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Therapeutic adequacy: presentation of a hospital protocol

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Abstract

Therapeutic adequacy is defined as a medical decision shared with patients and family members and that seeks to adjust therapeutic and diagnostic resources appropriate to each care plan. This article aims to present a protocol on therapeutic adequacy implemented in a university hospital. This protocol aims to guide practices of health professionals in the light of the bioethical, legal and clinical principles relevant to each case. It is concluded that the protocol can assist in the decisions to abstain or suspend certain treatment procedures of patients with severe, progressive and irreversible diseases.

Keywords: Palliative care. Decision making, shared. Protocols. Bioethics.

Resumo

Adequação terapêutica: apresentação de um protocolo hospitalar

A adequação terapêutica é definida como uma decisão médica compartilhada, com pacientes e familiares, que busca ajustar recursos terapêuticos e diagnósticos adequados a cada plano de cuidados. Este artigo objetiva apresentar um protocolo sobre adequação terapêutica implementado em um hospital universitário. Tal protocolo visa nortear práticas de profissionais da saúde sob a luz dos princípios bioéticos, legais e clínicos pertinentes a cada caso. Conclui-se que o protocolo pode auxiliar nas decisões de abstenção ou suspensão de determinado tratamento de pacientes com doença grave, progressiva e irreversível.

Palavras-chave: Cuidados paliativos. Tomada de decisão compartilhada. Protocolos. Bioética.

Resumen

Adecuación terapéutica: presentación de un protocolo de hospital

La adecuación terapéutica se define como una decisión médica, compartida con pacientes y familiares, que busca ajustar los recursos terapéuticos y diagnósticos a cada plan de cuidado. Este artículo tiene como objetivo presentar un protocolo de adecuación terapéutica desarrollado en un hospital universitario. El protocolo buscó orientar las prácticas de los profesionales de la salud a la luz de los principios bioéticos, legales y clínicos pertinentes a cada caso. Se concluye que el protocolo puede auxiliar en las decisiones de abstención o suspensión de un tratamiento en pacientes con enfermedad grave, progresiva e irreversible.

Palabras clave: Cuidados paliativos. Toma de decisiones conjunta. Protocolos. Bioética.

Research

The authors declare no conflict of interest.

The term "palliative care" designates the approach that promotes quality of life for patients living with diseases that threaten the continuation of life, through the prevention and control of suffering [1]. Early recognition, assessment and care of pain and other situations that cause physical, spiritual and/or psychosocial suffering are essential, because in this situation the main goal is not the cure of the disease, but individualized and comprehensive care for patients and their families. Multiprofessional work is essential to achieve excellence in treatment [2].

With the progression of the disease, the curative treatment reduces its impact, increasing the palliative potential [3]. Thus, life-sustaining measures – cardiopulmonary resuscitation, renal replacement therapy, vasoactive drugs, mechanical ventilation and artificial nutrition – can be equivalent to dysthanasia, generating suffering through inadequate actions to artificially prolong life. Ethical considerations are essential, aiming at the central concepts of principlism – autonomy, beneficence, non-maleficence and justice –, which should guide the practices of health professionals, denoting the need to enhance concepts such as therapy adequacy (TA) [4,5].

TA is understood as the decision-making on withholding (not implementing) or withdrawing (removing) a certain treatment considered disproportionate because, when dealing with an end-of-life or irreversible clinical condition, it is more likely to cause harm than to provide benefit to patients [6-8]. In these cases, measures that ensure physical and psychological well-being are maintained, which is equivalent to orthothanasia [9,10]. Orthothanasia is a term of Greek origin that means "correct death," that is, death that is not postponed or accelerated, in which proper care and treatment were performed without therapeutic futility [11].

Thus, the TA can be considered a restrictive medical conduct, as it limits the use of certain therapeutic resources, optimizing health care provision with an emphasis on relieving the suffering of patients and their families in the dying process. Therefore, it is distinguished from dysthanasia and euthanasia, where there is an intention to merely prolong or accelerate the dying process, respectively [9,12].

