

Experience with a Nine-step Policy Dealing with Requests for Medically Inappropriate Interventions for Cancer

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Abstract

The article outlines a nine-step process adopted at The University of Texas M D Anderson Cancer Center for handling patient requests for medically inappropriate interventions. The main step in the process is review by an Institutional Review Committee composed of the physician-in-chief, ethics committee members, and medical experts. The decision of the Review Committee is binding. The experience with this "futility" policy is discussed including a follow-up pilot project conducted by the Department of Gynaecologic Oncology that introduces a standardized advance care planning medical record progress note in which patient preferences about cardiopulmonary resuscitation, mechanical ventilation, and location of death are documented. The note is to be used at the beginning of non-curative therapy and is intended to help to avoid future requests for futile interventions.

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Introduction

Although great strides have been made in treating cancers, a significant number of patients still reach the point at which no curative treatment is available. Physicians then face the difficult task of informing patients that, although palliation is always possible, cure is not. All patients suffer when they hear this bad news, but some simply refuse to accept it. Placing their hopes in medical treatments and technological advances, they demand treatments their physician judges to be medically inappropriate. The physician is now faced with an ethical dilemma. Should he or she acquiesce to these sometimes frantic demands out of compassion for the patient, thereby compromising medical standards, or should the physician refuse to offer treatments that offer no hope of benefit?

In response to this dilemma, M D Anderson's ethics committee joined a Houston task force formed by Baylor College of Medicine's Baruch Brody, *PhD*, Director of the Center for Medical Ethics and Health Policy, and Amir Halevy, *MD*, Assistant Professor of Medicine and Medical Ethics, to write guidelines for patient demands for medically inappropriate interventions. The task force included physicians, lawyers, ethicists, and administrators from all the hospitals in the area. After two years' work, in early 1995, the task force developed a prototype policy to handle such cases. A major goal of this policy is

to provide a just process that meets the needs of both physicians and patients.

A Nine-step Process for Dealing with Requests for Medically Inappropriate Interventions

The nine-step process is summarized in Table I.

In the first step, the physician carefully explains to the patient or surrogate decision-maker the nature of the illness, the prognosis, options for palliative care, and why the disputed intervention is judged to be inappropriate. Next, a transfer to another physician or facility is offered, as is the opportunity to obtain a second opinion. The patient is also informed of the existence of the futility policy at this point. Third, the patient is offered all available supportive services such as chaplaincy, social work, and ethics.

These first three steps are merely a description of good medical care. During the fourth step, the policy takes a new turn. The attending physician obtains a second medical opinion and begins the process of collecting objective clinical information to support the contention that the requested intervention is medically inappropriate. Next, the physician notifies the patient or surrogate of the formal review of the case by an objective committee consisting of the chief operating officer, the physician-in-chief, members of the ethics committee, and designated medical experts. At this point, the patient

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TABLE I: NINE-STEP PROCESS FOR DEALING WITH REQUESTS FOR MEDICALLY INAPPROPRIATE INTERVENTIONS

Step 1:	Physician explains why intervention is inappropriate.
Step 2:	Second opinion and/or transfer offered to patient. Patient given copy of “futility” policy.
Step 3:	Services such as chaplaincy and social work offered.
Step 4:	Second opinion obtained. Physician requests Institution Review Committee (IRC) meeting and prepares objective clinical support.
Step 5:	Patient notified that IRC will meet after 72-hour preparatory period.
Step 6:	Physician and patient present to IRC.
Step 7:	IRC decision is binding.
Step 8:	No internal transfer is allowed except for palliation.
Step 9:	Only primary attending physician may invoke policy.

can still transfer to another physician at Anderson (external transfer is always the patient’s right). There is a mandatory 72-hour preparatory period before the meeting of the Institutional Review Committee, unless all parties agree to waive this requirement.

Step six is the meeting of the Institutional Review Committee, which hears presentations from both the attending physician and the patient or surrogate. The Institutional Review Committee’s deliberations are private, and their decision must be unanimous. If the intervention is judged to be medically inappropriate, it will be ended after a 24-hour grace period. Appropriate palliative care with respect for patient dignity will be maintained. If, on the other hand, the intervention is judged appropriate, it will be provided as long as the patient or surrogate requests it.

Step eight clarifies that, after a negative ruling by the Institutional Review Committee, the patient can no longer be transferred within the institution, except for palliative care.

