Jahi Mcmath & Medical Futility: California Law on Therapeutic Obstinacy & Non-Beneficial Treatment

UCLA • February 25, 2014

Thaddeus Mason Pope, J.D., Ph.D.
Hamline University Health Law Institute

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Preface

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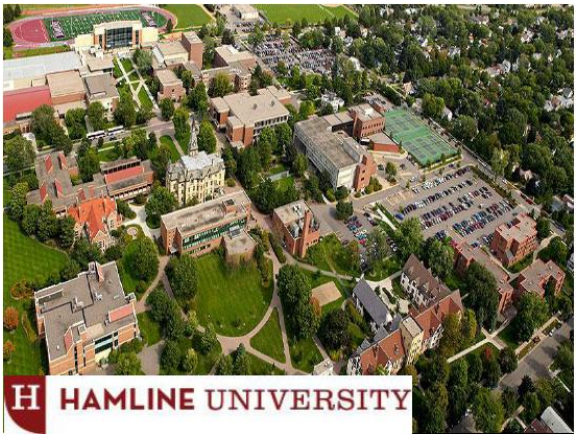
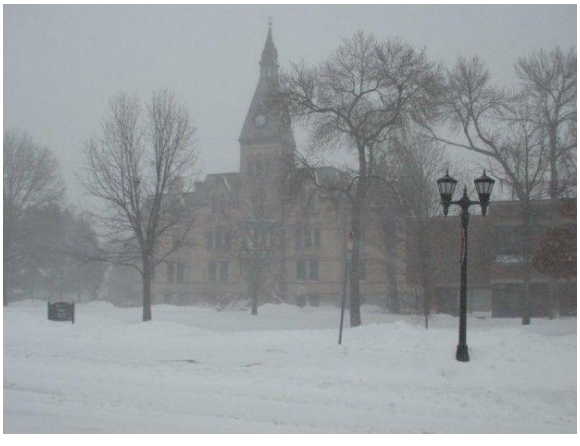
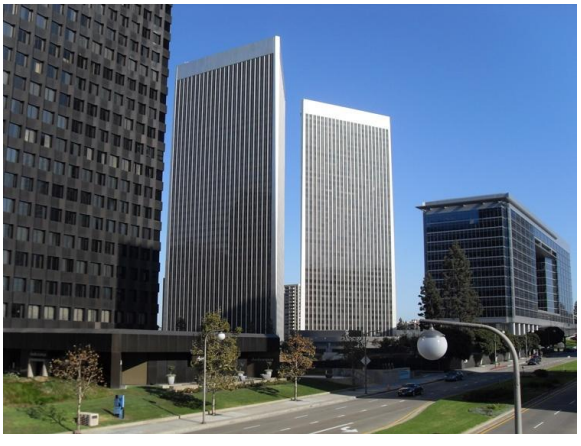
NO relevant personal financial relationships or intent to discuss an off-label / investigative use of a commercial product or device.

3







LACBA

LOS ANGELES COUNTY BAR ASSOCIATION

My talk

8

Orientation

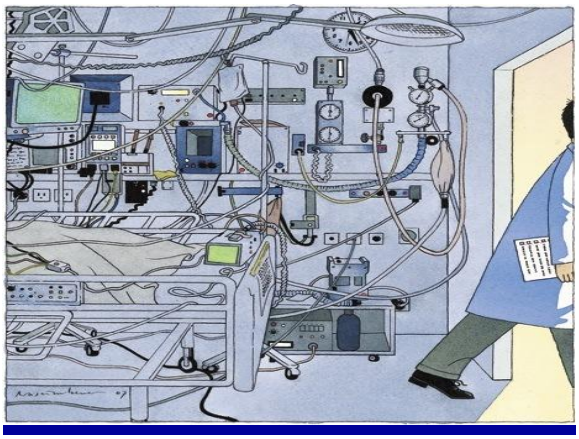
9

"I'm afraid there's really very little I can do."

