

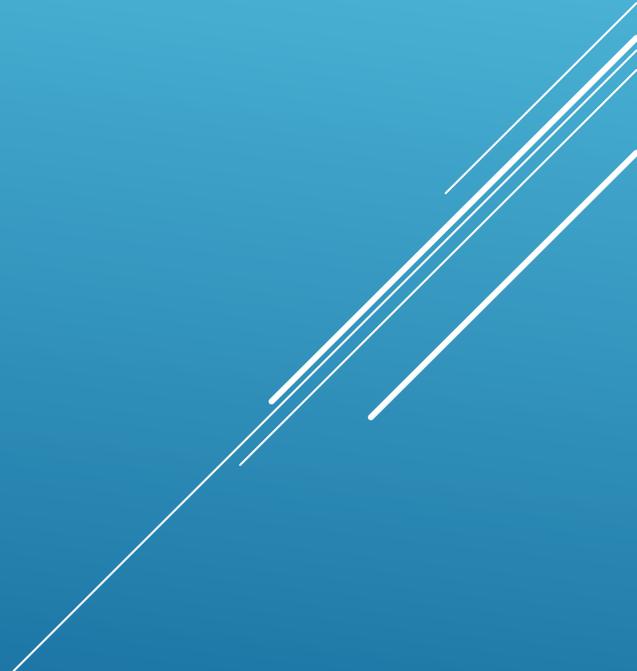
PALLIATIVE CARE FOR BODY, MIND, AND SPIRIT  
OCTOBER 23, 2021

BREAKOUT SESSION 4:  
MEDICAL FUTILITY AND WITHHOLDING AND WITHDRAWING TREATMENTS

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- ▶ This presentation is free of all commercial bias.
- ▶ I have no financial relationships or conflicts of interest to disclose.
- ▶ Michal Frederick MD, FAAFP, FAAHPM

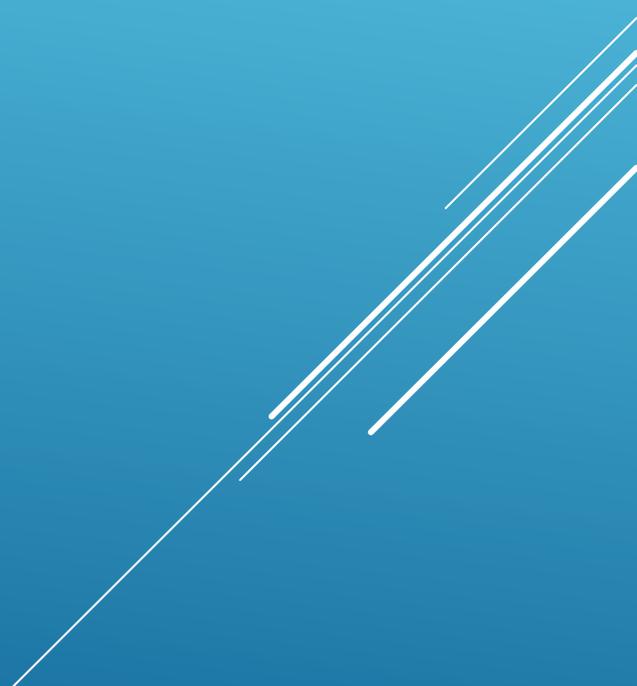
DISCLAIMER

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- ▶ At the conclusion of this session, participants will be able to:
  - ▶ 1. List and identify common factors that may lead to futility discussions,
  - ▶ 2. Communicate and negotiate to resolve conflict directly, applying the steps involved in resolving intractable conflict.
  - ▶ 3. List the principles for withholding or withdrawing therapy and applying these principles to artificial hydration, feeding and ventilation.

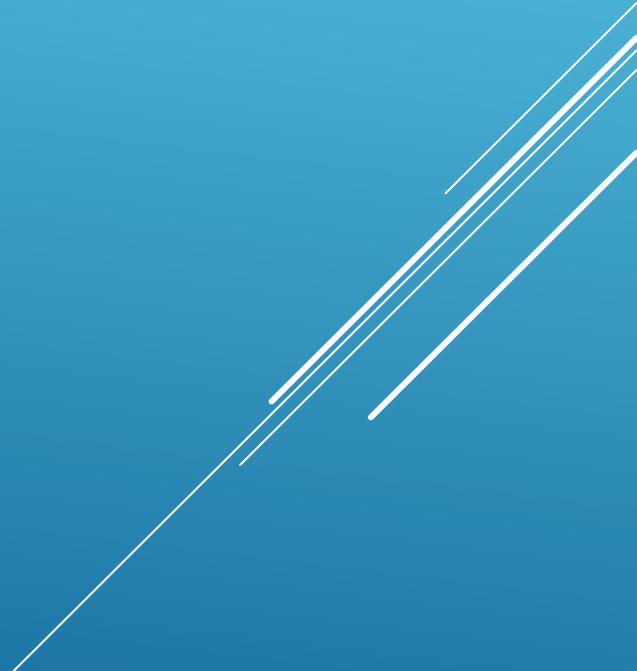
## OBJECTIVES

# CLINICAL CASE



- ▶ Won't achieve the patient's goal
- ▶ Serves no legitimate goal of medical practice
- ▶ Ineffective more than 99% of the time
- ▶ Does not conform to accepted community standards

## DEFINITIONS OF MEDICAL FUTILITY



## ▶ Difficult to Define

- Schneiderman and Jecker couldn't get response to define as <1%, <5%, <10% effective
- Treatment can be considered futile when it:
  - will not serve any useful purpose
  - causes needless pain and suffering
  - does not achieve the goal of restoring the patient to an acceptable quality of life
- Crit Care Med 1992; 20:427-433.

