Managing physician-family conflict during end of life care on the Intensive Care Unit

Clinical Problem

A ninety year old man, JA, was admitted to the Intensive Care Unit (ICU) following an out of hospital cardiac arrest. Shortly after admission he deteriorated into multi organ failure (MOF) with rising inotrope and oxygen requirements and anuria. The patient’s son (PA, his next of kin) was asked to come in to speak to the consultant intensivist. The initial intention of this conversation was to agree a ceiling of appropriate care.

The patient’s son reacted angrily to the suggestion that care may be limited and stated that his father would want “everything possible” doing. He explained that this was largely driven by their spiritual beliefs regarding sanctity of life. As a consequence of this conversation care was continued and escalated to include renal replacement therapy (RRT).

Management

Over the course of an approximately six week stay on ICU JA improved to the point of extubation and discontinuation of RRT. He was then reintubated for a hospital acquired pneumonia and again deteriorated into MOF requiring RRT. He was successfully weaned from this episode but remained profoundly weak and debilitated.

During this period there were many discussions between the medical team and PA regarding the perceived futility of ongoing intervention and escalation. The relationship between PA and the medical team deteriorated, PA recorded in writing every meeting with the doctors and frequently became upset and angry with individuals who were meeting with him. The consultants discussed the case as a team and felt that it was most appropriately managed by continuing treatment without limitation, and that seeking legal intervention was not indicated. Overall, therefore, a non-confrontational approach was chosen to minimise conflict.

During a third deterioration JA then suffered an unanticipated cardiac arrest on the High Dependency Unit. The consultant present at the time decided to bring PA into the bay whilst cardiopulmonary resuscitation (CPR) was ongoing. It was explained to PA that we were trying to resuscitate his father but it was not likely to succeed and that we would have to halt CPR. PA then agreed to halting of CPR.

During final discussions with PA he expressed his gratitude for the care given and left the hospital with no ongoing complaints or issues with his fathers care.

Discussion

There are a number of factors that may lead to conflict on ICU. In this case the patient’s son felt that his fathers religious views would lead to him wishing to receive all possible life prolonging treatments no matter the circumstances. The medical team, following the principle of non-maleficence, did not wish to undertake
uncomfortable interventions they perceived to be futile. This difference in perspective, possibly compounded by sub-optimal communication, led to conflict.

The conflict was managed by acceding to all the wishes of the patient’s surrogate. This case summary is intended to explore the frequency of conflict on ICU and the legal and ethical management of patients or their families that wish the ICU team to “do everything”.

Physician-family conflict on ICU is common. A recent study by Schuster et al\(^1\) explored rates of perceived conflict by questioning both doctors and patient surrogates (i.e. their immediate family). The overall rate of perceived conflict was 63%. Interestingly the physicians in the study were less likely to perceive conflict (28%) than the family (42%). This argues that we need to be vigilant for concealed discontent. The General Medical Council’s (GMC) “Good Medical Practice” document\(^2\) states a requirement for doctors to “Listen to, and respond to, their [patient’s] concerns and preferences”. I believe this should be extended to a patient’s next of kin.

The Schuster study\(^1\) also highlights a decreased chance of conflict when there are higher rates of family satisfaction with the bedside manner of the treating clinician. Communication is a key part of conflict avoidance and resolution. The American College of Critical Care Medicine consensus statement on end of life care\(^3\) describes a “family centred” approach as being “a comprehensive ideal”. This involves building an understanding of the patient’s likely wishes via good communication with the family. If we extend our duty of care to the family members themselves then it is interesting to note that family perception of incomplete information has been associated with higher rates of post traumatic stress disorder in relatives\(^4\). Overall effective communication is vital. It is also important the communication is consistent across specialties and professions. The multi-disciplinary team should try to resolve disagreements between themselves rather than provide patients or their family with contradictory information.

Mediation may be helpful or essential to resolving conflict. Knickle and colleagues\(^5\) describe how mediation can be helpful even when full agreement is not reached as it improves understanding between parties. Principles of mediation can be applied without the use of a third party, the dyadic model. Acting yourself as a mediator requires you to recognise your own positions and interests whilst also identifying the families position and interests and then trying to gain new perspective on the conflict.

Whilst second opinions may be helpful it is unusual for an intensive care doctor to make decisions such as these in isolation. More usually, in my experience, at the least two consultants in intensive care would be involved in addition to the parent team. Such a team approach makes an internal second opinion unlikely to be different. External, experienced, second opinions may be of more value but are more complex and costly to arrange.

