A Ministry-Wide Policy for Potentially Medically Inappropriate Care: One Year of Challenges and Successes

INTRODUCTION

It is a scenario familiar to clinical ethicists: a consultation from the Intensive Care Unit where a patient has had a long, protracted hospitalization and is not improving, despite all interventions. A provider may characterize the care as "futile" but feels some obligation to continue because "it is what the family wants." Mercy has worked over the past two years to implement a ministry-wide policy to help adjudicate medical care requests from patients or their surrogate decision makers when the care team no longer feels comfortable providing that specific medical intervention. This article is to summarize what has been effective with the policy's implementation and identify the challenges that remain.

BACKGROUND

To address this issue, Mercy ethicists worked with multiple specialty councils such as the critical care council to create a standardized process to address requests for potentially medically inappropriate care. Before the implementation of this ministry-wide policy, only one facility in Arkansas had a policy to address requests for care the medical team no longer felt was appropriate. The work to develop a ministry-wide policy began in St. Louis where Mercy is headquartered.

The policy focuses on proactive communication and follows the four recommendations of the policy statement endorsed by five critical care professional societies titled "An Official ATS/AACN/ACCP/ESICM/SCCM Policy Statement: Responding to Requests for Potentially Inappropriate Treatments in Intensive Care Units." In this statement, the five societies make a distinction between physiologically futile care and care that is potentially medically inappropriate. Care that is physiologically futile is a very high threshold, and there is no obligation to provide care that meets this threshold. With care that does not meet the physiologic futility threshold, termed "potentially medically inappropriate," the paper implores the importance of proactive communication as well as engaging multiple disciplines to help the family understand the severity of the patient's condition. The specialties mentioned in the paper include ethics and palliative care. Mercy also includes as standard practice our spiritual care department.

STRENGTHS

A strength identified in the implementation of the policy was that it was widely welcomed by providers of all specialties. One of the largest challenges in developing a ministry-wide approach to any initiative is provider buy-in; having the support of physicians facilitated the policy implementation. The endorsement of professional societies, including the disciplines of thoracic surgery, critical care nursing, pulmonologists, intensivists and critical care specialists (European and American) offers the credibility of professional consensus. Mercy ethicists responded to the provider receptiveness and socialized the policy with providers and caregivers to familiarize them with the purpose, definitions, and processes of the policy. Mercy ethicists met with not only providers but leaders of nursing units to help familiarize the care team with the new policy.

Another strength was the emphasis on proactive communication. How often we hear from families one physician seemed optimistic, and the next day they received "bad news" for the first time. Or they struggle to understand the optimism of one specialist only to be confronted later with an overall poor prognosis. Leadership appreciated that the policy implored that all reasonable measures ought to be taken to avoid an intractable conflict between provider and families. This policy wasn't designed to provide a fast lane or a foregone conclusion to withdraw care but to help clinicians thoughtfully walk through a difficult process.

Finally, providing a standardized process across the ministry gave providers more confidence in navigating these complex scenarios. Prior to the implementation of this policy, providers reported feeling unsupported, like they were "on an island" and open to liability since it was their medical judgment stating the care was potentially medically inappropriate. Having a document they can refer to helped providers feel assured they weren't reinventing the wheel each time they encountered this scenario. The participation of legal counsel in Complex Care discussions, and Public Relations personnel in those cases where families engage with social or traditional media, allows clinicians to focus on the clinical needs of patients.

CHALLENGES

With change, there will often be growing pains. Some of the challenges included communication issues, questions about who initiates the process, and variation in practice between providers. To begin, the communication issues stem from the fact that most patients have had an incredibly long length of stay, with multiple providers signing on and off weekly. Maintaining a consistent message across providers in various specialties can prove challenging. In practice, Mercy ethicists encourage providers to have a verbal handoff to the next provider to better articulate nuanced circumstances, but that does not always occur due to logistics, time limitations, or providers' communication preferences.

Another trend that has been noticed is that occasionally a caregiver other than a clinical provider will ask "Is this inappropriate care?" prior to any clinical care team member raising the question. This was an opportunity to provide education to our non-clinical care

team members that this policy is provider-led, meaning that it is paramount that the determination that the care is potentially medically inappropriate is made on clinical factors assessed by a physician. While other specialties and departments can offer invaluable insight and are integral to the process, it is critical that the initial assessment of the effectiveness of care is made by a physician familiar with the patient. This can cause moral distress in other care team members who might see things differently than the attending physician, but it is important to keep this distinction, so the process is initiated based on clinical appropriateness.

Another issue that Mercy ethicists have noted is that occasionally the attending physician simply wants to maintain the status quo even when there is a consensus among other members of the medical team, including previous attending physicians, that the care is potentially medically inappropriate. Ethicists try to work with these hesitant physicians to understand the rationale behind their hesitancy. If the hesitancy is rooted in fears of legal liability or angering the family members, ethicists draw on resources which can help share the burden as a team, providing support for legal and moral analysis, family coping skills, and managing conflict. However, if the current attending physician has a differing opinion of the appropriateness of the care or the long-term prognosis, they may continue care that they assess to be clinically appropriate.

Finally, in rare circumstances, a provider continues to escalate care according to family preferences while the rest of the care team has agreed to limitations on the potentially medically appropriate treatment. Like the previous challenge, it is important to understand the physician's reasoning for escalating care when there is otherwise a consensus. Mercy ethicists respect that providers might have differing medical judgments about what constitutes potentially medically inappropriate treatment but want to take care to mitigate fears of legal liability or hesitancy to upset family members further.

CONCLUSION

The implementation of the policy has largely been positive, but there will always be challenges to identify and overcome. Mercy is still learning from the implementation of this policy and will address new issues as they arise. In addition, as new providers come into Mercy, we anticipate that introduction will be needed for providers who have not already had experience with similar approaches. ✣

THERESA MCCRUDEN, JD/MA, HEC-C
Director of Ethics
Mercy FTSM

TRACY BORGMEYER, MA, LCSW, HEC-C
Director, Ethics
Mercy, Joplin & Southeast Kansas