MEDICAL FUTILITY:  
NON-BENEFICIAL TREATMENT

- ▶ Qualitative

- ▶ The treatment does not have a reasonable chance of providing a therapeutic benefit to the patient
- ▶ Not simply a physiologic benefit or change
- ▶ There is no victory of dying in perfect electrolyte balance or with normal K
- ▶ The patient cannot survive without intensive care
- ▶ The patient is unresponsive or in a persistent vegetative state

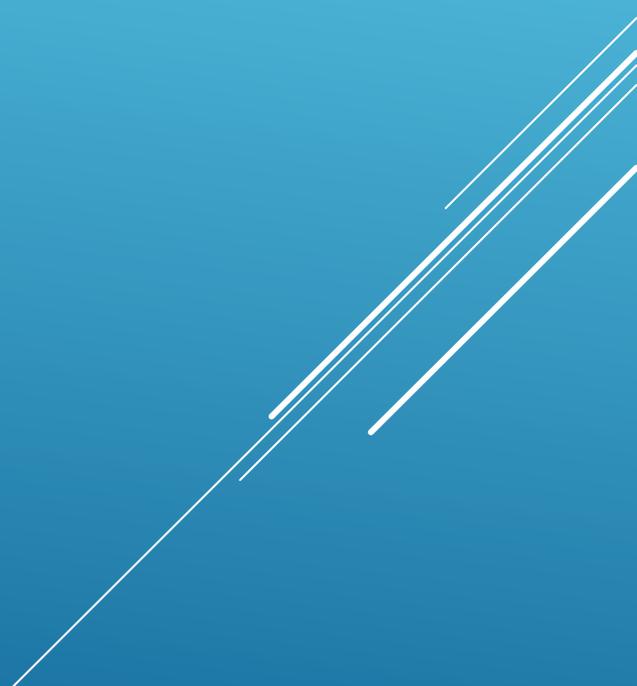
# MEDICAL FUTILITY

- ▶ Patients / families may be invested in interventions
- ▶ Clinicians / other professionals may be invested in interventions
- ▶ Any party may perceive futility

## CLINICIANS AND FUTILITY

- ▶ Unequivocal cases of medical futility are rare
- ▶ Miscommunication, value differences are more common
- ▶ Case resolution more important than definitions

IS THIS REALLY FUTILITY?

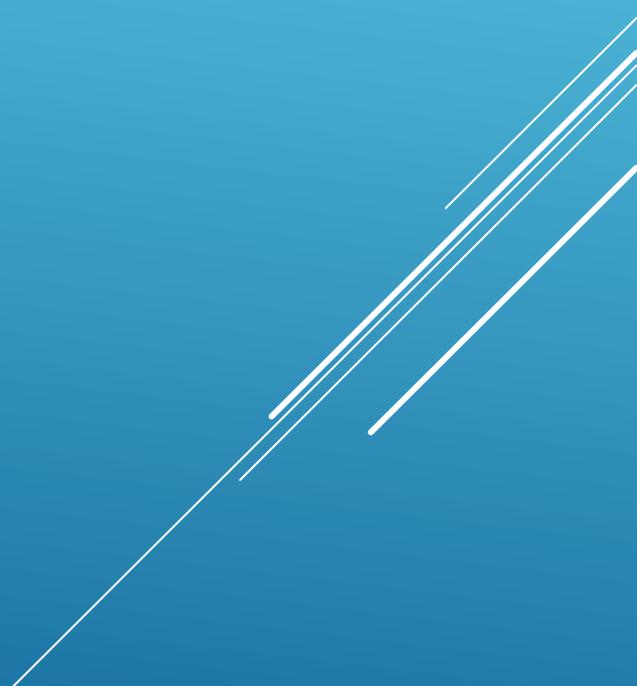


- ▶ Unresolved conflicts lead to misery
  - ▶ most can be resolved
- ▶ Try to resolve differences
- ▶ Support the patient / family
- ▶ Base decisions on
  - ▶ informed consent, advance care planning, goals of care

## CONFLICT OVER TREATMENT

- ▶ Misunderstanding
- ▶ Personal factors
- ▶ Conflicting values between family / clinicians

## DIFFERENTIAL DIAGNOSIS OF FUTILITY SITUATIONS

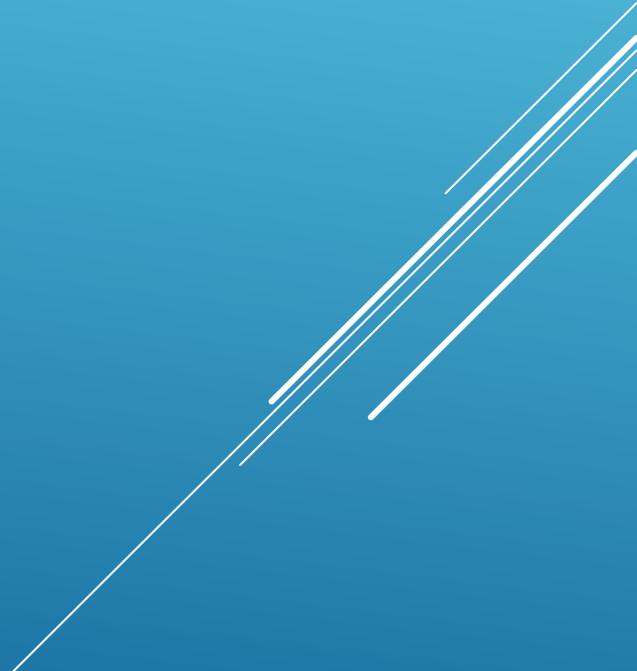


- ▶ Patient's stated preference
- ▶ Legislated hierarchy
- ▶ Who is most likely to know what the patient would have wanted?
- ▶ Who is able to reflect the patient's best interest?
- ▶ Does the proxy have the cognitive ability to make decisions?