Step nine limits the invocation of the policy to the attending physician. Members of the task force believed that other caregivers, such as nurses, should contact the ethics committee or their supervisor, if they judge a physician’s intervention to be inappropriate. The policy is designed to resolve disputes solely between the physician and his or her patient.

Overall, the policy has three justifications: it avoids harm to patients, avoids provision of unseemly care, and provides just allocation and good stewardship of medical resources. We understand that the first justification is ironic: patients do not believe that what they request will harm them. The second justification stems from the distaste and unease health care providers feel when they are forced to provide treatments they believe will harm their patients. And the third justification — note it is only one of three — is based on the fear that one of the great

burdens of medical care, both for patients and the community, is cost. If we are to keep costs as reasonable as possible, inappropriate interventions are the first that should be cut.

Results and Discussion

M D Anderson’s participation in the Houston-wide Task Force was motivated by our clinical ethics case experience. A full 20% of the requests for ethics consults involve cases in which the patient or family has requested what the physician judges to be medically inappropriate treatment. The Clinical Ethics Committee consultation team held one such ethics consult at the patient’s bedside, as her mother, father, and husband as well as the four-member consult team filled the hospital room. The patient was a 26-year-old woman with terminal cervical cancer that had been discovered during her pregnancy one and a half years ago. The tumour was discovered at 25 weeks of pregnancy, and after extensive counselling, the patient decided to postpone treatment until 32 weeks so that the fetus could mature. After her baby daughter was safely delivered, aggressive therapy was begun, but to no avail. She was now in the hospital because of dehydration and anxiety. The physician had been counselling her and her family, encouraging them to enter hospice care. They were adamant that “everything possible” be done: cardiopulmonary resuscitation, total parental nutrition, antibiotics, and admission to the hospital as necessary. The physician was certain that these methods would not deliver the best end-of-life care, but he was touched by the tragedy of which he was a part. He requested the ethics consultation.

During the ethics consultation, the patient explained that her primary goal was to be able to spend as much time as possible with her daughter. She did not regret her original decision to postpone therapy for her daughter’s sake and now wanted to be with her as long as possible. We explained that the “everything possible” she and especially her father had requested would not meet that goal. But, we would help her to make sure the time left to her would be a quality time spent with her family, and that it would include hospitalizations, intravenous hydration, and antibiotics. The patient and her father began to understand that cardiopulmonary resuscitation and time in intensive care would not increase her time with her family. A compromise the physician and patient could accept was struck.

Not all ethics consultations achieve this goal. A pivotal case for M D Anderson involved a patient with stage IV lung cancer, who was intubated after metastasis to the brain caused a tonicoclonic seizure. The patient’s husband and two adult sons focused on their promise to her that they would not let her die. She lingered in the intensive care unit for four weeks, subjected to aggres-

sive, probably inappropriate, interventions. This case in particular motivated M D Anderson to be the first of five institutions to adopt the prototype policy outlined by the Houston Task Force. The rest of the participating institutions have adopted it in principle until legislative support can be obtained.

Experience with the Nine-step Policy

The “futility” policy has been in effect at M D Anderson Cancer Center since May 1995. So far, we have not had to proceed beyond step three. We have not reached the innovative step four, nor for that matter, has any of the other hospitals that adopted the policy. So has the policy been useful? Yes. Having this kind of hospitalwide and, in fact, citywide support has given physicians the backing they need to do what they are convinced is appropriate. In several of our cases, the physician fully intended to invoke the futility policy if the ethics consultation did not resolve the dispute. This conviction allowed him or her, during the ethics consultation, to present an analysis of the situation with confidence and without resignation.

One case in particular comes to mind. The patient was a 63-year-old woman who had been treated aggressively and successfully for a glioblastoma for three years. The physician recommended the patient’s transfer to a subacute facility where she could be properly cared for during the remaining months of her life. The facility accepted only patients who were not to receive cardiopulmonary resuscitation. Her two sons would not agree to a do-not-resuscitate order. During the ethics consult, the attending physician kindly but firmly stated that he would not resuscitate this woman because doing so could only harm her. Finally, one son agreed, and the Do-Not-Resuscitate order was written. The second son never did agree; but the transfer was accomplished, and the patient lived peacefully for three more months. Another such case, again with a glioblastoma patient, resulted in a transfer to another physician at M D Anderson who believed that a fairly aggressive treatment course was still appropriate. Thus, the second case was resolved at step two. In short, having discrete steps of action allows our physicians to proceed deliberately in their discussion with patients and surrogates, and it gives them the security to be forthright when they need to be.

