

Avoiding medical futility in patients dying in a hospital: a position statement of the Polish Society of Internal Medicine Working Group on Medical Futility at Internal Medicine Units

Part 1: A dying patient who is not legally incapacitated but is incapable of making informed decisions regarding treatment that is considered medically futile

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Introduction Decision-making regarding patient care and treatment should be based on a detailed and repeated medical assessment of the patient's clinical status, previous management, possible treatment, and, at the same time, on the identification and acknowledgment of what is important to the patient. This becomes particularly relevant at the end of life, when all causative treatment options have been exhausted, the disease progresses, and the patient is close to imminent death. At this stage, there is a risk that the proposed treatment will be medically futile. Medical

futility refers to interventions that do not benefit the patient and often cause suffering of the patient and their family (and other close people).¹

The concept of futility is similar to the concept of persistence or overzealous therapy. Overzealous therapy is defined as “the use of medical procedures to maintain the life function of the terminally ill in a way that prolongs their dying, introduces excessive suffering or violates their dignity. Overzealous therapy does not encompass basic nursing procedures, relief of pain and other symptoms, feeding and hydration, as long as they

serve the patient's best interest."² The concept of futility, as understood by this Working Group, emphasizes the inability to achieve the goal of care, while persistence has a negative connotation and describes the conduct of an individual who uses medical interventions that are ineffective. Therefore, for the purpose of this position statement, the term "medical futility" was used. In contrast, the Polish Medical Code of Ethics (Kodeks Etyki Lekarskiej [KEL]) applied the term *uporczywość*, which may be translated into English as persistent or overzealous therapy (Article 32).

Medical futility can be avoided by withholding treatment (ie, not implementing a new treatment or not intensifying the current treatment) or by withdrawing treatment that has already been implemented. While the withdrawal of medical interventions may seem more radical from the ethical point of view, it is generally equivalent to withholding. Both withdrawal and withholding are aimed at serving the best interests of the patient and improving the quality of patient care. The avoidance of medical futility should not be mistaken with euthanasia.

This was explicitly stated in the World Medical Assembly (WMA) Declaration on Euthanasia adopted at the 39th WMA in Madrid in 1987 and reaffirmed in 2005: "Euthanasia, that is the act of deliberately ending the life of a patient, even at the patient's own request or at the request of close relatives, is unethical. This does not prevent the physician from respecting the desire of a patient to allow the natural process of death to follow its course in the terminal phase of sickness."³ This was also reaffirmed in the WMA Declaration on Euthanasia and Physician-Assisted Suicide adopted in 2019 in Tbilisi.⁴ Similarly, by prohibiting euthanasia and physician-assisted suicide (Article 31), the Polish KEL underlines that "the physician has no obligation to start resuscitation or a persistent treatment and to use extraordinary measures in terminally ill patients" (Article 32). Moreover, it obliges the physician to consider the patient's quality of life and to provide end-of-life care with respect for human life and dignity (Article 30).

Importantly, this code of conduct is also in line with religious ethics, including the moral teachings of the Catholic Church, which is the largest religious organization in Poland. The Expert Team on Bioethics of the Polish Bishops' Conference underlines that: "If a physician has exhausted all available options to reverse the progressive decline of the patient's biological processes, then neither the physician nor other individuals involved in the dying person's care can consider as unethical the decision to withhold/withdraw further treatment, that is, to decide not to use measures that are disproportionate to the circumstances; this would definitely be futile treatment, the withdrawing/withholding of which cannot be considered euthanasia."⁵ There are exceptional situations when the physician believes the intervention to be a futile treatment, but the patient

wishes to undergo this treatment, as some sort of a personal goal is more important for the patient than the suffering caused by prolonged dying. In such a situation, the most important thing is to ensure that the patient knows and understands their situation and to hear their arguments (eg, that the patient is waiting for a loved one). Other aspects to consider are whether the decision not to withhold treatment (according to the patient's will) for "the time needed" is not contrary to medical knowledge, physician's conscience, or if it does not harm the patient.

Optimally, the decision to consider a treatment as futile and not to implement it (ie, to withhold or withdraw the treatment) should be agreed on between the physician and the patient.