## PROXY SELECTION

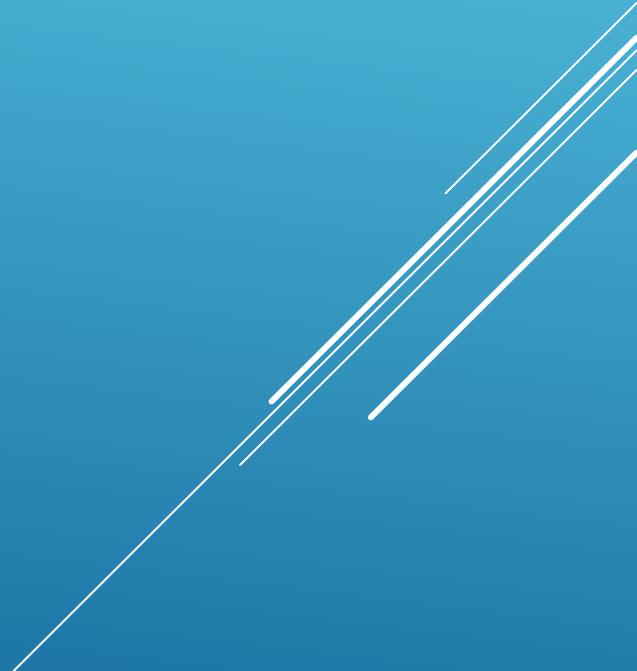
- ▶ Underlying causes
- ▶ How to assess
- ▶ How to respond

# MISUNDERSTANDING OF DIAGNOSIS / PROGNOSIS



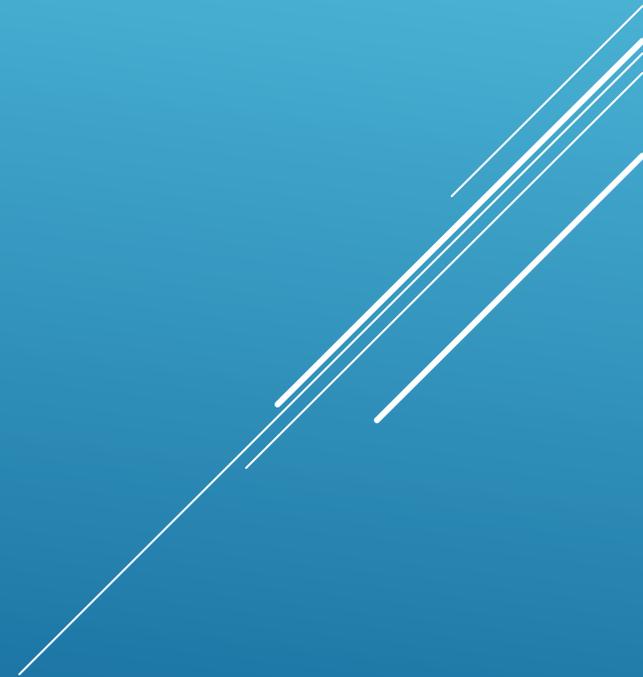
- ▶ Doesn't know the diagnosis
- ▶ Too much jargon
- ▶ Different or conflicting information
- ▶ Previous overoptimistic prognosis
- ▶ Stressful environment

MISUNDERSTANDING: UNDERLYING  
CAUSES...

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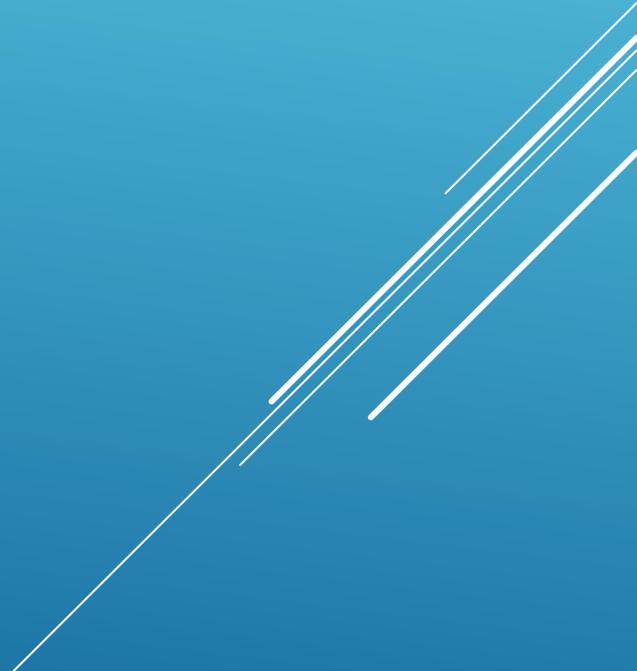
- ▶ Choose a primary communicator
- ▶ Give information in
  - ▶ small pieces
  - ▶ multiple formats
- ▶ Use understandable language
- ▶ Frequent repetition may be required

MISUNDERSTANDING:  
HOW TO RESPOND...



- ▶ Assess understanding frequently
- ▶ Do not hedge to “provide hope”
- ▶ Encourage writing down questions
- ▶ Provide support
- ▶ Involve other health care professionals

...MISUNDERSTANDING: HOW TO  
RESPOND

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- ▶ Mistrust
- ▶ Grief
- ▶ Guilt
- ▶ Intrafamily issues
- ▶ Secondary gain
- ▶ Physician / nurse

