



Model Policy on "Non-beneficial Treatment"

Lynette Cederquist, MD, [July 2009 "San Diego Physician" • Ethics in Medicine \(/publications/july-2009-san-diego-physician-%E2%80%A2-ethics-medicine\)](#)

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For most of us, facing the imminent death of a beloved family member can be the most heart-wrenching experience of our lives. Because most people still die in hospitals, they are usually receiving aggressive, life-sustaining treatments prior to death. Families have to grapple with decisions regarding withholding and withdrawing such support to allow their family member to die. These situations, unfortunately, often result in conflict between families and the healthcare team.

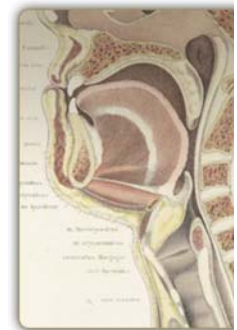
While no policy will ever make these decisions easy, they can certainly help guide clinicians through a difficult situation by establishing guidelines and standards of practice. There is ongoing debate within the bioethics field regarding who determines the point of futility and how that determination is reached, but the consensus of clinicians is that we must be able to set limitations of treatment based on our clinical experience and expertise. Expecting distraught family members to make such emotionally laden decisions, in my opinion, increases their burden of suffering as they are trying to come to terms with a major loss. My experience has been that some family members feel compelled to "demand everything" as a way of expressing their love and devotion to their family. In the majority of cases, they do in the end accept limitations set by a caring, communicative clinician.

Some physicians use the rationale of legal liability when they continue treatment they feel is no longer beneficial but that the family demands. Last year, we had one of our University of California lawyers review all of the cases filed against University of California Medical Centers, and she did not identify one successful lawsuit based on limitation of life-sustaining treatment based on futility determination. Thus, I am convinced that our fears are way out of proportion to reality and result in excessive, burdensome treatment.

The San Diego Bioethics Commission, chaired by Lynette Cederquist, MD, (UCSD), and Paula Goodman-Crews, LCSW (Kaiser Permanente), was developed within the San Diego County Medical Society with a vision of bringing together San Diego's medical community to develop standards in bioethics practices. So far, our commission has representation from UCSD, Kaiser Permanente, Sharp Grossmont, Sharp Coronado, the Veterans Health Administration, Rady Children's Hospital, Sharp Grossmont, Sharp Memorial, Sharp Mission Park, Scripps Mercy, Edgemoor, Navy Medical Center, San Diego Hospice, Silverado Hospice, Scripps La Jolla, and Palomar Medical Center. The first issue the commission has tackled is "non-beneficial treatment," also referred to as "medical futility." This is an issue with which every hospital and every ethics committee wrestles on a regular basis.

In a recent review of UCSD's ethics consultations, close to 50 percent of consults were requested because of conflicts surrounding perceptions of medical futility or medically ineffective treatment. This has been identified by all of the commission's participants as a major source of conflict, especially intractable cases that are not remediated by ethics facilitation. The nearly universal consensus has been that when faced with cases where physicians have determined treatment is non-beneficial, but the patient or surrogate continues to insist on treatment, most physicians continue treatment. Physicians tend to default to continuation of treatment even if their institution's policies support withdrawal of non-beneficial treatment. We believe that by developing a community standard to guide policy, each individual institution's policies and practices will be better enforced.

Last year, after input from all the members of the commission, we adopted our first model policy: "Model Hospital Policy on Non-beneficial Treatment and Conflict Resolution." This is a major step toward establishing a community standard. Bioethics Commission members will now be able to take this policy back to their individual institutions, with the added force of community consensus.



Model Hospital Policy on Non-beneficial Treatment and Conflict Resolution

I. Abstract

Frequently, conflicts arise when parties disagree on the best course of action in the care of a patient. If the treating team believes that:

1. continuing treatment is non-beneficial, or
2. the burden of suffering and intrusiveness of treatment significantly outweighs any potential benefit, or
3. a treatment is contrary to generally accepted medical standards,

but the patient or surrogate continues to request the disputed treatment, steps must be taken to resolve the dispute.

II. Definitions:

1. **Medically Non-beneficial (Futile) Treatment:** Medical treatment that has no realistic chance of providing a therapeutic benefit that the patient has the capacity to perceive or appreciate, such as merely preserving the physiologic functions of a permanently unconscious patient, or has no realistic chance of returning the patient to a level of health that permits survival without acute level of care or hospital setting.
2. **Responsible Physician:** The attending physician whose responsibility it is to make most major medical decisions with the patient.
3. **Surrogate/Agent:** An individual designated to make healthcare decisions on behalf of an unemancipated minor (usually a parent) or an adult patient who lacks the capacity to make such decisions. In cases where there is no legally designated agent via an advance directive, the physician will identify the most appropriate surrogate based on his or her determination of the person who has demonstrated the most knowledge of the patient's wishes and values, and can best provide substituted judgment.