Quill and colleagues\(^6\) describe an approach similar to that undertaken in the described case. They propose a step wise approach:

- understand what the patient means by “do everything”
• propose an overall philosophy of approach
• recommend a plan
• support emotional responses
• negotiate disagreements
• use a harm reduction strategy for requests for treatment that are unlikely to work

The authors propose that ultimately a patient’s wish for a “full CPR – no limits” status should be accepted but that termination of CPR after a single cycle would be acceptable. An avoidance of even the appearance of sham CPR is of course essential. This is broadly how the case in question was managed, with PA being accepted as the person best placed to identify what JA’s wishes would have been and full escalation and CPR being undertaken. This strategy helps avoid conflict but also accepts instigation of futile treatments.

An alternative approach is also potentially valid. The GMC states:

“If the patient asks for a treatment that the doctor considers would not be clinically appropriate for them, the doctor should discuss the issues with the patient and explore the reasons for their request. If, after discussion, the doctor still considers that the treatment would not be clinically appropriate to the patient, they do not have to provide the treatment.”

The GMC do make clear that in a situation where mediation and communication fails to produce an agreement a legal opinion must be sought.

Historically a paternalistic approach was felt to be acceptable with the American Medical Association stating:

“When an intervention is medically inappropriate it is justifiable to not raise the topic.”

Case law supported the GMC position, with cases such as Burke vs GMC, where the court of appeal upheld the right of doctors to withdraw artificial support if felt to be in a patient’s best interests. The judge further stated that he endorsed the concept that if a patient wishes a form of treatment not offered:

 “…the doctor will, no doubt, discuss that form of treatment with him … but if the doctor concludes that this treatment is not clinically indicated he is not required (i.e. he is under no legal obligation) to provide it to the patient although he should offer to arrange a second opinion.”

More recent court rulings have had a different perspective. A 2013 Supreme Court case, between the family of Mr D James and Aintree Hospitals, illustrated a lack of legal support for medical teams who deem treatment futile in disagreement with a patient’s family. In this case the Supreme Court ruled that “futility” could not be used to describe a treatment which benefitted the patient but did not manage or palliate the underlying disease. This could easily be applied to attempts to place a Do Not Attempt CPR order in patients with underlying non-survivable conditions. The Supreme Court judge further ruled that doctors:
“must try and put themselves in the place of the individual patient and ask what his attitude to the treatment is or would be likely to be; and they must consult others who are looking after him or interested in his welfare, in particular for their view of what his attitude would be.”

A further case\textsuperscript{11}, of a patient with breast cancer and a cervical spine injury, demonstrated that there had to be very convincing reasons not to involve a patient (or their surrogates) in CPR decisions. The trust in this case were found to have breached the patient’s human rights by not adequately discussing decisions regarding CPR, even though CPR was deemed futile.

In combination these rulings demonstrate a shift in legal position. There is an increase in support for the opinions of a patient or patient’s family rather than the treating medical staff. It has been argued that the judge in the James case may not have understood the full ramifications of their decision, in response to this The Intensive Care Society and Resuscitation Council UK are seeking legal advice with the intention of producing guidance for members\textsuperscript{12}. Doctors however tread on increasingly uncertain legal ground when limiting or refusing treatment in conflict with family wishes.

Another issue with refusing family requests for treatment escalation is the emotional and financial costs. Dedicating energy and emotion to seeking legal support for your position may detract from the care of the patient in question and others on the ICU. It may further hinder communication and a working partnership with a patient’s family. Financial costs to the trust may also be significant. Time is a factor, medical conditions evolve far faster than legal proceedings and failure to escalate whilst awaiting a ruling would leave doctors open to criticism or legal proceedings against them.

**Lessons learnt**

Refusing escalation or initiation of treatment in opposition to family wishes is fraught with difficulty, whilst it may be felt to be right, it may not be practical. Negotiation, mediation and the seeking of a second opinion may all be utilised in attempts to reach agreement with a family. Good communication is essential. In the face of a flat refusal to consider any limitation of care I think the pragmatic response may be to accede to their request.

In the future further rulings or formal guidance will hopefully bring greater clarity and support. In the mean time we should to continue to practice defensive medicine in this area.

**References**

11. R (David Tracey) v Cambridge University Hospitals NHS Foundation Trust & Ors [2014] EWCA Civ 33