What the physician adds to the physician-patient relationship is medical knowledge and experience. If necessary, the physician can also seek advice in this matter from other medical specialists. The patient's contribution is their own life, goals, values, hopes, the wish to be respected for their humanity, especially at the time of increasing weakness and dependency on others. It is making decisions at the end of life, when we increasingly see the importance of time (for conversations, reflection, decisions), of good communication based on honesty and respect, and of whole-person care centered on the patient's needs of not only physical but also psychosocial and spiritual nature. This is the best model of the physician-patient relationship to prepare for the end of life and dying. It helps both parties to make the goals of care more attainable and fosters acceptance of what is inevitable, thus facilitating realistic choices. It also enables the patient to deal with important issues that are still relevant to them. Finally, it provides the foundation for mutual trust and understanding that are so important at the time when the patient has to rely on others and hope that respect, autonomy, and dignity will be central to the care plan. Thus, the most recent definition of advanced care planning (ACP), approved by the multidisciplinary Delphi panel,⁶ underlines that ACP is a process that supports adult patients in "understanding and sharing their personal values, life goals, and preferences regarding future medical care." This process should also lead the patient to designate a person with medical power of attorney (still unavailable in Poland), and to authorize or not authorize the release of health information—in the event of the patient's incapacity—to designated persons. It is also worth preparing a list of individuals whom the patient wishes to be physically present during dying and death, that is, individuals who should be allowed in the room when the patient becomes incapacitated, along with a list of individuals whom the patient does not wish to be allowed. This is particularly important in the case of patients in conflict with the family or with some family members, as well as patients who do not have a family and their trusted individuals are not considered "closely related

persons” as defined by law. According to the Polish Act of 6 November 2008 on Patient’s Rights and the Patients’ Rights Ombudsman, a “closely related person” is a spouse, a relative within the second degree by consanguinity or affinity, a surrogate decision-maker, a person in cohabitation, or a person designated by the patient.

In Poland, ACP is rarely used outside the palliative medicine setting. In an Internet survey study among physicians belonging to the Polish Society of Lung Diseases, a minority of respondents providing care for patients with advanced chronic obstructive pulmonary disease reported that they routinely (always or often) discussed end-of-life issues with their patients, such as the need to decide on invasive mechanical ventilation (35.6%), cardiopulmonary resuscitation (12.6%), or the place of dying (13.2%).⁷

It is often the case that patients at the end of life, especially emergency patients, were not forced to face up to their actual health and life situation before a hospital admission. Both patients and their loved ones are thus determined to fight the condition and are unwilling to accept imminent death. At the same time, clinicians usually do not have an opportunity to know their patients before they are admitted to the hospital. During hospitalization, they usually do not discuss the values and goals with their patients, and they do not initiate ACP. They often follow routine hospital procedures aimed at protecting life at all costs. This practice has been shaped by numerous factors. So far, no guidelines on the management of patients dying in the hospital have been developed in Poland. The availability of consultants in palliative medicine for hospitalized patients is very limited (neither palliative care support teams nor palliative medicine consultants are financed from public funds). Ethics consultations in difficult situations regarding medical decisions are available only in few hospitals. Moreover, there are no laws in Poland regulating at least the possibility to choose a person with medical power of attorney to represent the patient when they become incapable of making informed decisions on treatment.⁸ All these factors determine the frequency with which the patients receive treatment that may fulfill the criteria for medical futility, especially in the hospital setting.

Guided by the need for good clinical practice that would ensure the best care of patients dying in the hospital, the Polish Society of Internal Medicine (Towarzystwo Internistów Polskich [TIP]) convened the Working Group on Medical Futility at Internal Medicine Units, including experts in different fields of medicine, law, philosophy, and theology.

At the first stage, the Working Group has developed standards of care aimed at avoiding medical futility in patients who are incapable of making informed medical decisions but at the same time are not legally incapacitated.

The position statement on preparing for the end of life in terms of medical decision-making in

adult patients dying in a hospital, who are capable of making informed decisions or have become legally incapacitated, will be presented separately.

Legal aspects of medical futility in Poland are presented in a separate publication (in Polish).⁹

Methods This Working Group was established by the resolution of the TIP Executive Board as of July 9, 2020.

This position statement was being developed from September 2020 to September 2022. First, the members of the Working Group acquainted themselves with relevant literature and current legislation in Poland. Moreover, the Working Group assessed the physicians’ experience with introducing the protocol for avoiding medical futility in intensive care unit patients incapable of making medical decisions, developed by the experts of the Polish Society of Anaesthesiology and Intensive Care.¹ The standards of management in end-of-life medical treatments developed by the Patients’ Rights Ombudsman were discussed.¹⁰ An editorial team including 4 members (WS, MK, PG, MS) drafted a document that was then discussed by all members of the Working Group until a consensus was reached. Before publication, the document was forwarded for endorsement to medical scientific societies in Poland.

Recommended measures The measures undertaken by a health care team to avoid medical futility in patients dying in a hospital and incapable of making informed medical decisions were divided into 3 components: those relating to the patient, those relating to families, and those relating to the care team (FIGURE 1). It is important that the family and the care team do not perceive efforts to avoid medical futility as giving up on necessary interventions, but as taking care of introducing appropriate interventions that best serve the individual patients.