It should be noted that, legally, physicians who insists on maintaining treatment or any innocuous, deceptive, expendable and degrading procedure for a patient suffering from an incurable disease, exposing them to pain and suffering and acting contrary to the individual's or their legal guardian's will, will be practicing dysthanasia. Within the scope of civil and criminal accountability, they will be liable for bodily harm, illegal constraint, torture and cruel treatment imposed on the patient and their family.

The TA decision-making process must be individualized, as the autonomy and preferences of the patient and their family are considered the main guidelines, both from an ethical and legal perspective [9]. In this context, we note CFM Resolution 1,805/2006 [13] and the single paragraph of article 41 of the Code of Medical Ethics (CEM) [14], which regulate the practice of orthothanasia and disapprove of dysthanasia [15]; and CFM Resolution 1,995/2012 [16], which provides for advance directives (AD).

CFM Resolution 1,805/2006 describes in article 1 that *the physician is allowed to limit or suspend procedures and treatments that prolong the life of a patient in the terminal phase of a serious and incurable illness, respecting the will of the person or of their legal representative* [13]. Article 2 states that:

The patient will continue to receive all necessary care to alleviate the symptoms that lead to suffering, ensuring comprehensive care, physical, psychological, social, spiritual comfort, including assuring the right to hospital discharge [13].

CEM states that *in the case of an incapable patient, in the absence of the legal representative, the physician will be responsible for deciding on the measures mentioned in the heading of this article* [14]. Thus, it is reiterated that it is essential to consider the principle of autonomy in the TA decision-making process: first the person, then the legal representative, and, finally, the physician.

Moreover, CEM [14], in item XXII of chapter I "Fundamental Principles," provides that in clinical conditions with no possibility of cure or non-treatable, the professional will avoid unnecessary diagnostic and therapeutic procedures and will provide the individual under their responsibility with all appropriate palliative care. In article 41, the code

states that it is prohibited for a physician to reduce a patient's life, even if requested by the patient or by their legal representative.

Article 41 also prescribes that, in cases of incurable and terminal illness, the physician must provide all available palliative care without carrying out useless or obstinate diagnostic or therapeutic actions, always considering the sole will of the patient or, in their impossibility, that of their legal guardian.

CFM Resolution 1,995/2012 [16] provides for AD, defining them in article 1 as the set of desires, previously and expressly manifested by patients, about care and treatments that they want, or do not want, to receive when they are unable to express, freely and autonomously, their will. Article 2 refers to decisions on care and treatment of patients who are unable to communicate or express their will freely and independently, and indicates that the physician must take their AD into consideration, noting that:

1. *If the patient has designated a representative for this purpose, their information will be taken into consideration by the physician;*
2. *Physicians will no longer take into consideration the AD of the patient or representative that, according to their analysis, are in disagreement with the precepts dictated by the Code of Medical Ethics;*
3. *The patient's AD will prevail over any other non-medical opinion, including the will of family members;*
4. *The physician will register, in the medical record, the AD that were directly communicated to them by the patient;*
5. *If the patient's AD are not known, and there is no designated representative, available family members or lack of consensus among them, the physician will refer to the institution's Bioethics Committee, where available, or, in the absence thereof, to the hospital's Medical Ethics Committee or to the Regional and Federal Council of Medicine to base their decision regarding ethical differences, when deeming this measure necessary and convenient* [16].

CFM Resolution 1,995/2012 also ensures patient autonomy regarding the care and treatments that they may receive provided they are consistent with the aforementioned guidelines. It also supports medical decision-making in TA situations with comatose, post-coma unresponsive, or mentally disabled persons without family members or legal representatives. Thus, there is observance of the TA-related ethical and normative aspects that support the withdrawal or not of the indication of treatment considered disproportionate.

The need for TA arises when the possibility of the medical procedure causing harm outweighs the expected potential benefit, which commonly occurs in critically ill patients with a limited life prognosis. In this context, it needs to be defined how and for how long critically ill patients with a poor prognosis should be treated curatively [1,2,9,17].

It is important to note that health care provided in a hospital setting must be based on a care plan whose design considers that curative measures do not linearly precede palliative measures. Thus, palliative approaches should be concomitant with curative approaches, ensuring relief from symptoms that cause discomfort after the diagnosis of any serious disease that implies a limited life prognosis. Thus, TA can be understood as a process of combining curative and palliative measures, enabling individualized and humanized care with the implementation of appropriate therapies [8,17].