Development of the Gynaecologic Oncology Centre Advance Care Planning Medical Progress Note

With the futility policy in place, the Clinical Ethics Program has begun a preventive strategy. Our hypothesis is that a contributing factor to patients’ desperate demands is that they are not forewarned—hearing that the illness has progressed beyond any curative treatment comes as a shock. The follow-up initiative of the

Clinical Ethics Program, this time beginning solely with gynaecologic oncology patients, is to design a standardized way of informing patients earlier in treatment that, although, we can offer various treatments, the intent is only palliative. Working with Dr Charles Levenback, Assistant Professor of Gynecology and Medical Director of Quality Improvement, we created a medical record progress note to be used as soon as it is known that patients can no longer benefit from curative treatment. Five physicians in the Gynaecologic Oncology Department have agreed to use it.

The content of the progress note is based on a survey of 13 physicians in that specialty (Table II). Twelve respondents believed that the attending physician was the correct person to initiate end-of-life planning; 10 felt comfortable discussing the terminal nature of the illness, talking about the spiritual/religious needs of the patient, as well as offering a prediction of median survival; nine were willing to discuss use of mechanical ventilation at the end of life; and eight would ask the patient to identify a surrogate decision maker and felt comfortable discussing preferences regarding the patient’s final care setting, hospital or hospice. Since only seven would choose to discuss intravenous nutritional support, that topic was not included in the Advance Care Planning Medical Progress Note.

The Gynaecologic Oncology Centre Advance Care Planning Progress Note begins with the question, “Patient wishes to participate in discussion today? Yes No.” If the patient agrees, the physician informs the patient that the disease is not curable and offers the median survival estimate range, in months. The patient has, of course, the right to refuse this information.

TABLE II: SURVEY REGARDING PHYSICIANS’ PREFERENCES IN DISCUSSING END-OF-LIFE CARE

n = 13 gynaecologic oncology physicians

Discussion should be initiated by:

(several respondents checked more than one response)

Physician	12 (92%)	
Patient	4 (31%)	
Family members	3 (23%)	
Fellow	2 (15%)	
Nurse	1 (8%)	
Physician should discuss:	Yes	No
Terminal nature of illness	10 (77%)	3 (23%)
Estimate of median survival	10 (77%)	3 (23%)
Spiritual needs of patient	10 (77%)	3 (23%)
Mechanical ventilation	9 (69%)	4 (31%)
Surrogate decision maker	8 (62%)	5 (38%)
Patient’s preference for location of end-of-life care	8 (62%)	5 (38%)
IV nutritional support	7 (54%)	6 (46%)

The physician then identifies the patient's choice for a surrogate decision-maker in case the patient becomes incompetent, and offers a referral to complete the Texas State Durable Power of Attorney for Health Care form if the patient has not yet done so. The physician leads into the next series of questions by asking whether the patient has discussed end-of-life issues with the surrogate. The physician then asks for the patient's preferences regarding cardiopulmonary resuscitation, mechanical ventilation and final care setting—the options for the latter being home, hospice, hospital, or undecided. Each question is followed by space for comments. The physician also asks the patients to discuss her current anxieties and concerns.

Patients who have had this discussion are interviewed by a psychologist to ascertain their satisfaction with it. Although most admit that it was difficult, they say they are glad the physician initiated it. After only one discussion with the physician, patients have questions and are often confused about what awaits them. Advance care planning is a process; we all know that patients cannot absorb much information while under stress.

The project to standardize advance care planning is still in the pilot phase. Our intention is to give patients time, while they are still feeling relatively well, to adjust to the status of their disease and to accomplish important end-of-life goals. We hope that the intervention will

reduce last-minute demands for futile care. Thus, we are attempting to resolve the ethical dilemma of demands for medically inappropriate interventions both early on, at the beginning of non-curative therapy, and at the crisis point when physicians and patients are in conflict. We would like to avoid demands for futile treatments, but since we cannot avoid them all, we offer our physicians institutional support and our patients a fair means of resolving the impasse.

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