The actions of the care team members must be guided by respect for the dignity, beliefs, and values of the patient. Health care workers should use available measures to help the family of the dying patient go through the dying process, and to reduce the risk of grief complications (ie, when it is impossible to work through grief and move on to the stage of reorganization / adaptation after the loss). Family, but also the care team members, should be confident that they did what had to be done, and that avoiding medical futility made it possible to focus on what was most important and best for the dying patient.

Patient-centered measures The first component, which refers to the measures focused on the patient incapable of making informed decisions, encompasses the following 4 stages:

1. Setting up a committee, declaring a treatment as futile based on evaluation of a previous treatment and the patient’s medical history, preliminary decision on the best strategy of care;

TEAM

PATIENT

FAMILY

Providing support for the care team, reinforcing the belief in the value of end-of-life patient care, good team communication

Organizing a clinical/physicians' committee:

treating physician, head physician, specialists in other fields of medicine relevant to the patient's clinical status, palliative medicine consultant (if possible); patient's nurse, other clinicians depending on the patient's clinical status

1 Declaring a treatment as futile based on medical assessment of previous treatment and medical history

Developing a care plan based on conclusions drawn by the committee in cooperation with consultants and care team members:

- withdrawing/withholding interventions/treatments considered by the committee as futile;
- implementation/continuation/escalation of an optimal care plan focused on the quality of life and preparation for natural death, encompassing palliative care, nursing care, communication with the family members (including remote communication, eg, by phone or online), helping the patient deal with important issues (identified based on medical history or during the family meeting), spiritual/religious care, interventions that foster a sense of dignity and respect for the patient and the family (eg, treatment diary, "Get to know me" board) and that support the medical personnel;
- ensuring that the care team agrees on the care plan and establishing whether there is a need for an ethics consultation at this stage.

2 Preparation for a family meeting (provided that the patient signed a privacy release to allow contact with the family members while hospitalized) to collect information about the patient to facilitate an optimal care plan focused on the quality of life and acceptance of imminent natural death

Meeting of the clinical care team (patient's physician and nurse, head physician, psychologist/chaplain/other team members depending on the situation) with the family:

- asking the family about their perception of the situation and the patient's condition;
- describing the actual situation of the patient, providing explanation, clarification in case of doubt;
- giving space for reactions and questions and ensuring that the family members understand all aspects of the conversation;
- acknowledging emotions, showing compassion, asking how they are coping;
- describing the proposed care plan that includes withdrawing/withholding futile treatment and that focuses on the quality of life and dying;
- asking the family about what would be important for the patient within this care plan (eg, meeting religious needs, saying goodbye to someone, bringing valuable pictures/items, and taking care of these needs, if possible);
- asking the family members about what would be important for them in the patient care, and taking care of these needs, if possible;
- describing proposed measures/interventions aimed at fostering dignity/respect for the patient and the family, inviting the family to participate in these interventions (eg, preparing the "Get to know me" board);
- suggesting the way of communication between the care team and the family members, ensuring that support is available to help them cope with the process of dying;
- taking care to ensure the family presence at the side of the dying patient, emphasizing how important the family presence is (if not feasible, deciding on how to arrange for remote presence/goodbye over the phone or the Internet);
- summary, inviting the family members to recapitulate (asking them to describe the "take home" message from the meeting).

3 Developing an optimal care plan focused on the quality of life and acceptance of imminent natural death, with consideration of any matters and issues that are important to the patient (eg, those described by the family members during the meeting)

Ongoing communication with the family based on compassion, honesty, transparency, and attentiveness (provided that the patient signed a privacy release to allow contact with the family members while hospitalized)