It should be noted that TA is considered a multifactorial, subjective and complex process whose definition must be organized in a shared way, considering the team of health professionals involved in care, the patient (or legal representative) and family members [6,18,19].

The objective of this article is to describe the process of developing and implementing a TA protocol in a university hospital in the state of Rio Grande do Sul, Brazil.

Method

This is an experience report describing the process of development and implementation of a TA protocol in the University Hospital of Santa Maria (HUSM). The institution, which is large and has 403 beds installed, is a benchmark for medium and high complexity care in the central region of the state of Rio Grande do Sul – an area with almost 2 million inhabitants [20].

The work from the initial steps to the completion of the protocol was carried out between March and May 2018. The Health Care Management (GAS) established a TA protocol due to the profile

of patients treated at the HUSM: complex, with multiple comorbidities, and oncological. Because of this need, GAS invited professionals from HUSM Sectors, Units and Services that were notoriously involved in the care of patients with this profile, including the Bioethics Committee (CoBi) of the hospital, to develop the protocol.

As instructed by the Patient Health and Safety Surveillance Sector – Quality (SVSSQ), responsible for document management at HUSM, the protocol was developed adopting the following steps:

1. Sectors, Units and Services defined a professional as responsible for the preparation – literature review, active search for Ministry of Health protocols, guidelines and related consensus;
2. The professional in charge, after preparing the protocol, called those responsible for the Sectors, Units and Services to discuss the protocol and finished the first version;
3. The first version of the protocol was submitted to the SVSSQ for adjustments – assessment of the items' compliance with HUSM standards, formatting and dissemination;
4. The professional made the adjustments and returned the protocol to the SVSSQ for completion of the flows and formatting of the protocol;
5. SVSSQ submitted the protocol to the Information Technology (IT) Sector, which made it available on the hospital intranet as "under validation." This step enabled all health professionals working at the HUSM to view the protocol before its validation;
6. The professional in charge defined the date and place for the presentation and validation of the protocol and requested that the SVSSQ released it;
7. The professional responsible for the protocol performed the presentation for validation and submitted to the SVSSQ the requested adjustments and a list with the names of the persons attending the presentation;
8. SVSSQ sent the finished file to the IT sector for making it available as a protocol "Implemented" at the HUSM.

This study did not involve research with human beings, according to CNS Resolution 196/1996, item II.2. This is a report of a process for the development and implementation of a TA protocol, according to the institutional flow established for the validation and implementation of protocols.

Results

Steps for designing the therapy adequacy protocol

Indication of the therapy adequacy protocol

The protocol can be applied to hospitalized patients, as assessed by the assistant medical team or a physician designated by it, in case of advanced severe disease or condition of end of life, non-recovery and/or risk of death.

The TA is indicated when it is recognized that the patient is in the final stage of life, that is, with an estimated life expectancy of up to 12 months, including the period of imminent death (hours or days). In addition, TA is indicated in the following cases: advanced, progressive and incurable conditions; generalized frailty and coexistence of conditions associated with life expectancy of up to 12 months; life-threatening conditions if there is a sudden acute crisis; acute life-threatening conditions associated with a catastrophic event [21-23].

Inclusion criteria

The criteria for patient eligibility for TA are:

- Having received an accurate diagnosis of serious illness or health conditions;
- At the time of assessment, not being a candidate for a treatment of proven efficacy that could change the prognosis of near death or when the therapies in use have ceased to be effective;
- The diagnosed conditions must be progressive, irreversible and have a defined prognosis [21].

The definition of the prognosis can be based on general indicators of clinical and functional decline and/or specific clinical indicators [21-23] or by using a surprise question: *Would you be surprised if this person dies in the next few months, weeks or days?* [21]. The answer to this question must be intuitive, involving a series of clinical indicators, presence of comorbidities, social aspects and other factors that enable a complete analysis of a clinical condition of decline. A positive answer to this question, although subjective, represents a limited life prognosis, with indication of TA [21].