Surrogate driven over-treatment

11

Clinician	Surrogate
CMO	LSMT



End
orientation

15

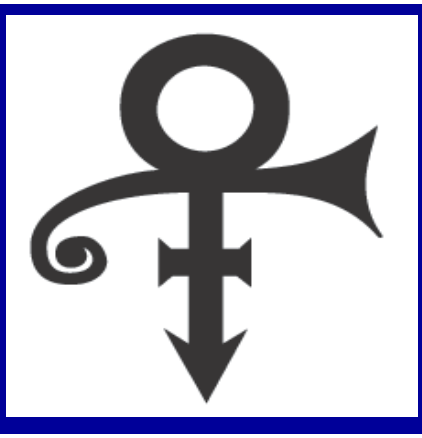
1. Vocabulary
2. Prevalence
3. Causes
4. Prevention

5. Consensus

6. Intractable

Vocabulary

20



21

1. Futile
2. Inappropriate
3. Provisionally inappropriate

28

Futile treatment	Interventions that cannot accomplish the intended physiological goals	1) Clinicians should explain that the requested treatment is ineffective and explore the surrogates' reasons for the request. 2) If conflict persists or if there is any doubt about the futility determination, clinicians should consult another qualified provider to evaluate the case. 3) Clinicians should consider expert consultation to mediate the conflict. 4) Institutions should retrospectively review the case to identify opportunities to prevent future similar occurrences.	1. A surrogate requests antibiotics as treatment for an acute MI in a critically ill patient. 2. A clinician refuses to provide CPR in a patient with rigor mortis.

Inappropriate Treatment	Treatments which may accomplish an effect desired by the patient, but for which there are widely accepted rules that prohibit their use	1) Clinicians should work to understand the reason for the request and clearly communicate the rule that governs the request. 2) Clinicians should involve individuals with expertise in interpreting existing regulations to ensure the rule is correctly interpreted and applied. 3) Clinicians should consider involving expert consultants to assist in clear communication and psychosocial support. 4) Institutions should retrospectively review these cases to identify opportunities to prevent future similar occurrences.	1. A surrogate requests long term ventilator support to a patient who is brain dead (in a state in which there are statutes permitting unilateral cessation of treatment in brain dead patients). 2. A surrogate requests that clinicians circumvent the lung organ allocation policy to help a critically ill patient get faster access to an organ for transplantation. 3. A patient requests a prescription for a lethal dose of barbiturates (in states where PAS is illegal).

Provisionally Inappropriate Treatment	Treatments that have at least some chance of accomplishing the effect sought by the patient or surrogate and are not prohibited by an existing rule, but medical professionals believe that competing ethical considerations justify treatment refusal.	Dispute resolution should be accomplished via the process outlined in recommendation 3 and in **Table 3**.	1. A surrogate requests ongoing mechanical ventilation for a patient with widely metastatic cancer and refractory multi-organ failure with progressive extremity necrosis from high-dose vasopressors. 2. A surrogate requests initiation of dialysis for a patient in a persistent vegetative state

Figure 1- Recommended approach to the management of disputed requests in ICUs

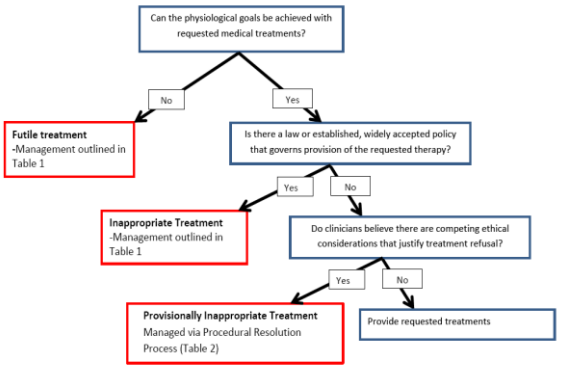


Table 2- Model policy highlighting procedural steps for resolution of conflict regarding life-sustaining treatments