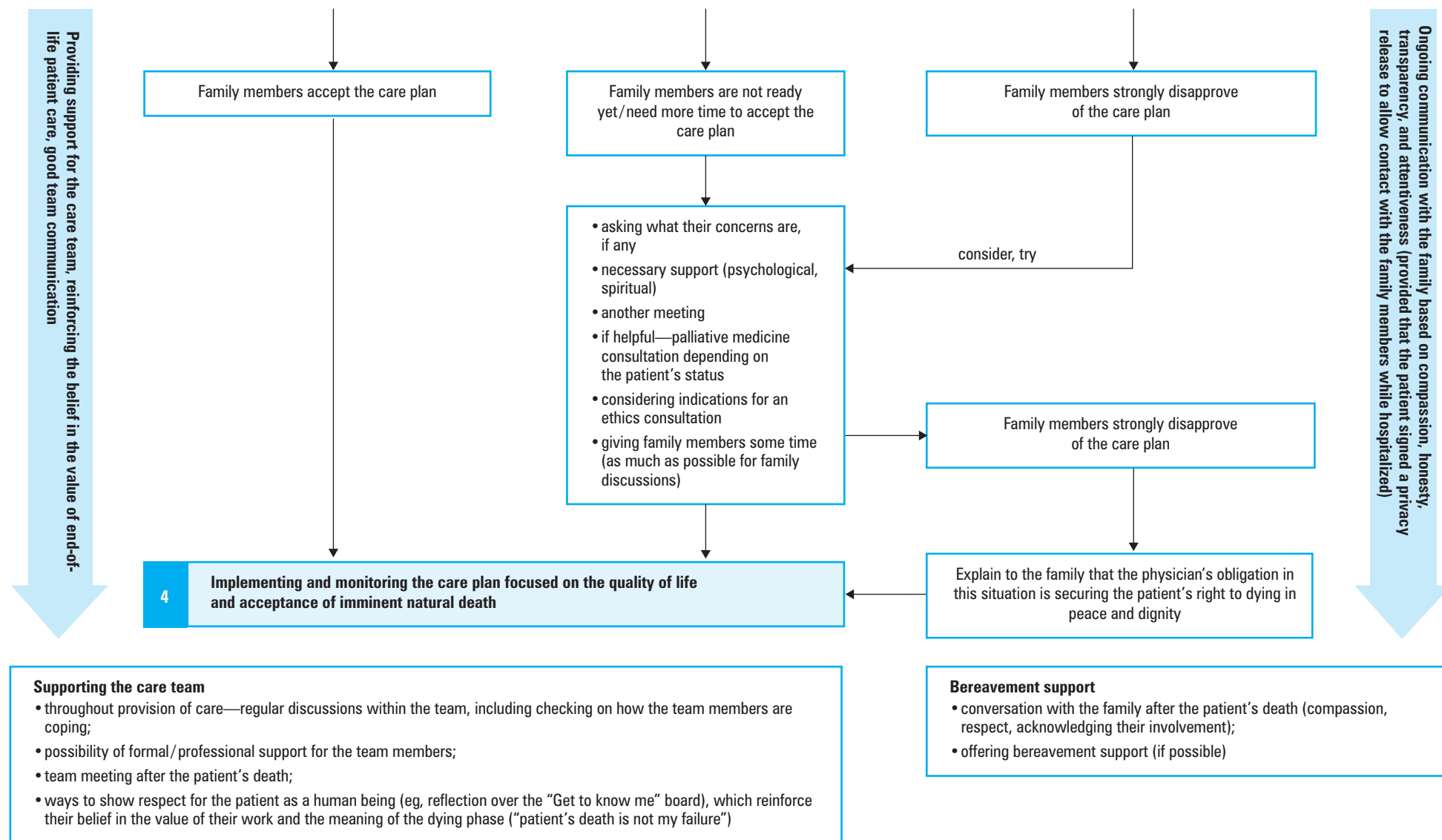


FIGURE 1 Avoiding medical futility in patients dying in a hospital: components and actions

2. Preparing for a meeting with family members (if the patient has a family, if the family members are available and concerned about the patient, unless the patient does not wish them to be present at the end of their life and states it explicitly before becoming incapacitated) in order to collect information about the patient to develop an optimal care plan focused on the quality of life and acceptance of imminent death;
3. Developing optimal care plan that focuses on the quality of life and acceptance of imminent death, but with consideration of any matters and issues that are important to the patient (eg, those described by the family members during the meeting);
4. Implementing the care plan that focuses on the quality of life and acceptance of imminent natural death; monitoring of care.

Declaring a treatment as futile based on evaluation of a previous treatment and the patient's medical history Various clinical situations may increase the risk of medical futility in Polish hospitals, particularly given that there are no guidelines for the management of patients dying in the hospital, the ACP and screening for palliative needs are rarely done, and there are no legal regulations on a medical power of attorney.

A situation associated with an increased risk of medical futility is an admission of a patient at the end of their life (at a high risk of approaching death), who is incapable of making informed decisions, does not have a person with medical power of attorney, has not been legally incapacitated, has had no prior ACP discussions, and has not been assessed for palliative care needs in the emergency department (ED). Let us use the following example: a woman in agony with advanced metastatic thyroid follicular carcinoma was brought to the ED by her family members who were no longer able to care for her. Previous tracheostomy allowed clearance of airway secretions. At the ED, the patient suffered from respiratory arrest, and the physician decided to put the patient on mechanical ventilation, which should be considered a futile treatment.

Another situation is a patient with advanced incurable disease and worsening health status despite medical interventions, for example, a patient with advanced dilated cardiomyopathy leading to end-stage heart failure, ineligible for heart transplant, in a critical condition, without logical contact, subjected to multiple resuscitation procedures at a hospital, showing the features of medical futility.

On admission to a hospital, palliative care screening is necessary in order to provide adequate interventions.¹¹ The decision on whether medical interventions are justified and not futile should then be based on an ongoing clinical assessment and the work of a committee consisting of a treating physician, head physician, specialists in various fields of medicine relevant to the patient's clinical condition, and, if possible, a

palliative medicine consultant. Depending on the situation, it may be helpful to involve other medical professionals, especially the patient's nurse.