Research

Presence of general indicators of clinical and functional decline [24-26]

- Decreased activities – declining functional performance status (e.g., Barthel score), limited self-care, staying in bed or chair for 50% of the day – and increase dependence in most activities of daily living;
- Presence of comorbidity – considering the greatest indicator predicting mortality and morbidity;
- General physical decline and increasing need for support;
- Advanced disease: unstable condition, deterioration and symptoms requiring a complex approach;
- Decreasing response to treatments, with reduced reversibility;
- Choice of no additional active treatment;
- Progressive weight loss (>10%) in the last six months;
- Repeated unplanned admissions or decompensation of underlying medical condition;
- Sentinel event: serious fall, bereavement, transfer to long-stay institution;
- Serum albumin <2.5 mg/dl;
- Need for considerable assistance and frequent medical care (Karnofsky 50%);
- Symptoms, difficulty with self-care, staying in bed more than 50% of the day (Performance Status Ecog 2).

The decline must be established and documented, based on objective information, in the medical record [21]. Specific clinical indicators need to be observed – flexible criteria with some overlaps, especially in people with frailty and other comorbidities [23].

Progress with rapid or predictable decline

Metastatic cancer

- Predictors for cancer patients, using Karnofsky and Performance Status ECOG, can help, but should not be applied in isolation [25,26];
- The most important predictors in cancer are the performance status and the functional capacity;
- If the patient spends more than 50% of the time in bed, the prognosis is generally estimated at about three months or less.

Progress with erratic decline

The characteristic progress of chronic diseases – such as organ failure and neurological pathologies – show an erratic decline. Chart 1 summarizes some indicators of advanced disease in specific morbidities.

It is absolutely necessary to start addressing the evolution of the disease in a patient with dementia early, while the cognitive deficit still allows the patient to discuss how they would like to be treated in later stages [23]. When considering the progress of specific clinical indicators presented by the patient, it is essential to identify episodes that indicate acute changes, with low possibility of reversal. These indicate a greater need to implement palliative care in the established care plan [21].

Chart 1 Pathologies with progress with erratic decline

Organic deficiencies	**COPD**	• FEV1 <30%; • Recurrent hospital admissions: at least three in the last 12 months; • Long-term oxygen therapy criteria; • mMRC degree 4/5; • Signs and symptoms of right HF; • Other factors: anorexia, previous infections with resistant microorganisms.
	Heart disease	• NYHA 3 or 4; • Repeated hospital admissions with symptoms of HF; • Difficult physical or psychological symptoms, despite optimal and tolerable therapy.
	Kidney disease	• Stage 4 or 5 kidney disease; • Patients who choose the "no dialysis" option or discontinue RRT; • Symptomatic renal failure: nausea and vomiting, anorexia, pruritus, reduced functional status, or intractable fluid overload.

continues...

Chart 1. Continuation

Neurological diseases	**Parkinson's disease**	• Reduced independence, need for help with activities of daily living; • Increasing periods of "off"; • Dyskinesia, reduced mobility and falls; • Psychiatric signs: depression, anxiety, hallucinations, psychosis; • Presentation of a pattern similar to that of frailty.
	Frailty	• Deterioration of functional status as assessed by Barthel/PPS/Karnofsky; • A combination of at least three of the following symptoms: weakness, reduced walking speed, significant weight loss, exhaustion, low level of physical activity, or depression.
	CVA	• Minimal state of consciousness or persistent vegetative state or dense paralysis; • Lack of improvement within three to six months of disease onset; • Cognitive impairment/post-CVA dementia.
	Dementia syndromes	• Does not walk without assistance; • Urinary and fecal incontinence; • No consistent and meaningful dialogue; • Unable to perform activities of daily living; • Stage 3 or 4 pressure injuries; • Reduction of oral intake; • Recurring infections.

COPD: chronic obstructive pulmonary disease; FEV1: forced expiratory volume in one second; mMRC: *Modified Dyspnea Scale* (Modified Medical Research Council); NYHA: New York Heart Association, functional classification; HF: *heart failure; RRT: renal replacement therapy; PPS: Palliative Performance Scale; CVA: cerebrovascular accident (stroke)* [3]

Steps for implementing the TA protocol

Communication with the team

After checking the criteria for TA, the team involved in health care should be informed and the indication of TA should be discussed [4,5]. Thus, the objective is to establish consensus in the team, with subsequent recording in the medical record (Flowchart 1, in the Appendix).