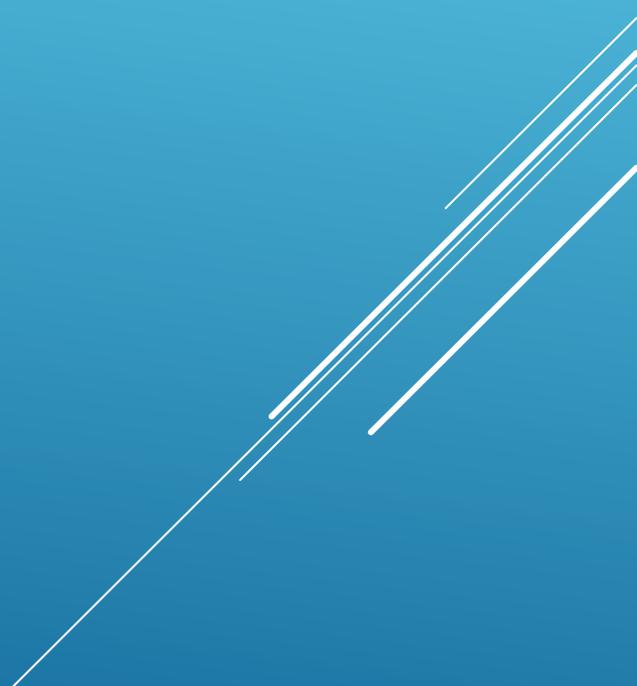
## PERSONAL FACTORS

- ▶ Disagreement over
  - ▶ goals
  - ▶ benefit

## TYPES OF FUTILITY CONFLICTS

- ▶ Religious
- ▶ Miracles
- ▶ Value of life

# DIFFERENCE IN VALUES



- ▶ Earnest attempts in advance
- ▶ Joint decision making
- ▶ Negotiation of disagreements
- ▶ Involvement of an institutional committee
- ▶ Transfer of care to another physician
- ▶ Transfer to another institution

## A DUE PROCESS APPROACH TO FUTILITY

- ▶ *Medical Care* is never futile
  - ▶ Relief of pain and suffering (palliative care) is always possible and beneficial
  - ▶ Only specific therapeutic interventions or treatments may be defined as futile
    - ▶ Cardiopulmonary resuscitation
    - ▶ Artificial hydration and nutrition
    - ▶ Mechanical ventilation
    - ▶ Parenteral antibiotics

# MEDICAL FUTILITY

# Medical Futility

## Summary

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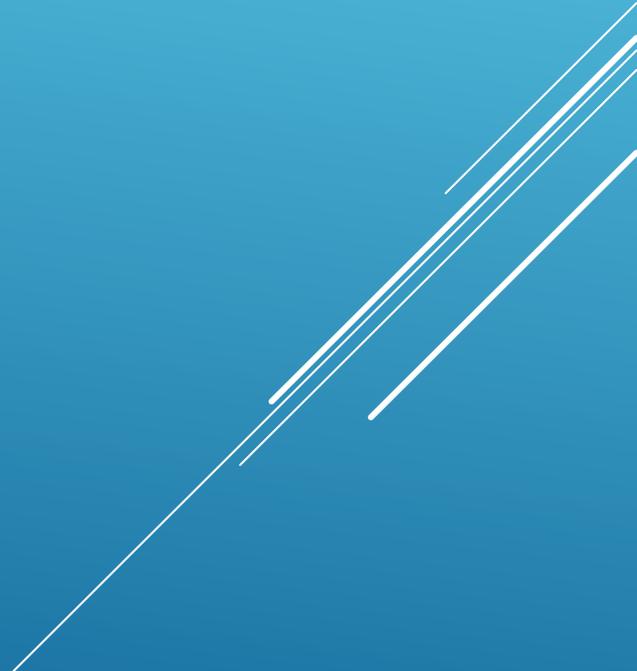
**Withholding,  
Withdrawing Life-  
Sustaining Treatments**

- ▶ The clinician helps the patient and family
  - ▶ elucidate their own values
  - ▶ decide about life-sustaining treatments
  - ▶ dispel misconceptions
- ▶ Understand goals of care
- ▶ Facilitate decisions, reassess regularly

ROLE OF THE CLINICIAN...

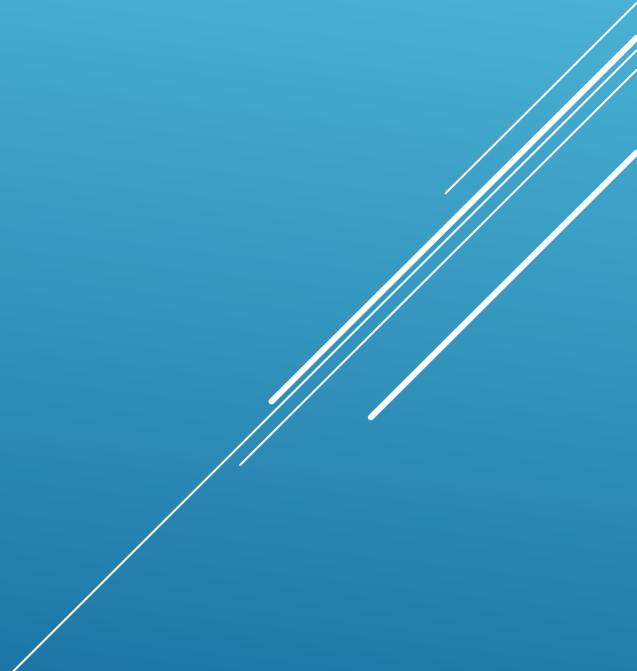
- ▶ Discuss alternatives
  - ▶ including palliative and hospice care
- ▶ Document preferences, medical orders
- ▶ Involve, inform other team members
- ▶ Assure comfort, nonabandonment

...ROLE OF THE CLINICIAN

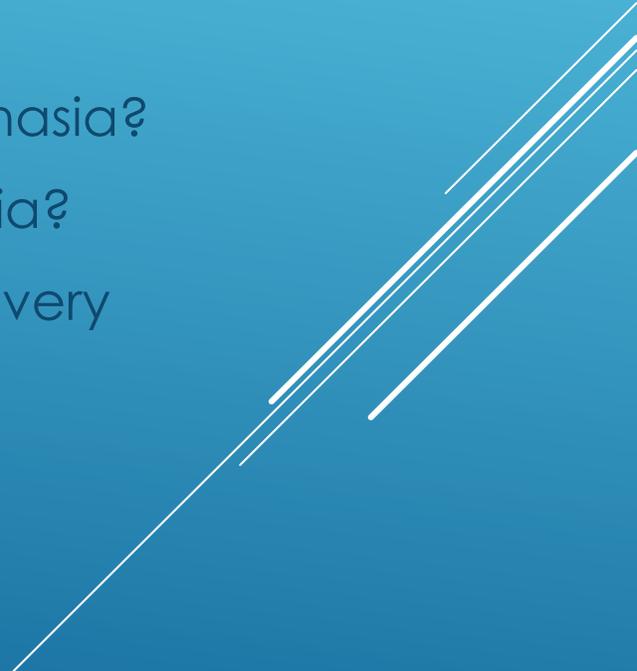
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- ▶ Karen Quinlan (1976)
- ▶ Nancy Cruzan (1990)
- ▶ Terrie Schiavo (2005)