The preliminary decision of the committee to avoid medical futility should be driven by not only good clinical practice and best medical knowledge but also the patient's preferences and values. If the treating physician did not have the opportunity to discuss with the patient what is important to them, and if the patient is unable to communicate, such information is usually provided by the family. Therefore, an appropriate meeting of the health care team with the patient's family or other trusted individuals indicated by the patient, except when the patient has explicitly excluded such an option (eg, the patient stated, in writing or orally, that they do not wish any family member to be informed about their health, and this information was documented in the patient's medical records). As long as this wish is explicit, it should be honored (including situations when some individuals, not necessarily family members, have been authorized by the patient to be informed, while others have been not). Considering the ongoing social changes, it is going to be increasingly common that the patient does not have a family, or the family members are not willing to accompany the dying patient, or it is impossible to reach the family members, for example, because no one knows that they exist or there are no contact details. Nevertheless, an effort should always be made to identify individuals who may know the patient, their needs and beliefs, because such an information is invaluable for planning optimal goals of care at the end of life. Also, the very presence of the family by the side of the dying patient increases the quality of dying and death.

As there are numerous misconceptions and social fears about decision-making at the end of life, it is important to clearly define what type of interventions are futile, and which should be continued and should not be withheld or withdrawn.

Apart from nursing and palliative care interventions, patients should receive nutrition and hydration (including tube feeding as long as it is not hurtful for the patients).

In a dying patient (the final days or hours before death), if eating and drinking via the oral or enteral route is not possible, physician may consider parenteral hydration if there are reasonable medical indications (eg, if the intervention reduces confusion), and always assess if it is not burdensome for the patient. It is important to ensure that the consequences of withdrawing hydration and nutrition are not a direct cause of death. Basic care plan (including hydration) should be adjusted to the patient's capacities, to what may relieve their symptoms, and what the patient may benefit from in their last moments of life.¹²

Preparation for a family meeting to collect information about the patient to facilitate an optimal care plan focused

on the quality of life and acceptance of imminent natural death. If the meeting is possible, it should be preceded by developing a care plan based on conclusions drawn by the committee in cooperation with the consultants and the care team members. The care plan should not only limit the use of procedures or treatments considered by the committee to be futile, but it should also emphasize the care goals that focus on the quality of life and preparation for natural death, such as palliative care, nursing care, communication with the family members (including remote communication, eg, by phone or online, if other forms of communication are not possible), helping the patient deal with important issues (identified based on their medical history or during the family meeting), spiritual care (including religious care if this is the patient's wish), interventions that foster respect for the patient and the family (eg, intensive care unit diary, "Get to know me" board).^{13,14} An important aspect to consider in the care plan is the availability of a palliative medicine consultant (especially for the patients with symptoms difficult to control or other psychological, social, or spiritual problems), as well as the family presence at the dying patient's bed (if impossible, at least remote communication should be ensured). Before the family meeting, the care team should agree on the care plan, and establish if there is a need for an ethics consultation at this stage. If the team is aware of any ongoing conflict between the patient and their family or between the family members who want to be involved in the patient care, it is worth emphasizing that the patient is the most important person in the process, and that everyone should have the patient's best interest in mind, but also that the time left is perhaps the last chance for reconciliation. A good idea is to invite a psychologist to the meeting with the family members who are in conflict with the patient. If there is a conflict between the family members, it might be useful to organize individual meetings for opposing groups.

When preparing for the family meeting, it is important to remember that the aim is to collect information about the patient and to prepare the family for the patient's dying and death to provide optimal end-of-life care. The aim of the meeting is not to obtain permission from the family to implement or withdraw from medical interventions, as from a legal perspective their opinion is irrelevant.

Developing optimal care plan focused on the quality of life and acceptance of imminent natural death, with consideration of any matters and issues that are important to the patient (eg, those described by the family members during the meeting). The family meeting should lead to developing an optimal care plan that is based on the best clinical practice and respect for things that are important to the patient. If the meeting is possible, it should include a treating physician, head physician, patient's nurse, and, depending on the situation, a chaplain, a psychologist, or

another member of the care team. The meeting should take place in a comfortable space (eg, not in a corridor). If possible, the family members should be informed about the topic of the conversation prior to the meeting (eg, if the meeting is arranged by phone); and the participants (including physicians) should have sufficient time for the meeting (they cannot be in a hurry).

