-831.
30. Garland A, Connors AF. Physicians' influence over decisions to forego life support. *J Palliat Med* 2007;10:1298-1305.
31. Curtis JR, Park DR, Krone MR, Pearlman RA. Use of the medical futility rationale in do-not-attempt-resuscitation orders. *JAMA* 1995;273:124-128.
32. Cook DJ, Guyatt GH, Jaeschke R, Reeve J, Spanier A, King D, Molloy DW, Willan A, Streiner DL; Canadian Critical Care Trials Group. Determinants in Canadian health care workers of the decision to withdraw life support from the critically ill. *JAMA* 1995;273:703-708.
33. Gramelspacher GP, Zhou XH, Hanna MP, Tierney WM. Preferences of physicians and their patients for end-of-life care. *J Gen Intern Med* 1997;12:346-351.
34. O'Donnell H, Phillips RS, Wenger N, Teno J, Davis RB, Hamel MB. Preferences for cardiopulmonary resuscitation among patients 80 years or older: the views of patients and their physicians. *J Am Med Dir Assoc* 2003;4:139-144.
35. Steinhauser KE, Christakis NA, Clipp EC, McNeilly M, McIntyre L, Tulsky JA. Factors considered important at the end of life by patients, family, physicians, and other care providers. *JAMA* 2000;284:2476-2482.
36. Emanuel EJ. A communal vision of care for incompetent patients. *Hastings Cent Rep* 1987;17:15-20.
37. Misak CJ, White DB, Truog RD. Medical futility: a new look at an old problem. *Chest* 2014;146:1667-1672.
38. Daniels N. Accountability for reasonableness. *BMJ* 2000;321:1300-1301.
39. Daniels N, Sabin J. Limits to health care: fair procedures, democratic deliberation, and the legitimacy problem for insurers. *Philos Public Aff* 1997;26:303-350.
40. Hampshire S. 'Justice Is Conflict.' *New York Rev Books* 2000;47:80.
41. Spielman B. Collective decisions about medical futility. *J Law Med Ethics* 1994;22:152-160. [Discussion pp. 161-162.]
42. Emanuel EJ. The ends of human life: medical ethics in a liberal polity. Cambridge, MA: Harvard University Press; 1991.
43. Gutmann A. Why deliberative democracy? Princeton, NJ: Princeton University Press; 2004.
44. Pope TM. Dispute resolution mechanisms for intractable medical futility disputes. *NY Law Sch Law Rev* 2013;58:347-368.
45. American Academy of Pediatrics. Committee on Bioethics. Institutional ethics committees. Committee on Bioethics. *Pediatrics* 2001;107:205-209.
46. Burns JP, Truog RD. Futility: a concept in evolution. *Chest* 2007;132:1987-1993.
47. Pope T. Multi-institutional healthcare ethics committees: the procedurally fair internal dispute resolution mechanism. *Campbell Law Rev* 2009;31:257-332.
48. Mobley MJ, Rady MY, Verheijde JL, Patel B, Larson JS. The relationship between moral distress and perception of futile care in the critical care unit. *Intensive Crit Care Nurs* 2007;23:256-263.
49. American Association of Critical-Care Nurses. AACN standards for establishing and sustaining healthy work environments: a journey to excellence. *Am J Crit Care* 2005;14:187-197.
50. Sibbald RW, Chidwick P. Best interests at end of life: a review of decisions made by the Consent and Capacity Board of Ontario. *J Crit Care* 2010;25:171.e1-7.
51. Schneiderman LJ, Jecker NS, Jonsen AR. Medical futility: its meaning and ethical implications. *Ann Intern Med* 1990;112:949-954.
52. American Medical Association Council on Ethical and Judicial Affairs. Opinion 2.20 - Withholding or withdrawing life-sustaining medical treatment. 1996 [accessed 2012 Jan 16]. Available from: <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion220.page>.
53. Veatch RM, Spicer CM. Futile care: physicians should not be allowed to refuse to treat. *Point. Health Prog* 1993;74:22-27.
54. American College of Physicians. How can our nation conserve and distribute health care resources effectively and efficiently? Philadelphia: American College of Physicians; 2011.
55. ABIM Foundation. American Board of Internal Medicine; ACP-ASIM Foundation. American College of Physicians-American Society of Internal Medicine; European Federation of Internal Medicine. Medical professionalism in the new millennium: a physician charter. *Ann Intern Med* 2002;136:243-246.
56. Ballard P. Summary of Maryland Health Care Decisions Act. 2014 [accessed 2015 May 4]. Available from: <http://www.oag.state.md.us/Healthpol/HCDASummary.pdf>
57. Mason E. Value pluralism. In: Zalta E, editor. Stanford encyclopedia of philosophy. 2011 [accessed 2015 May 7]. Available from: <http://plato.stanford.edu/entries/value-pluralism/>
58. Howitt P, Darzi A, Yang GZ, Ashrafian H, Atun R, Barlow J, Blakemore A, Bull AM, Car J, Conteh L, *et al.* Technologies for global health. *Lancet* 2012;380:507-535.
59. Engelhardt HT Jr. Critical care: why there is no global bioethics. *J Med Philos* 1998;23:643-651.
60. Veatch RM. Generalization of expertise. *Stud Hastings Cent* 1973;1:29-40.
61. Baum NM, Jacobson PD, Goold SD. "Listen to the people": public deliberation about social distancing measures in a pandemic. *Am J Bioeth* 2009;9:4-14.
62. Goold SD, Biddle AK, Klipp G, Hall CN, Danis M. Choosing Healthplans All Together: a deliberative exercise for allocating limited health care resources. *J Health Polit Policy Law* 2005;30:563-601.