LEGAL PERSPECTIVE (US)

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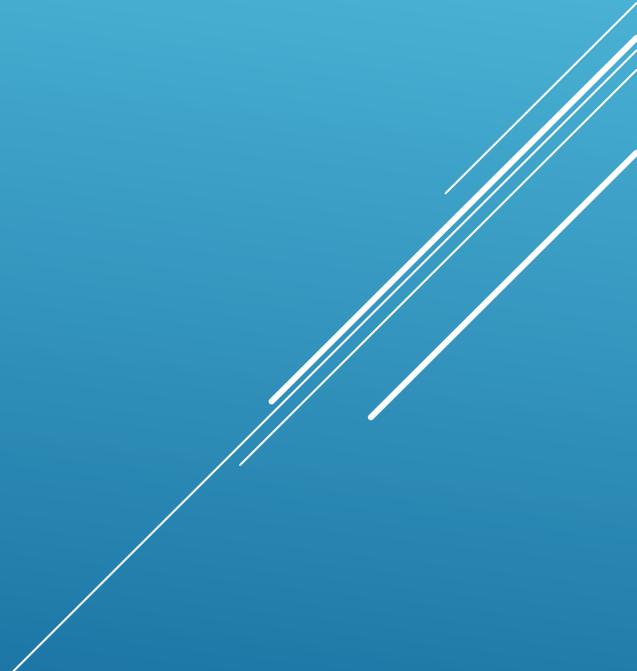
# COMMON CONCERNS

- ▶ Legally required to “do everything?”
  - ▶ Is withdrawal, withholding euthanasia?
  - ▶ Can the treatment of symptoms constitute euthanasia?
  - ▶ Is the use of substantial doses of opioids euthanasia?
  - ▶ Aren't withholding and withdrawing interventions very different?
- 
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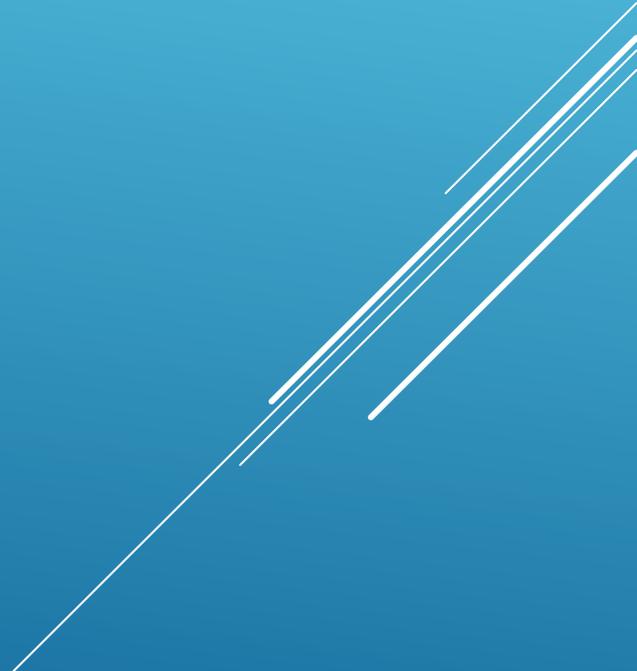
- ▶ Resuscitation
- ▶ Elective intubation
- ▶ Surgery
- ▶ Dialysis
- ▶ Blood transfusions, blood products
- ▶ Diagnostic tests
- ▶ Artificial nutrition, hydration
- ▶ Antibiotics
- ▶ Other treatments
- ▶ Future hospital, ICU admissions

## LIFE-SUSTAINING TREATMENTS

# 6-STEP PROTOCOL TO DISCUSS TREATMENT PREFERENCES...

1. Be familiar with policies, statutes
  2. Ask the patient, family what they understand
  3. Discuss general goals of care
  4. Discuss specific treatment preferences
- 
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# ...6-STEP PROTOCOL TO DISCUSS TREATMENT PREFERENCES

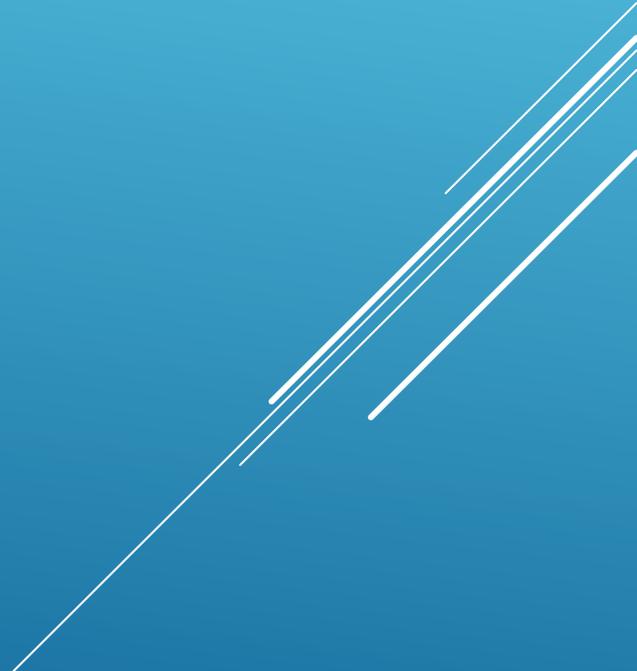
5. Respond to emotions
  6. Review and revise
- 
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- ▶ Difficult to discuss
- ▶ Food, water are symbols of caring
- ▶ Establish overall goals of care
- ▶ Will artificial feeding, hydration help achieve these goals?