It is important to ensure good communication that is full of empathy and compassion, aimed at presenting the positive aspect of care focused on the patient as a human being that experiences the process of dying. The family members should be asked about important points that the patient would like to be included in the care plan, and the care team should ensure that these points have actually been included. Showing the family members that the care team is attentive to the patient and respects the patient's dignity, spiritual needs, and other important values, really helps build trust in the care team. How much health information is revealed to the family depends on whether the patient has signed the release of information form authorizing the health care providers to share health information to specific individuals, or whether they are "closely related persons" as defined by Polish law (the Act of 6 November 2008 on Patient's Rights and the Patients' Rights Ombudsman). Even if the conversation involves only the individuals who are informally considered as family, and who have not been authorized to be informed about the patient's health status, it is necessary to treat them with respect when collecting information about the patient and the patient's needs. Moreover, it is necessary to show respect for their emotional relationship with the patient, and for the anxiety they feel about the patient's future. If, for legal reasons, it is not possible to share with them the information about the patient's health and medical interventions or prognosis, they should be ensured that they would be allowed to be present by the patient's side until the end, unless this is impossible for organizational reasons or because the patient explicitly stated that they do not wish to receive visitors.

The meeting and detailed conclusions should be documented in the patient's medical records. If the family members need more information or if there are sudden changes in the patient's health status, the meeting should be repeated, ideally involving the same participants.

The family members may not be ready to accept the fact that the patient is dying, and they may need more time to cope with the situation, discuss it with each other, and consider different options. Time may also be needed to bring closure to things that are important to the patient, which were voiced by the family (eg, the patient may be expecting someone's arrival). The physician should attempt to find out if the family members have any concerns, if they need psychological or spiritual support, or if they need help in organizing the "second consultation" (to talk with

a consultant in a given field of medicine depending on the patient's situation).

However, it is possible that despite these efforts, the family would strongly disapprove of the proposed care plan or disagree with the clinical assessment. If it is in the patient's best interest to immediately implement the care plan aimed at avoiding medical futility, and there is no time for more family meetings, and also when the behavior of the family members becomes increasingly demanding, the final meeting should be offered to: 1) reiterate that the proposed intervention is a good medical practice, and serves the patient's best interest; 2) explain to the family that the physician's obligation in this situation is securing the patient's right to die in peace and dignity; and 3) to inform the family that, from a legal perspective, their consent is not required and their objection has no legal force. It would be beneficial to ask a legal counsel of the hospital to participate in such a meeting, so that this information can be shared by an individual with legal expertise.

Implementation and monitoring of the care plan focused on the quality of life and acceptance of imminent natural death When the care team and the family agree on the care plan, but also in a situation when all family meetings are inconclusive, the care team should proceed to implement the care plan aimed at avoiding medical futility. A decision to implement such a plan should be well-documented and formalized. This position statement contains proposed documentation, which has been approved by the TIP after extensive consultation with other medical communities. Importantly, the decisions made by the physicians and recorded in the protocol for avoiding medical futility can be changed at any stage of the treatment, if justified on medical grounds or if the patient's condition changes.

When implementing the proposed care plan, goal-oriented outcomes should be regularly assessed and whole-patient care, along with communication with the family members, should be carefully documented.

Family-centered measures Numerous patient-oriented measures are also relevant for families. Over the entire period of care, communication with families should be based on compassion, honesty, transparency, and attentiveness, even if the patient did not sign a privacy release to allow the family to contact them while hospitalized or to authorize the care team to provide specific details on their treatment.

The family meetings to discuss the avoidance of medical futility are particularly difficult, and they also considerably affect the way the family members cope with the situation. It is important to show concern for the family and to offer them necessary support (if possible), for example, spiritual or mental health support. There are very helpful programs for the families to participate in.

These programs support the expression of spirituality and foster respect for the patient's dignity (eg, Three Wishes Project).¹⁵⁻¹⁷

Families should have an opportunity to be present at the side of the dying patient, even when there are sanitary restrictions (eg, caused by the pandemic) or other emergency situations.^{18,19} If the family cannot be physically present, remote communication should be allowed to ensure that they can say goodbye.²⁰⁻²³ All these factors impact the quality of end-of-life care, shape the way the families cope with the dying process and then grief, and may help them to find strength to go on living.²⁴

It is very important that the physicians and other care team members talk to the family after the patient dies, express sympathy and respect, acknowledge their involvement in the end-of-life care, and provide information on or offer bereavement support, if possible. Information and bereavement support were even considered as one of the basic indicators of high-quality care of patients dying in a hospital in Sweden, and they continue to be assessed as part of the Swedish registry of palliative care.²⁵

Care team-centered measures When providing care for dying patients, the care team-centered measures are largely based on good communication within the care team and reinforcing their belief in the value of their work. When taking care of the patient at the end of their life, it is necessary to regularly discuss the patient's condition, to check up on how the team members cope with the situation, and to provide professional support to those who need it.²⁶ Ways to show respect for the patient as a human being should be emphasized (eg, reflection over the "Get to know me" board, moment of silence/prayer after resuscitation or other emergent events leading to death).²⁷ This reinforces the team's belief in the value of their work, and the meaning of the dying phase ("the patient's death is not my failure", "high-quality end-of-life care and peaceful death are my success"). A care team meeting after the patient's death or taking time to pause for reflection may be valuable.