1)	Prior to initiation of and throughout the formal dispute resolution procedure, clinicians should enlist expert consultation to aid in achieving a negotiated agreement.
2)	Surrogate(s) should be given clear notification in writing regarding the initiation of the formal conflict resolution procedure and the steps and timeline to be expected in this process.
3)	Clinicians should obtain a second and independent medical opinion to verify the diagnosis and prognosis.
4)	There should be case review by an interdisciplinary institutional committee.
5)	If the committee agrees with the clinicians, then clinicians should offer the option to seek a willing provider at another institution and should facilitate this process.
6)	If the committee agrees with the clinicians and no willing provider can be found, surrogate(s) should be informed of their right to seek appeal to an independent body.
7a)	If no willing provider can be found and the surrogate does not seek independent appeal or the appeal affirms the clinicians' position, clinicians may withhold or withdraw the contested treatments, and should provide high quality palliative care.
7b)	If the committee agrees with the patient or surrogate's request for life prolonging treatment, clinicians should provide these treatments or transfer the patient to a willing provider.

Original Investigation

The Frequency and Cost of Treatment Perceived to Be Futile in Critical Care

Thanh N. Huynh, MD, MSHS; Eric C. Kleerup, MD; Joshua F. Wiley, MA; Terrance D. Savitsky, MBA, MA, PhD; Diana Guse, MD; Bryan J. Garber, MD; Neil S. Wenger, MD, MPH

JAMA Intern Med. 2013;173(20):1887-1894. doi:10.1001/jamainternmed.2013.10261
Published online September 9, 2013.

1. No meet patient goal
2. Imminent death
3. Permanent unconscious
4. No survive outside ICU
5. Burden > benefit

35

Value laden

36

Prevalence

37

"Conflict . . .in ICUs . . . epidemic proportions"

38

Original Investigation

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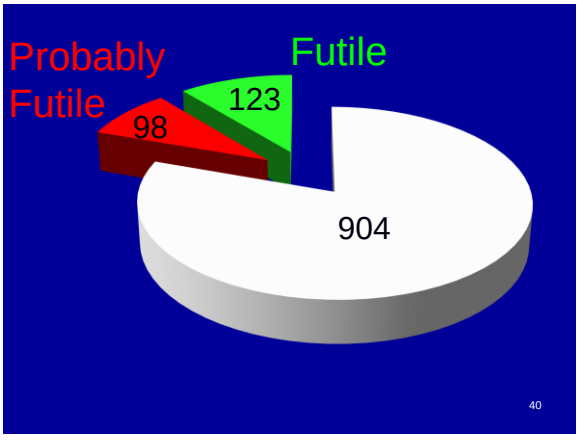

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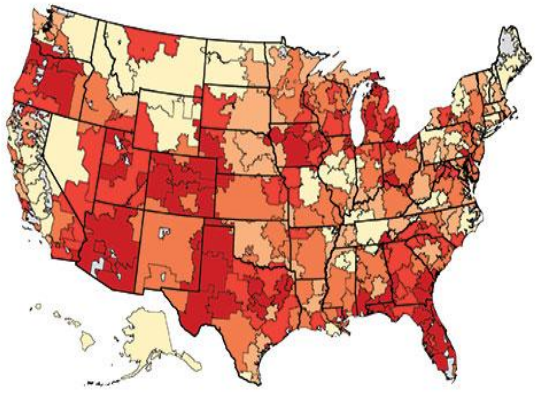
Clinician driven over-treatment

41



Causes

43

Question and Responses[a]	Public, % (n=1006)	Professionals, % (n=774)
If doctors believe there is no hope of recovery, which would you prefer?		
Life-sustaining treatments should be stopped and should focus on comfort	72.8	92.6
All efforts should continue indefinitely	20.6	2.5