Communication with patient, legal representative and family

With the consensus of the team involved in health care, the patient – or their legal representative – and the family are informed about the evolution and prognosis of the presented condition and the patient's and the family's wills are learned [5,9]. In this approach, the patient's autonomy and decision-making capacity must be assessed, in addition to verifying the existence of an AD document (Flowchart 2, in the Appendix).

Consensus between team and family

Throughout the TA definition process, support should be provided to the team involved, the patient (or legal representative) and family members, considering personal beliefs and values involved in each case. If there is no consensus, assistance can be sought from the institution's bioethics committee, if deemed appropriate (Flowchart 1, attached).

Types of therapy adequacy

There are two ways to execute a TA: by not starting a measure (withholding) or by removing a pre-existing measure (withdrawal) [4]. From an ethical perspective, both are considered morally equivalent; however, there are differences from a psychological, philosophical, social and clinical perspective, among others. Therefore, it is considered more difficult to withdraw than to withhold a measure, which must be taken into consideration when communicating with the parties involved [4,28].

Withholding treatments

Not initiating medical treatment, even if it results in death, may be acceptable under appropriate circumstances for TA. Still, a treatment should not be implemented if that is in accordance with the request previously presented by the patient in their AD document [4].

Nonperformance of cardiopulmonary resuscitation

Cardiopulmonary resuscitation (CPR) is an attempt to restore cardiopulmonary function and includes endotracheal intubation and assisted ventilation, external cardiac compression, and electrical cardiac defibrillation. The decision not to institute CPR must be recorded in the medical record as a do-not-resuscitate (DNR) order [28].

In the absence of a DNR order, the patient will receive CPR, so the physician should discuss this issue with patients whenever appropriate. A DNR order, written or verbal, can be followed only after informed consent from the patient – or legal representative – is obtained and properly documented in the medical record. The decision for DNR, provided it is properly prepared by the responsible physician, must be complied with [5,28].

The physician must inform the patient – or legal representative – of the invasive nature of CPR and, where relevant, of its extremely low probability of success under certain conditions. The DNR order can be given by the physician who provides hospital care directly to the patient or by another physician designated by them and must be recorded and signed by the professional within 24 hours from its institution. The DNR order is valid only for this period and expires if it is not properly recorded [28].

When registering, the physician must indicate the DNR order in the medical evolution heading and in the medical prescription in the care section. It is also necessary to record in the header: patient medical condition, ability or grounds for inability to make decisions, identification of legal representative, and terms of discussion with the patient or legal representative [28].

The health care team must implement adequate palliative care – aiming to control symptoms and addressing psychological, social and spiritual aspects – and, if deemed necessary, request support from the palliative care team. Patients with a DNR order will continue to receive high-quality medical care, with the definition of procedures that will be maintained, such as treatment of infections, transfusion, nutrition, hydration and diagnostic tests, consistently with the implementation of palliative care [19]. This definition must be recorded in the medical record, with indication in the heading of the medical evolution and in the medical prescription in the care section.

The DNR order must be revoked if the patient's medical condition or will change, after discussion with the patient or their legal representative. In addition, the indication of DNR will be discussed at each hospital admission, unless it is clear that the reason why the DNR was authorized remains unchanged. The DNR order, however, must be rewritten and documented in the medical record at each admission [28].

In some cases, a patient with a DNR order may accept elective intubation for a potentially reversible condition, such as pneumonia. In case that occurs, the DNR order can be canceled if the legal representative agrees. If the DNR order is suspended by the legal representative, they must be instructed to consider the patient's will [5,28].

Patients with a DNR order may undergo palliative procedures or others, but if the caregiver believes there is a significant risk that CPR will be required, the patient will be asked if the DNR order can be suspended during the procedure and recovery. The duration of the recovery period considered for the suspension, which is defined by the medical team, will be noted in the medical record and, if the patient does not want to suspend the DNR order in this situation, the assistant physician must be notified. They will define with the professional in charge whether the procedure will be performed with the DNR order maintained [28].