Efforts should be made to implement formal measures aimed at supporting the care team.²⁸

Recommendations of the Working Group

1. It is necessary to develop and implement guidelines for the management of patients with advanced incurable disease who die in a hospital that would encompass whole-patient and family care.
2. Efforts should be made to screen all patients with advanced incurable diseases for palliative care needs on admission to the hospital, which may help define realistic goals of care and avoid medical futility.
3. In the hospital setting, it is necessary to support the idea that the acceptance of imminent natural death is not giving up on treatment

but is rather implementation or intensification of measures that focus on what is most important to the dying patient (FIGURE 1).

4. The medical assessment of a previous treatment and medical history, which is the first step on the way to declaring a treatment as futile, should be done by a committee consisting of medical professionals.

5. When avoiding medical futility in patients incapable of making informed decisions, it is necessary, if possible, to discuss and decide with the patient's family on the optimal care plan that honors the issues and values important to the patient, unless the patient explicitly stated that they did not wish the health care providers to contact their family members or provide them with information on the patient's condition.

6. Efforts should be made to ensure that the dying patient has access to palliative medicine consultations.

7. Spiritual interventions to address the spiritual needs of the patients (especially at the end of life) and their families should be implemented in hospitals.

8. It is important to ensure that there are programs available in hospitals to support the families after the loss and that physicians and nurses are trained in bereavement support and communication.

9. It is important to ensure that spiritual and psychological support is available in hospitals to medical personnel providing care to the dying patients.

10. Aspects related to medical futility and providing care to patients dying in a hospital and their families should be included in undergraduate and postgraduate education curricula for physicians and nurses to ensure that they are trained to provide high-quality care.

ARTICLE INFORMATION

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REFERENCES

1. Kübler A, Siewiera J, Durek G, et al. Guidelines regarding the ineffective maintenance of organ functions (futile therapy) in ICU patients incapable of giving informed statements of will [in Polish]. *Anaesthesiol Intensive Ther.* 2014; 46: 215-220. [↗](#)
2. Boloz W, Krajnik M, Adamczyk A, et al. The consensus of the Polish Working Group on End-of-Life Ethics [in Polish]. *Med Paliat Prakt.* 2008; 2: 77.

3. WMA declaration on euthanasia. World Medical Association website. Published November 5, 2019. <https://www.wma.net/policiespost/wmadeclarationoneuthanasia/>. Accessed September 23, 2022.

4. WMA declaration on euthanasia and physician-assisted suicide. World Medical Association website. Published November 23, 2021. <https://www.wma.net/policiespost/declarationoneuthanasiaandphysicianassistedsuicide/>. Accessed September 23, 2022.

5. Expert Group of Polish Episcopal Conference on Bioethics: discontinuing futile therapy cannot be equated with euthanasia [in Polish]. Polish Episcopal Conference website. <https://episkopat.pl/en/zespol-ekspertow-kep-ds-bioetycznych-zaprzestanie-terapii-darejnie-nie-moze-byc-utozsamiene-z-eutanazja/>. Accessed September 23, 2022.

6. Sudore RL, Lum HD, You JJ, et al. Defining advance care planning for adults: a consensus definition from a multidisciplinary Delphi panel. *J Pain Symptom Manage.* 2017; 53: 821-832.e1. [↗](#)

7. Brozek A, Damps-Konstanska I, Pierzchała W, et al. End-of-life care in COPD: a survey carried out with Polish pulmonologists. *Pol Arch Intern Med.* 2019; 129: 242-252.

8. Szeroczyńska M, Czarkowski M, Krajnik M, et al. The Polish Working Group On End-of-Life Ethics. Institution of the health care agent in Polish legislation: position of the Polish Working Group on End-of-Life Ethics. *Pol Arch Med Wewn.* 2016; 126: 313-320. [↗](#)

9. Szczeklik W., Krajnik M., Pawlikowski J. et al. Preventing medical futility in adult patients dying in a hospital – a position statement of the Polish Society of Internal Medicine's Working Group on Medical Futility at Internal Medicine Units. Part 1: A dying patient who is not legally incapacitated but is incapable of making informed decisions regarding treatment that is considered medically futile [in Polish]. *Med. Prakt.* 2023; 4: 121-140. [↗](#)

10. Patients' Rights Ombudsman Team on developing standards of conduct in medical therapies used in end of life period [in Polish]. Government of Poland website. <https://www.gov.pl/web/rpp/terapia-medyczne-w-okresie-rekomendacje-sie-zycia-zakonczenie-prac-zespolu>. Accessed September 23, 2022.