63. Lilly CM, De Meo DL, Sonna LA, Haley KJ, Massaro AF, Wallace RF, Cody S. An intensive communication intervention for the critically ill. *Am J Med* 2000;109:469-475.
64. Lilly CM, Sonna LA, Haley KJ, Massaro AF. Intensive communication: four-year follow-up from a clinical practice study. *Crit Care Med* 2003;31:S394-S399.
65. Daly BJ, Douglas SL, O'Toole E, Gordon NH, Hejal R, Peerless J, Rowbottom J, Garland A, Lilly C, Wiencek C, *et al.* Effectiveness trial of an intensive communication structure for families of long-stay ICU patients. *Chest* 2010;138:1340-1348.
66. Scheunemann LP, McDewitt M, Carson S, Hanson LC. Randomized, controlled trials of interventions to improve communication in intensive care: a systematic review. *Chest* 2011;139:543-554.
67. Lautrette A, Darmon M, Megarbane B, Joly LM, Chevret S, Adrie C, Barnoud D, Bleichner G, Bruel C, Choukroun G, *et al.* A communication strategy and brochure for relatives of patients dying in the ICU. *N Engl J Med* 2007;356:469-478.
68. Davidson JE, Powers K, Hedayat KM, Tieszen M, Kon AA, Shepard E, Spuhler V, Todres ID, Levy M, Barr J, *et al.*; American College of Critical Care Medicine Task Force 2004-2005, Society of Critical Care Medicine. Clinical practice guidelines for support of the family in the patient-centered intensive care unit: American College of Critical Care Medicine Task Force 2004-2005. *Crit Care Med* 2007;35:605-622.
69. Campbell ML, Guzman JA. Impact of a proactive approach to improve end-of-life care in a medical ICU. *Chest* 2003;123:266-271.
70. Campbell ML, Guzman JA. A proactive approach to improve end-of-life care in a medical intensive care unit for patients with terminal dementia. *Crit Care Med* 2004;32:1839-1843.
71. Kaufer M, Murphy P, Barker K, Mosenthal A. Family satisfaction following the death of a loved one in an inner city MICU. *Am J Hosp Palliat Care* 2008;25:318-325.
72. Azoulay E, Pochard F, Chevret S, Jourdain M, Bornstain C, Wernet A, Cattaneo I, Annane D, Brun F, Bollaert PE, *et al.* Impact of a family information leaflet on effectiveness of information provided to family members of intensive care unit patients: a multicenter, prospective, randomized, controlled trial. *Am J Respir Crit Care Med* 2002;165:438-442.

AMERICAN THORACIC SOCIETY DOCUMENTS

73. Peigne V, Chaize M, Falissard B, Kentish-Barnes N, Rusinova K, Megarbane B, Bele N, Cariou A, Fieux F, Garrouste-Orgeas M, *et al.* Important questions asked by family members of intensive care unit patients. *Crit Care Med* 2011;39:1365–1371.
74. Pochard F, Azoulay E, Chevret S, Lemaire F, Hubert P, Canoui P, Grassin M, Zittoun R, le Gall JR, Dhainaut JF, *et al.*; French FAMIREA Group. Symptoms of anxiety and depression in family members of intensive care unit patients: ethical hypothesis regarding decision-making capacity. *Crit Care Med* 2001;29:1893–1897.
75. West HF, Engelberg RA, Wenrich MD, Curtis JR. Expressions of nonabandonment during the intensive care unit family conference. *J Palliat Med* 2005;8:797–807.
76. Back AL, Arnold RM, Baile WF, Fryer-Edwards KA, Alexander SC, Barley GE, Gooley TA, Tulskey JA. Efficacy of communication skills training for giving bad news and discussing transitions to palliative care. *Arch Intern Med* 2007;167:453–460.
77. McDonagh JR, Elliott TB, Engelberg RA, Treece PD, Shannon SE, Rubenfeld GD, Patrick DL, Curtis JR. Family satisfaction with family conferences about end-of-life care in the intensive care unit: increased proportion of family speech is associated with increased satisfaction. *Crit Care Med* 2004;32:1484–1488.
78. Platt FW, Gaspar DL, Coulehan JL, Fox L, Adler AJ, Weston WW, Smith RC, Stewart M. “Tell me about yourself”: the patient-centered interview. *Ann Intern Med* 2001;134:1079–1085.
79. Curtis JR, Engelberg RA, Wenrich MD, Shannon SE, Treece PD, Rubenfeld GD. Missed opportunities during family conferences about end-of-life care in the intensive care unit. *Am J Respir Crit Care Med* 2005;171:844–849.
80. Quill TE, Arnold RM, Platt F. “I wish things were different”: expressing wishes in response to loss, futility, and unrealistic hopes. *Ann Intern Med* 2001;135:551–555.
81. Gries CJ, Curtis JR, Wall RJ, Engelberg RA. Family member satisfaction with end-of-life decision making in the ICU. *Chest* 2008;133:704–712.
82. Carlet J, Thijs LG, Antonelli M, Cassell J, Cox P, Hill N, Hinds C, Pimentel JM, Reinhart K, Thompson BT. Challenges in end-of-life care in the ICU. Statement of the 5th International Consensus Conference in Critical Care: Brussels, Belgium, April 2003. *Intensive Care Med* 2004;30:770–784.
83. Scheunemann LP, Arnold RM, White DB. The facilitated values history: helping surrogates make authentic decisions for incapacitated patients with advanced illness. *Am J Respir Crit Care Med* 2012;186:480–486.