1. Surrogate demand
2. Provider resist

45

Surrogate demand

46

Cognitive

47

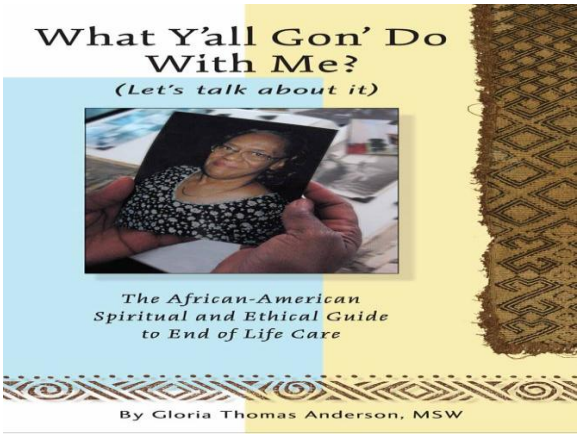
Iatrogenic

- Inadequate communication
- Uncoordinated, conflicting
- Undue pressure

49

Mistrust

50

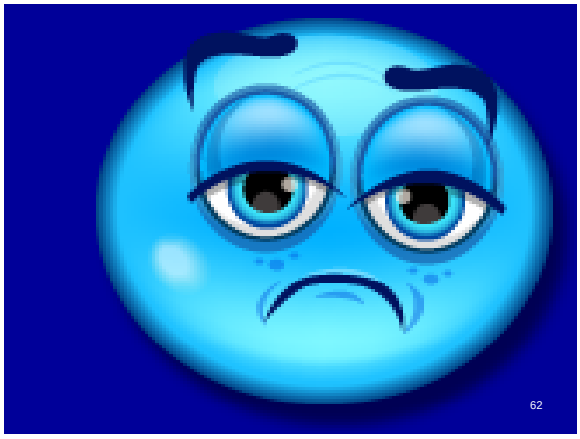


Emotional Barriers

56

Psychological Barriers

60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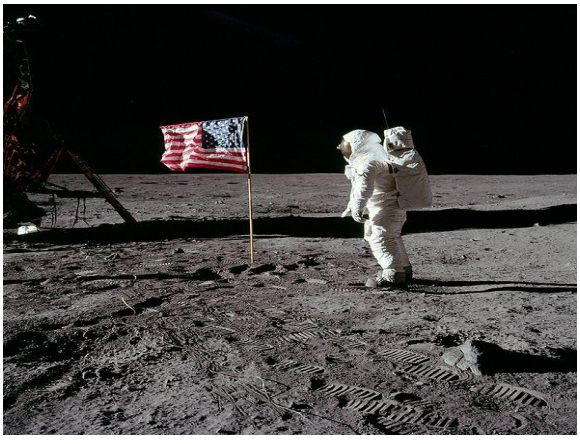
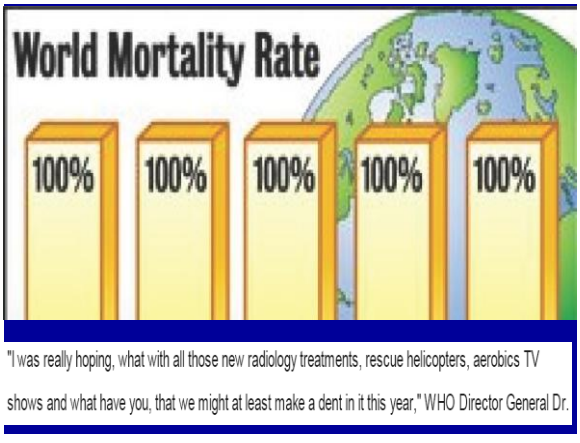
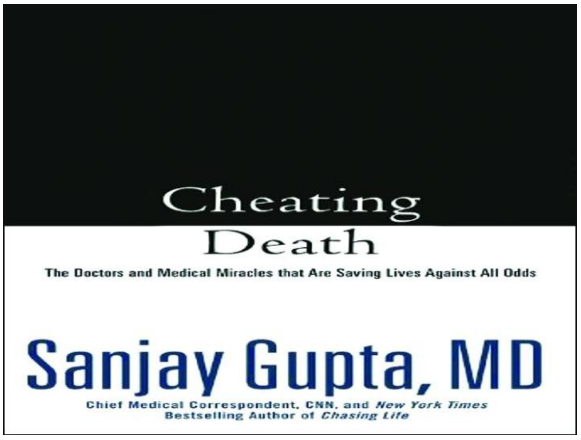
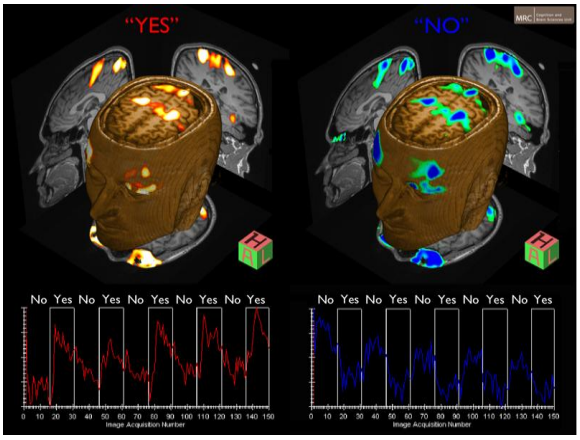