III. Principles

1. Healthcare providers are obligated to respect patient autonomy and patient's or surrogate's informed decisions and directives about treatment to the extent that those decisions/directives are consistent with medically appropriate treatment. Patients with decision-making capacity or their surrogate always have the right to refuse treatment.
2. A healthcare provider or institution is not obligated to comply with healthcare instruction(s) or decision(s) that requires non-beneficial treatment or treatment contrary to generally accepted healthcare standards.
3. Healthcare providers are obligated to ensure optimal comfort care at all times throughout the course of treatment.

IV. Determination of Treatment Plan

1. The responsible physician will determine whether a treatment is appropriate. The responsible physician or his/her designee should discuss the patient's diagnosis and prognosis, appropriate treatment options, including the efficacy of each treatment alternative and its risks and benefits, and the patient's goals for treatment with the patient and/or surrogate so that the patient or surrogate can make an informed decision. The responsible physician or his/her designee should also discuss what falls within appropriate and inappropriate treatment and acceptable limits for the physician, patient, and institution. To the extent possible, joint decision-making should occur between the patient or surrogate and responsible physician in making a judgment of non-beneficial or excessively burdensome treatment.
2. When the responsible physician makes a judgment that treatment is non-beneficial or excessively burdensome, he or she should inform the patient or surrogate of the judgment, the medical rationale supporting it, the alternative treatment options, and their likely outcomes. The responsible physician should recommend that the treatment be withheld or withdrawn and explain that all medically appropriate and optimal comfort care will continue to be provided.
3. With the patient's or surrogate's consent, the non-beneficial treatment may be withdrawn or withheld in compliance with applicable procedures.
4. The discussions noted in paragraphs 1 and 2 above should be documented in the patient's medical record.

V. Conflict Resolution Process:

Typically, there are three forms of conflict: 1) intra-professional (between members of the treating team); 2) intra-familial; and 3) between the treating team and the patient/surrogate. Depending on the form of conflict, the following steps should be taken:

1. If conflict arises among members of the treating team, such as a dispute between nursing and physician(s), a team meeting should be held to discuss the case and try to arrive at a consensus regarding the treatment plan.
2. If conflict arises between family members, or between the physician and the patient or surrogate, a family conference should be held along with the treating team, including the nurses, physicians, social worker, and chaplain to attempt to achieve consensus regarding prognosis, goals of care, and treatment plan.
3. When the responsible physician, after consensus of the treating team, determines that a treatment is non-beneficial, he or she should inform the patient or surrogate of this determination, including the rationale supporting this determination. The attending physician should recommend that the non-beneficial treatment(s) be replaced with optimal comfort/palliative care while reassuring the family that the patient will not be abandoned.
4. If the conflict persists, the responsible physician should offer to seek another opinion from an additional physician with the appropriate expertise, with input from the patient/surrogate about the choice of the physician who will provide the second opinion. In addition, the patient/surrogate may seek counsel and input from other individuals to provide spiritual counsel or social support.

5. If the conflict persists, or if at any point in the process a values conflict is identified, an ethics consultation should be requested. The ethics consultant may meet with the members of the treating team as well as the patient/surrogate. The role of the ethics consultant is to apply bioethical principles to help facilitate a resolution of the conflict.
6. If the conflict persists, the case will be presented to an ad-hoc meeting of the Ethics Committee to review the case. The patient/surrogate should be given the opportunity to participate in the Ethics Committee case review.
7. If the Ethics Committee supports the treating physician's determination that certain proposed treatments are non-beneficial, the patient/surrogate should be informed of this determination. Once the determination is made that a particular treatment is non-beneficial, that treatment will not be provided at this hospital.
8. If the patient/surrogate still disagrees with withdrawing/withholding the disputed treatment, the patient/surrogate will be allowed a reasonable period of time to:
 - a. arrange transfer to another hospital that is willing to comply with their treatment choices, or
 - b. commence legal proceedings regarding the decision to limit treatment.
9. If the Ethics Committee does not support the physician's determination, and the physician chooses not to provide the treatment, the patient/surrogate will be offered transfer of care to another physician who is willing to offer treatment. Until transfer is accomplished, the treating physician is responsible for continuing treatment.