11. Gradalski T. Medical referral criteria for palliative care in adults: a scoping review. *Pol Arch Intern Med.* 2022; 132: 16223. [↗](#)

12. NICE guideline: Care for the dying in the last days of life. National Institute for Health and Care Excellence website. Published December 16, 2015. <https://www.nice.org.uk/guidance/ng31>. Accessed September 23, 2022.

13. Billings JA, Keeley A, Bauman J, et al. Massachusetts General Hospital Palliative Care Nurse Champions. Merging cultures: palliative care specialists in the medical intensive care unit. *Crit Care Med.* 2006; 34: S388-S393. [↗](#)

14. Gajic O, Anderson BD. "Get to know me" board. *Crit Care Explor.* 2019; 1: e0030. [↗](#)

15. Swinton M, Giacomini M, Toledo F, et al. Experiences and expressions of spirituality at the end of life in the intensive care unit. *Am J Respir Crit Care Med.* 2017; 195: 198-204. [↗](#)

16. Vanstone M, Neville TH, Clarke F, et al. Compassionate end-of-life care: mixed-methods multisite evaluation of the 3 wishes project. *Ann Intern Med.* 2020; 172: 1-11. [↗](#)

17. Azad MA, Swinton M, Clarke FJ, et al. Experiences of bereaved family members receiving commemorative paintings: a qualitative study. *JAMA Netw Open.* 2020; 3: e2027259. [↗](#)

18. Münch U, Müller H, Deffner T, et al. Recommendations for the support of suffering, severely ill, dying or grieving persons in the corona pandemic from a palliative care perspective: recommendations of the German Society for Palliative Medicine (DGP), the German Interdisciplinary Association for Intensive and Emergency Medicine (DIVI), the Federal Association for Grief Counseling (BVT), the Working Group for Psycho-oncology in the German Cancer Society, the German Association for Social Work in the Healthcare System (DVSG) and the German Association for Systemic Therapy, Counseling and Family Therapy (DGFS) [in German]. *Schmerz.* 2020; 34: 303-313.

19. Patients and family at the end of life. Royal College of Physicians of Edinburgh. https://www.rcpe.ac.uk/sites/default/files/sa_statement_-_patients_and_family_at_end_of_life_care_final_-_updated_september_2020.pdf. Accessed September 23, 2022.

20. Krajnik M, Gajewski P, Golota S, et al. Spiritual care as an essential part of holistic approach to patients with COVID-19. Polish Association for Spiritual Care in Medicine Position Statement [in Polish]. *Medycyna Praktyczna.* 2020; 12: 146-152.

21. How to help relatives of a dying patient say goodbye over the phone [in Polish]. Polish Association for Spiritual Care in Medicine website. <https://ptodm.org.pl/badz-przy-mnie/25738,jak-pomoc-bliskim-umierajacego-chorego-pozegnac-sie-z-nim-przez-telefon>. Accessed September 23, 2022.

22. COVID Ready Communication Playbook. VITAL talk website. <https://www.vitaltalk.org/guides/covid19communicationskills/>. Accessed September 23, 2022.

23. Multidisciplinary Working Group "ComuniCovid" [Italian Society of Anesthesia and Intensive Care (SIAARTI), Italian Association of Critical Care Nurses (Aniarti), Italian Society of Emergency Medicine (SIMEU), and Italian Society of Palliative Care (SICP)]. How to communicate with families of patients in complete isolation during SARS-CoV-2 pandemic multidisciplinary working group "ComuniCovid" [in Italian]. *Recenti Prog Med.* 2020; 111: 357-367.

- 24 Ersek M, Smith D, Griffin H, et al. End-of-life care in the time of COVID-19: communication matters more than ever. *J Pain Symptom Manage.* 2021; 62: 213-222.e2. [↗](#)
- 25 Elmstedt S, Mogensen H, Hallmans DE, et al. Cancer patients hospitalised in the last week of life risk insufficient care quality - a population-based study from the Swedish Register of Palliative Care. *Acta Oncol.* 2019; 58: 432-438. [↗](#)
- 26 Owoc J, Manczak M, Tombarkiewicz M, Olszewski R. Burnout, well-being, and self-reported medical errors among physicians. *Pol Arch Intern Med.* 2021; 131: 626-632. [↗](#)
- 27 Pierce A, Hoffer M, Marcinkowski B, et al. Emergency department approach to spirituality care in the era of COVID-19. *Am J Emerg Med.* 2021; 46: 765-768. [↗](#)
- 28 Taylor B, Xyrichis A, Leamy MC, et al. Can Schwartz Center Rounds support healthcare staff with emotional challenges at work, and how do they compare with other interventions aimed at providing similar support? A systematic review and scoping reviews. *BMJ Open.* 2018; 8: e024254. [↗](#)