Except in emergencies, no health care professional will be obligated to perform interventions on a patient with a maintained DNR order if they believe that doing so would violate their ethical or religious beliefs or professional integrity. In case there are no professionals willing to perform a procedure with the DNR order maintained and the patient refuses to suspend it,

the assistant physician will discuss with the patient the reason for the intervention and for the suspension of the DNR order. If it is suspended during the procedure or during the recovery period, the professional responsible for the procedure, or someone designated by them, will document this change in status in the medical record [28].

The assistant physician is the responsible for assembling a team willing to care for the patient, and the institution's bioethics committee can be contacted to assist in resolving conflicts. In case of hospital discharge, the DNR indication and the treatments to be maintained must be registered in the recommendations and care section in the discharge note [28].

Nonperformance of other life-sustaining measures

Physicians should discuss with the patient or their legal representative about their will regarding withholding treatments that could be considered life-sustaining measures. These procedures include mechanical ventilation, high fraction of inspired oxygen (FiO2), use of vasoactive drugs, extra-renal dialysis, nutrition, hydration and transfer to the intensive care unit (ICU). These measures can only be withheld after the patient's or legal representative's informed consent is obtained and properly documented in the medical record, as explained in flowcharts 1 and 2 (Appendix) [5,21,28].

When appropriate, the assistant physician must clearly indicate in the medical record the objective of the treatment implemented and this information must be communicated to the entire team involved in health care. When there is no indication for DNR, but there is a definition for withholding some component of CPR, it is necessary to write a specific order indicating no endotracheal intubation and assisted ventilation, nonperformance of external cardiac compression or nonperformance of electrical cardiac defibrillation [28].

This definition must be registered in the medical record and indicated in the medical evolution heading and in the medical prescription in the care section. In case the patient is discharged from the hospital, it is necessary to register the definition of withholding some component of CPR and which treatments should be maintained in the recommendations and care section of the discharge note [28].

Withdrawing therapies

In appropriate circumstances, withdrawing medical treatment may be acceptable, even if it results in death. Thus, there may be discontinuation according to the will of the patient or of their legal representative, upon informed consent or a request previously presented by the patient (AD) [4,5].

The physician will register the definition of treatment maintenance whenever requests for withdrawal are inappropriate, that is, if they are in disagreement with bioethical precepts and could harm the patient. When a therapy considered a life-sustaining measure is withdrawn, the comfort of the patient and the psychological aspects of the patient, the family and the entire team involved in health care should be considered [28].

This definition must be registered in the medical record and indicated in the medical evolution heading and in the medical prescription in the care section. No health care professional will be obligated to participate in the care of a patient with withdrawn therapy if doing so violates their ethical, religious beliefs or professional integrity.

Similarly, the assistant physician is responsible for assembling a team willing to care for the patient and, in the event of conflicts, the hospital's bioethics committee can be contacted. In case there is evolution to hospital discharge, it is necessary to register the indication for withdrawal of treatments and which treatments should be maintained in the recommendations and care section in the discharge note [5,28].

Final considerations

The application of palliative care has been spreading rapidly; however, there are still methodological gaps to be filled. Adjusting and modifying the therapeutic practices of a medical team within a hospital requires the construction and implementation of formal, legally-based technologies. In addition, executing a TA protocol in a health care service and assigning professionals to monitor its application are essential factors in the implementation of humanistic and ethical practices.

Providing professionals with knowledge in the field of palliative care is essential to build a collective and horizontal discussion in the internal process

of work and decision-making by the physician and the multiprofessional health care team. Furthermore, patients empowered about their diagnosis and aware of the mechanisms that are available to them, such as AD, guarantee professionals and family members the certainty that their will is going to be complied with, preserving the human dignity inherent to all.

Thus, the TA protocol is a resource developed according to the guidelines of the Federal Council of Medicine (CFM) and based on bioethical, legal and clinical principles collected in the relevant literature. Therefore, it is characterized as a basis for changing paradigms involving new therapeutic technologies and possibilities.

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Melissa Agostini Lampert conducted the literature review and approved the manuscript for submission. Ariel Eduardo Billig wrote the manuscript and made corrections and adjustments. Luisiana Filipin Onófrio built the flowcharts and carried out the literature review. Grasiele Gallina Seeger wrote the abstract and revised the manuscript and references. Raquel Prado Thomaz participated in the writing and revised the manuscript.

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