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Relationship of Therapy to Prognosis in Critically Ill Patients

Garth F. Tagge, M.D.

For the reasons so clearly outlined in the paper by Dr. Cassem, there was developed a patient care classification integrating the intensity of therapy to be rendered a critically ill patient with the prognosis for his survival as a whole person. Serious use of the classification requires the unqualified endorsement of the institution which utilizes it, for it is clear that the categorization system involves awesome decisions — decisions which should be shared by the primary physician, the Medical Director of the ICU, and appropriate consultants. It is also mandatory that the wishes of the patient and/or his family be given the highest priority in the deliberations. The classification system must not be instituted in a casual manner but should be approved for use in the intensive care unit by the Board of Directors of the hospital and the Executive Board of the Medical Staff

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and the ICU Committee. It must also enjoy the support of the Medical Staff members who use the ICU.

Given this support there is every expectation that the classification can serve the following functions: (a) to force the conscious decision as to use or omission of heroic measures (including cardiopulmonary resuscitation); (b) to promote dialogue between the primary physician, ICU staff and the family with respect to the treatment goals and likelihood of success; (c) to prevent confusion in those charged with the overall care of the ICU; (d) to encourage the development of a treatment plan based on a frequent reassessment of the patient which does not ask the ICU staff to render extraordinary care to a patient who has no reasonable hope for survival as a whole person; (e) to minimize the medico-legal risks; (f) to dignify the entire ICU operation for the patient, his family, and the staff; and most importantly, (g) to guarantee continual reassessment of each individual case with respect to the goals of treatment and the determination of that point in time when treatment should be stopped — when the goals are no longer attainable.

The Intensive Care Unit activi-

ties for which this classification has been structured bear much medico-legal implication. However, the official position of the American Medical Association on the pertinent matters, coupled with the fact that the classification system has been employed at Mount Sinai Hospital and Massachusetts General Hospital, would seem to constitute sufficient precedent for its use in an institution which deals with critically ill patients on a large scale — as long as it is implemented in the formal manner suggested, and as long as it receives the institution's endorsements recommended above.

Patient Care Classification

Category I

Maximal therapeutic effort without reservation.

Category II

Maximal therapeutic effort without reservation, but the patient is to be re-evaluated at a specific future time, e.g., 24 hours.

Category III

No new therapy (such as transfusions, antibiotics, etc.) is to be initiated. Conservative, passive medical care replaces heroic measures. Particular attention is given to comfort, including the use of oxygen and diuretics for shortness of breath, fluids for symptoms of dehydration, analgesics for relief of pain, etc. Relief of suffering is the primary goal. Those mechanical therapeutic measures including volume ventilators, cardiac pacemakers,

etc., *already initiated*, may be continued, but are *not* initiated anew.

Category IV

All therapy will be stopped, and life support assistance will be discontinued.

Assignment and Use of the Classifications

On admission to the ICU patients will be assigned to a treatment classification, ordinarily Category I. Assignment of treatment classification is the responsibility of the primary physician. Each day on unit rounds the classification is to be assessed. Whenever a question is raised whether the treatment of a patient with an irreversible illness is improper or inhumane, it should be discussed at unit rounds. The question may arise from the patient himself, the family, the primary physician, the ICU staff or Unit Director, or consultants called by the primary physician. If there is consensus about treatment, no change in classification occurs. If the patient or the family or someone not at rounds has raised the question, the primary physician or anyone he or the Unit Director designates should explain the treatment rationale to the person who raised the question. If treatment rationale remains unclear at unit rounds, the patient may be assigned to Category II by the primary physician.

Category II is for that patient whose chances for survival are slim, but in whom the attending physician and other responsible

members of the ICU team are unwilling to abandon the pursuit of life and health. This designation indicates that the primary physician and other responsible parties may expect continuation of maximal therapeutic effort for a definite but limited period of time (24 hours), despite the fact that there is little likelihood for survival. This arrangement eliminates the problem of placing unrealistic demands upon the ICU staff for an unlimited period of time when, in fact, chances for survival are slim. Patients in this category are re-evaluated by the primary physician in conjunction with responsible members of the ICU team and are either reclassified or continued in Category II for an additional 24 hours by mutual agreement and understanding.

Other purposes for assignment to Category II are (a) to provide opportunity for the primary physician to obtain further consultation and support in the management of a difficult case, and (b) to insure dialogue between the primary physician and Unit Director and staff. If the ICU staff (nurses and physicians) do not understand the reasons for a specific treatment of a patient, or fail to see how it can reverse the patient's illness, they are encouraged to request clarification of this at unit rounds from the primary physician and/or Unit Director. If the primary physician is not present they are encouraged to make their request known to the Unit Director so that he may

relay the request to the primary physician. Since the majority of staff conflicts have arisen from communication failures, use of unit rounds to clarify specific treatment consideration is strongly recommended.

Category III is for the patient who may have been in either Category I or Category II, but whose clinical course has deteriorated to the point that there is every expectation that he will not survive despite maximal therapeutic efforts. In these patients, conservative and passive medical care replaces heroic measures. The Category III patient is not an ICU candidate at this point, but social and ethical considerations may dictate his continued presence in the ICU until the propitious time for his transfer to the general medical or surgical floor. To designate a patient as Category III requires the concurrence of the primary physician, his consultants, the intensive care doctors, and representatives of the senior nursing staff. In every instance the wishes of the patient's family are considered, but in no instance is the onus for failure to pursue aggressively therapeutic goals placed upon members of the family. The decision to designate a patient as Category III implies that he has no chance of survival as a whole person. Moreover, a Category III designation implies an agreement or consensus in the medical and nursing management of the patient and the family to avoid meaningless, expensive and time-

consuming therapy. Such decisions allow for more attention to be appropriately redeployed to the other patients, with greater benefit. While it may not occur too frequently that the Category III patient cannot be promptly removed from the ICU setting in the university hospital, this is not the case in the community hospital where factors other than the medical condition of the patient are at work to influence the census.