## EXAMPLE 1: ARTIFICIAL FEEDING, HYDRATION

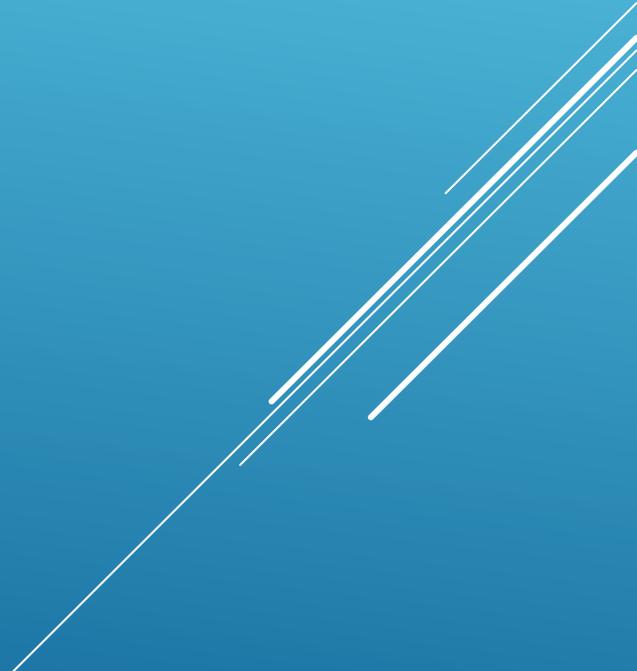
- ▶ Cause of poor appetite, fatigue
- ▶ Relief of dry mouth
- ▶ Delirium
- ▶ Urine output

ADDRESS MISPERCEPTIONS

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- ▶ Identify feelings, emotional needs
- ▶ Identify other ways to demonstrate caring
  - ▶ teach the skills they need

HELP FAMILY WITH NEED TO GIVE  
CARE

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- ▶ Loss of appetite
- ▶ Decreased oral fluid intake
- ▶ Artificial food/fluids may make situation worse
  - ▶ breathlessness
  - ▶ edema
  - ▶ ascites
  - ▶ nausea/vomiting

NORMAL DYING

- ▶ Rare, challenging
- ▶ Ask for assistance
- ▶ Assess appropriateness of request
- ▶ Role in achieving overall goals of care

## EXAMPLE 2: VENTILATOR WITHDRAWAL

- ▶ Remove the endotracheal tube after appropriate suctioning
- ▶ Give humidified air or oxygen to prevent the airway from drying
- ▶ Ethically sound practice

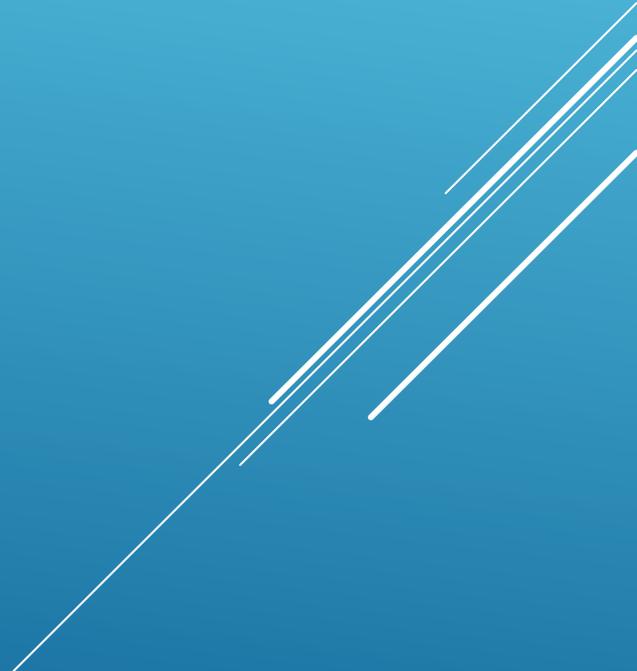
## IMMEDIATE EXTUBATION

- ▶ Describe the procedure
- ▶ Reassure that comfort is a primary concern
- ▶ Medication is available
- ▶ Patient may need to sleep to be comfortable

PREPARE THE FAMILY...

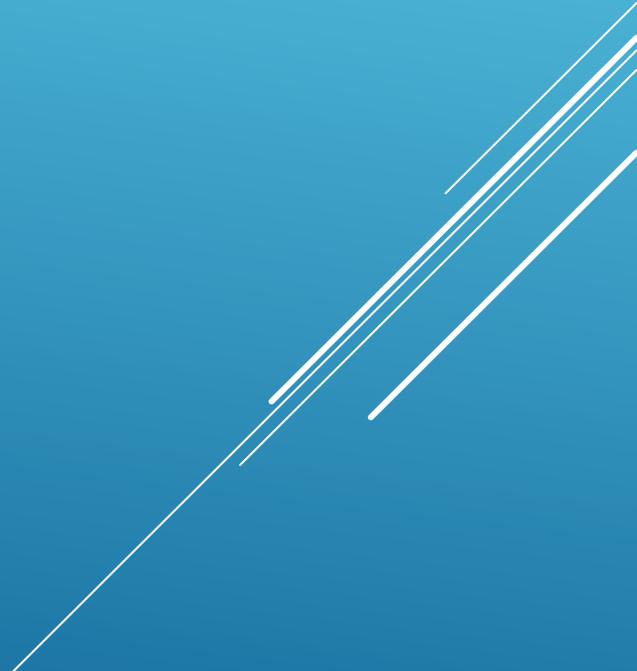
- ▶ Involuntary movements
- ▶ Provide love and support
- ▶ Describe uncertainty, especially in prognosis

