New guidelines aim to resolve conflicts in treating critically ill patients

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Who should decide what life-prolonging medical treatments the intensive care patient should receive: the clinician or the patient's family?

The answer in almost all circumstances should be "both," according to the authors of a new policy statement from the American Thoracic Society aimed at providing guidance for crucial decision-making for the care of patients with advanced critical illness while preventing conflicts between medical staff and family caregivers.

"Neither individual clinicians nor families should be given unchecked authority to determine what treatments will be given to a patient," explained Douglas White, M.D., M.A.S., UPMC Chair for Ethics in Critical Care Medicine, associate professor in the University of Pittsburgh Department of Critical Care Medicine, and co-chair of the committee that produced these guidelines. "Clinicians should neither simply acquiesce to treatment requests that they believe are not in a patient's best interest, nor should they unilaterally refuse to provide treatment. Instead, if conflicts arise between clinicians and patients' families, a fair process of dispute resolution should be undertaken, in which neither individual can unilaterally impose his or her will on the other."

The guidelines, which will appear in the June 1st issue of the *American Journal of Respiratory and Critical Care Medicine*, are a new resource for an estimated 80,000 health professionals. They are supported by the Society of Critical Care Medicine, the American Association of Critical Care Nurses, the American College of Chest Physicians and the European Society of Intensive Care.

When a clinician is asked by the family of a critically ill patient to administer invasive interventions that the clinician believes will not benefit the patient, "such disagreements can present particular challenges, since they bring into conflict important interests of patients, clinicians and society," Dr. White said. "The cases are difficult because there are generally no clear, substantive rules to appeal to and because ICU patients are especially vulnerable because of their overwhelming illness and lack of ability to seek out another doctor if they disagree with the plan."

The guidelines emphasize that conflicts in the ICU can and should be prevented through early and intensive communication between the patient's family and the health care team. When conflicts cannot be resolved with ongoing dialogue, the policy statement recommends early involvement of expert consultants, such as palliative care and ethics consultants, to help find a negotiated agreement. If a dispute remains unresolvable despite intensive communication and negotiation, the committee recommends a fair process of dispute resolution, involving a review of the case by a multidisciplinary ethics committee within the hospital, ongoing mediation, a second medical opinion, offering family the option to seek to transfer the patient to an alternate institution, and informing the family of their right to appeal to the courts.

"Families need to be given a voice regarding what treatments are consistent with the patient's values and preferences, and physicians' professional integrity also needs to be respected, meaning that they should not be compelled to administer treatments that violate good medical practice," Dr. White said.

The policy statement also outlines innovative procedures for two additional situations. When families request treatment that is truly futile, meaning that it simply cannot accomplish its physiologic aims, the clinician should refuse to administer the treatment and should clearly explain the rationale behind the treatment decision. In addition, for situations in which medical urgency does not allow compliance with the longer dispute resolution process, the committee has provided

expedited steps that, nevertheless, ensure a fair process.

"These guidelines provide clinicians with a framework to manage treatment disputes with an emphasis on procedural fairness, frequent communication, expert consultation and timeliness," said co-chair Gabriel T. Bosslet, M.D., assistant professor of clinical medicine at the Charles Warren Fairbanks Center for Medical Ethics at Indiana University. "We hope that states will adopt laws similar to these guidelines, so that all sides in a particular dispute can have the resources they need to come to a resolution."

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