When the primary physician designates a patient for treatment Category III, it is essential that he obtain the support of the Unit Director, ICU physicians, nursing staff, and his own consultants. This is probably most conveniently given through discussion at unit rounds, although the prior discussion may indicate that such supportive consensus is already clear. If the primary physician is uncertain whether his clinical reasoning has been properly understood by the ICU staff, he is encouraged to check with the Unit Director.

At the transition from Category II to Category III the primary physician, on whom this difficult decision falls, should avail himself of any consultation he wishes. Designation of Category III is an issue entirely independent of the question whether the patient should remain in the ICU. Because of the high cost of ICU beds, there is considerable pressure to make economic considerations primary in deciding where a particular patient should

reside. It is recommended that economic considerations alone never be made the sole criterion for disposition and treatment of patients.

Category IV includes those patients in whom human life technically exists but a human person no longer exists — e.g., patients with brain death. The conscious decision is made to relinquish a life which no longer has meaning. Such a decision requires a specific definitive statement made after proper consultation with appropriate specialists, as well as laboratory analyses such as EEG or cerebral angiography in which the patient is judged to have absolutely no hope for survival. As in Category III, the decision to designate a patient as Category IV requires the concurrence of the primary physician, his consultants, the intensive care doctors, representatives of the senior nursing staff, and the family. The definitive act of commission, namely turning off mechanical ventilators or other life support systems, is entertained; the final act is subject to local policy, custom and legal opinion.

Designation of a patient for Category IV is to follow the same recommendations as those given for III. The definitive act of commission, such as turning off a mechanical ventilator, is to be performed only by an appropriate physician, after consultation with and concurrence of the family, where indicated. Placing the patient in Category III or IV obviates the occasional problem

where the primary physician may want the ICU personnel to continue maximal therapy for appearance sake long after he and his consultants have abandoned hope for the patient's survival.

In this system, unanimous decisions are desirable, but in the event of a difference of opinion in categorization, the Medical Director of the ICU should be prepared to assume responsibility as the final authority. Whenever a patient is classified in Categories II to IV, his classification must be reviewed and reassigned daily. If it becomes proper that patients in treatment Category III should be returned to Category I, prompt notification of the ICU staff is essential.

It is recommended that a subcommittee of the Critical Care Committee be established to serve in an advisory capacity in situations where controversy exists as to the appropriateness of continued intensive therapy in critically ill patients. Such controversy would ordinarily arise when patients are transferred from Categories II to III or III to IV.

Although the Unit Director may suggest a review by the committee, the ultimate request should come from the primary physician. In the case of non-private patients, such a review must have the approval of the responsible attending physician. When requested by the primary physician, the subcommittee will act as expeditiously as possible to review all available information regarding the patient, calling on

whatever resources it deems necessary. The subcommittee will then recommend to the primary physician what it considers to be a proper course of action. It should be emphasized that the committee's role is advisory, and the primary physician may accept or reject the decision of the subcommittee.

Discussion

The changing clinical status of several desperately ill patients, lying side by side in an intensive care unit, can generate confusion among the ICU staff unless periodic reassessments of treatment goals and prognoses are made. The more formal such reassessments by responsible members become, the more salutary will be the benefits to the intensive care activities.

The malpractice insurance carriers are concerned with the increasing emphasis on intensive care. Some anticipate possible increases in malpractice suits when heroic measures are carried out with increasing frequency on critically ill patients.

Aggressive interventions commonly inflicted upon patients on the verge of circulatory or respiratory collapse generate psychological pressures among the family members; often these are transferred to the physician in the form of hostility when hostility is undeserved. These may ultimately have litigation implications. Psychodynamic defenses developed by the patient and family often involve hostility reactions toward the physicians and the

ICU staff. Commonplace responses of family members of critically ill patients include: technological paranoia, accusations of brutalization, insistence on treatment at any cost, insistence on heroic treatment of an unsalvageable patient, and demands to hasten death. The formal, structured reassessments of patients by the responsible members of the ICU staff are a useful means to reduce medico-legal risks.

Coming to grips with the treatment in relation to the prognosis discourages avoidance on the part of the primary physician of the responsibility for deciding about the use or omission of heroic measures. This may obviate the frequent situation where a confused house officer or nurse is faced with the responsibility for these decisions on an emergency basis. For example, when orders for therapy are: (a) do everything you can, but if the patient

arrests, do not resuscitate; (b) if the patient bleeds, transfuse him; (c) give antibiotics and steroids but not parenteral nutrition. These are unrealistic in the ICU setting. Frequently they merely prolong the process of dying or are insufficient for survival. Half treatment of a critically ill patient is illogical and must be avoided.

It is important that the categorization of a patient be based upon ethical, religious, technological, economic, legal, and psychosocial grounds as well as upon medical grounds. Decisions which consider only a few of these aspects may be incomplete or incorrect. The more formal the classification process, and the more participation from responsible members of the ICU staff, the more likely the decision will encompass the appropriate aspects, and the more likely the decision will be the correct one.

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