...PREPARE THE FAMILY

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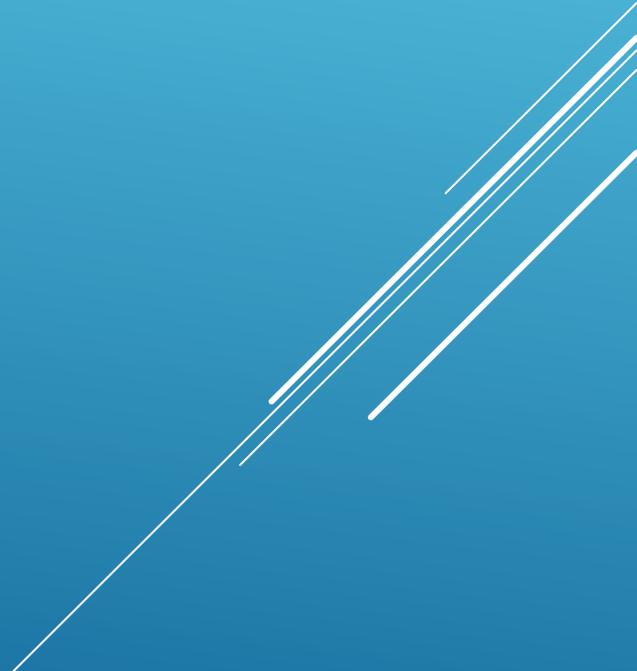
- ▶ Anticipate and prevent discomfort
- ▶ Have anxiolytics, opioids immediately available
- ▶ Titrate rapidly to comfort
- ▶ Be present to assess, reevaluate

ENSURE PATIENT COMFORT

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- ▶ Breathlessness
  - ▶ opioids
- ▶ Anxiety
  - ▶ benzodiazepines

PREVENT SYMPTOMS

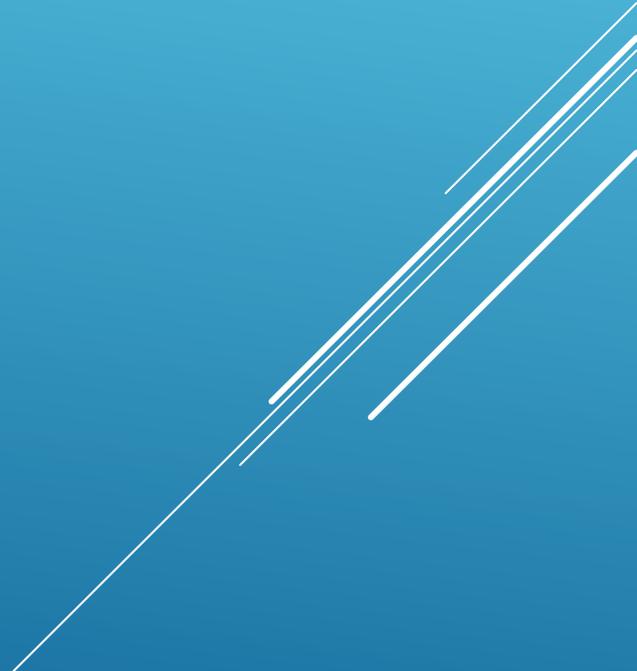
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- ▶ Determine degree of desired consciousness
- ▶ Bolus 2-20 mg morphine IV, then continuous infusion
- ▶ Bolus 1-2 mg midazolam IV, then continuous infusion
- ▶ Titrate to degree of consciousness, comfort

## PREPARING FOR VENTILATOR WITHDRAWAL

- ▶ Prior to procedure
  - ▶ discussion and agreement to discontinue
    - ▶ with patient (if conscious)
    - ▶ with family, nurses, respiratory therapists
  - ▶ document on the patient's chart

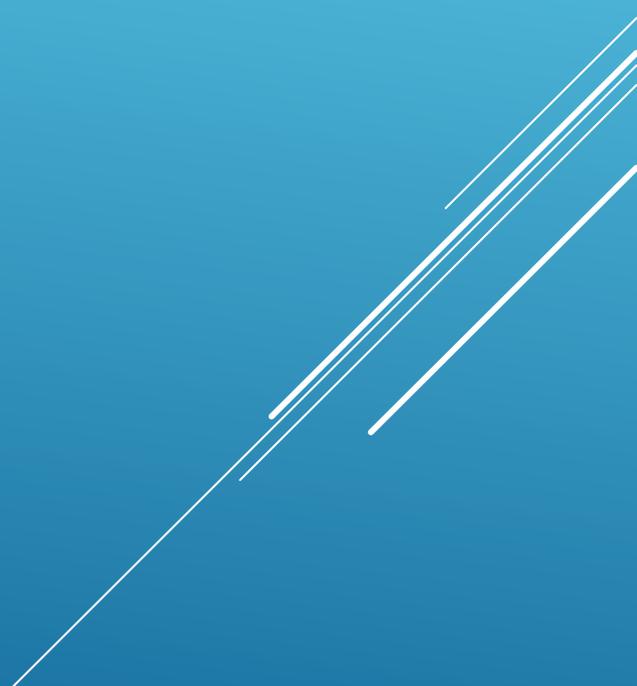
PRIOR TO WITHDRAWAL



- ▶ Procedure

- ▶ shut off alarms
- ▶ remove restraints
- ▶ NG tube is removed
- ▶ family is invited into the room
- ▶ pressors are turned off
- ▶ parents may hold child