World Mortality Rate
100%
100%
100%
100%
100%
"I was really hoping, what with all those new radiology treatments, rescue helicopters, aerobics TV shows and what have you, that we might at least make a dent in it this year," WHO Director General Dr.


Never give in, never give in, never, never, never, never, . . .


Cheating
Death
The Doctors and Medical Miracles that Are Saving Lives Against All Odds
Sanjay Gupta, MD
Chief Medical Correspondent, CNN, and New York Times
Bestselling Author of Chasing Life


"YES"
"NO"
No Yes No Yes No Yes No Yes No Yes
No Yes No Yes No Yes No Yes No Yes

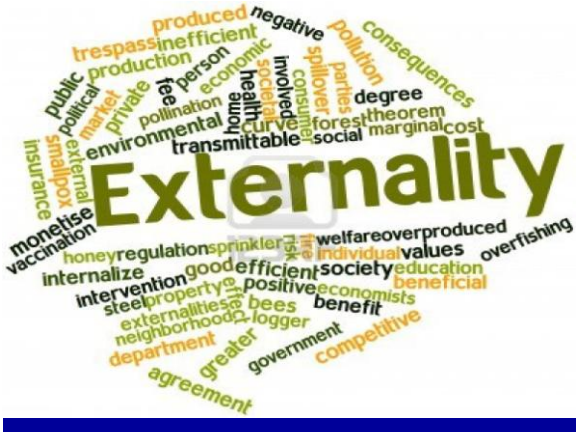

Ceci n'est pas une pipe.


autonomy

Religion

72

Question and Responses[a]	Public, % (n=1006)	Professionals, % (n=774)
If the doctors treating your family member said futility had been reached, would you believe that divine intervention by God could save your family member?		
Yes	57.4	19.5
No	35.5	61.1



PewResearchCenter

NUMBERS, FACTS AND TRENDS SHAPING THE WORLD

NOV. 21, 2013

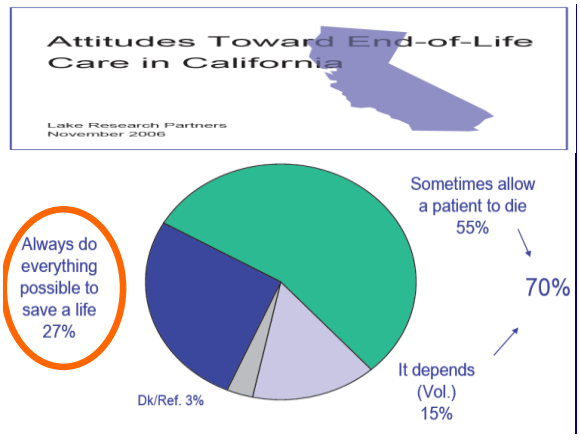
Views on End-of-Life Medical Treatments

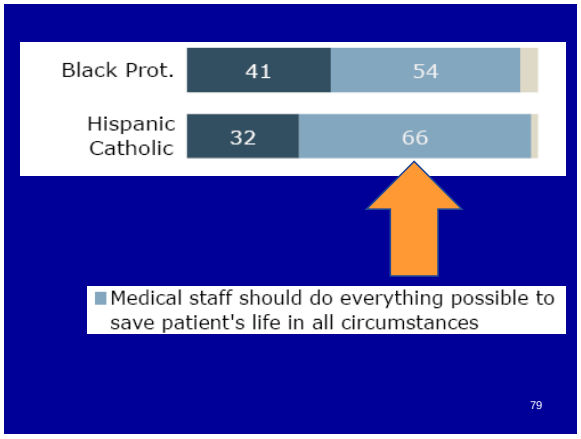
Growing Minority of Americans Say Doctors Should Do Everything Possible to Keep Patients Alive