# WITHDRAWAL PROTOCOL— PART 1

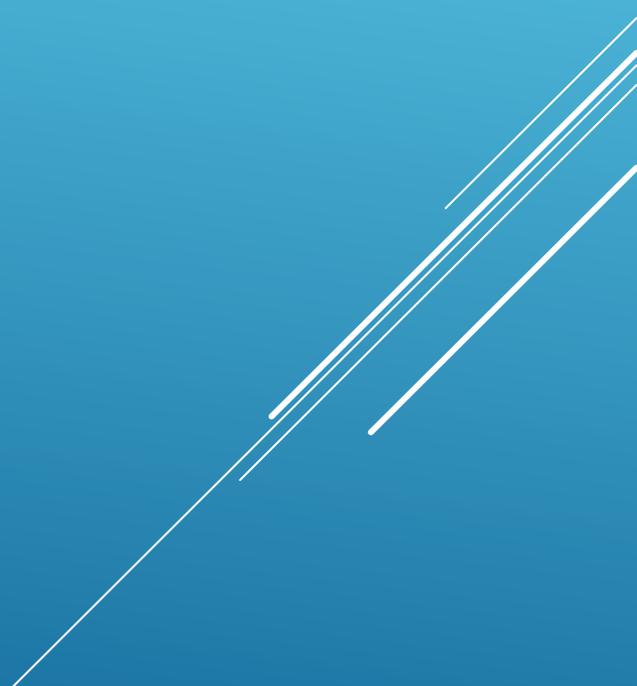


- ▶ Establish adequate symptom control prior to extubation
- ▶ Have medications in hand
  - ▶ midazolam, lorazepam, or diazepam
- ▶ Set  $\text{FiO}_2$  to 21%
- ▶ Adjust medications
- ▶ Remove the ET tube

## WITHDRAWAL PROTOCOL— PART 2

- ▶ Invite family to bedside
- ▶ Washcloth, oral suction catheter, facial tissues
- ▶ Reassess frequently

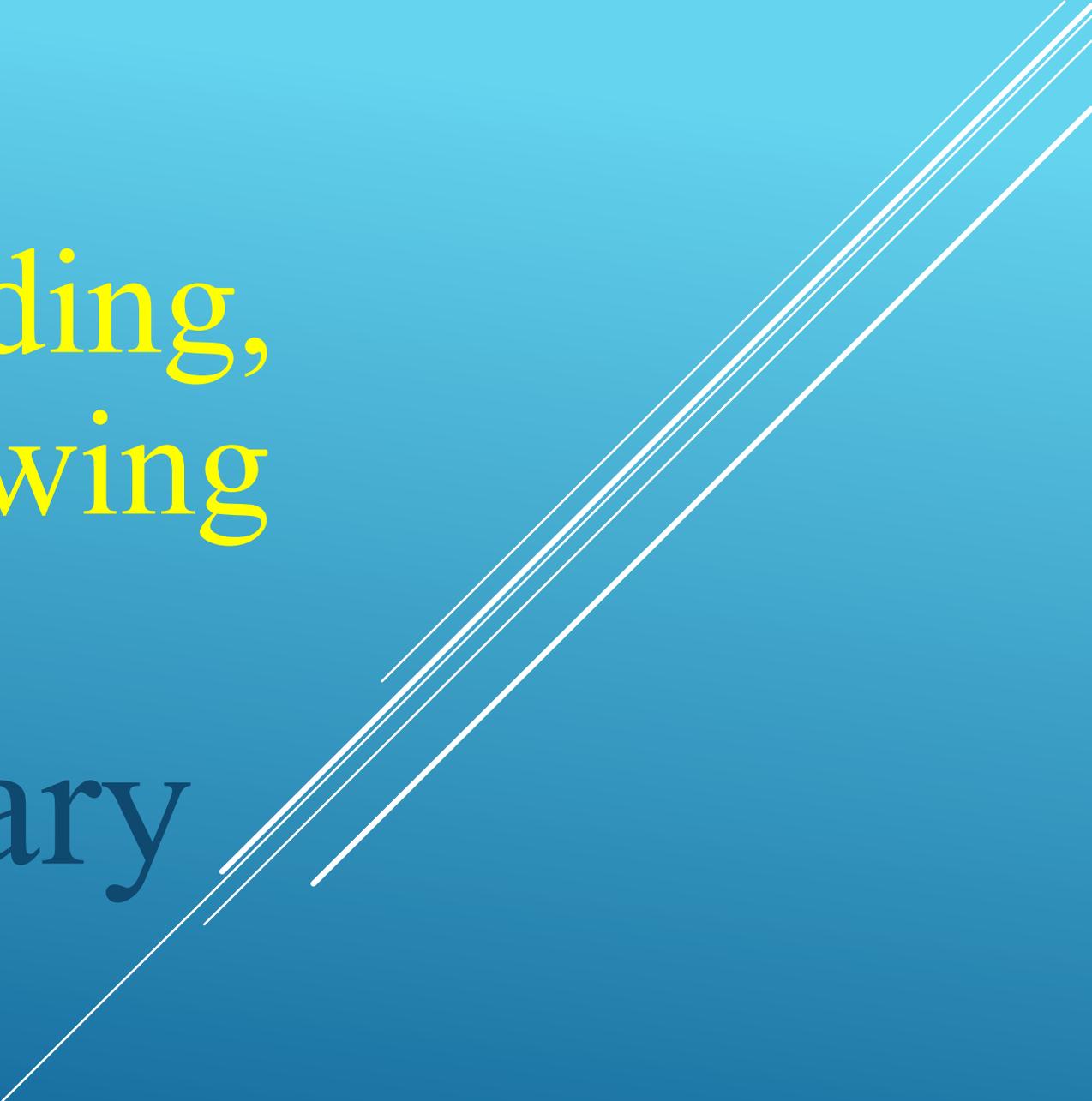
## WITHDRAWAL PROTOCOL— PART 3...



- ▶ After the patient dies
  - ▶ talk with family and staff
  - ▶ provide acute grief support
- ▶ Offer bereavement support to family members
  - ▶ follow up to ensure they are okay

## ...WITHDRAWAL PROTOCOL— PART 3

Withholding,  
Withdrawing  
Therapy  
Summary

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