Views About End-of-Life Treatment Over Time

% of U.S. adults

	1990	2005	2013	Diff. 90-13
Which comes closer to your view?				
There are circumstances in which a patient should be allowed to die	73	70	66	-7
Doctors and nurses should do everything possible to save the life of a patient in all circumstances	15	22	31	+16
Don't know	12	8	3	-9
	100	100	100	



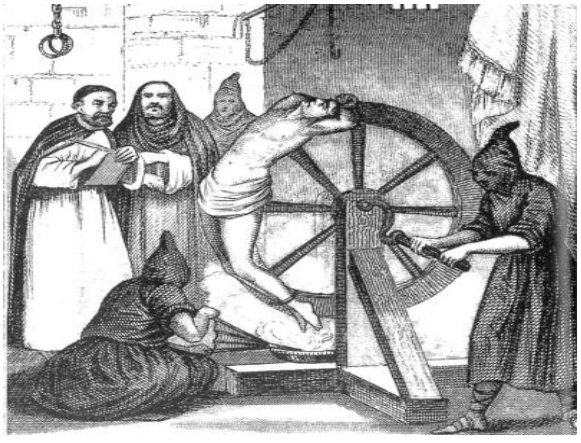


Clinicians resist

80

Avoid patient suffering

81



"This is the Massachusetts General Hospital, not Auschwitz."

Moral distress

85

Absenteeism

Retention

Quality

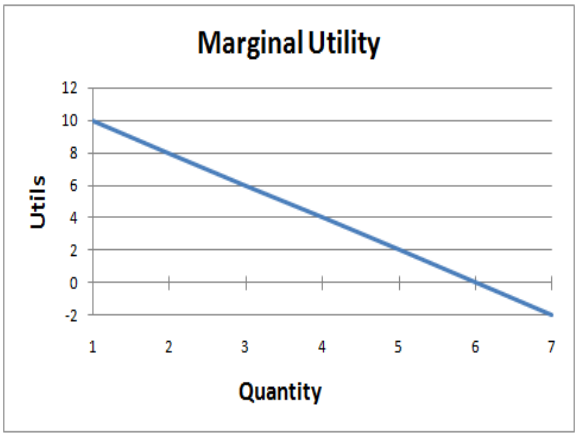
87

Integrity of profession

88

Stewardship

91



Distrust surrogate

94

66% accurate

50% = pure chance

96

Prevention

97

71%: "More important to enhance the **quality** of life for seriously ill patients, even if it means a **shorter life.**"

National Journal (Mar. 2011)

99

Question and Responses[a]	Public, % (n=1006)	Professionals, % (n=774)
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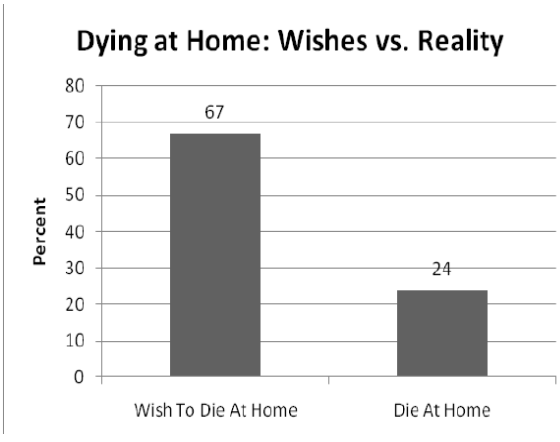
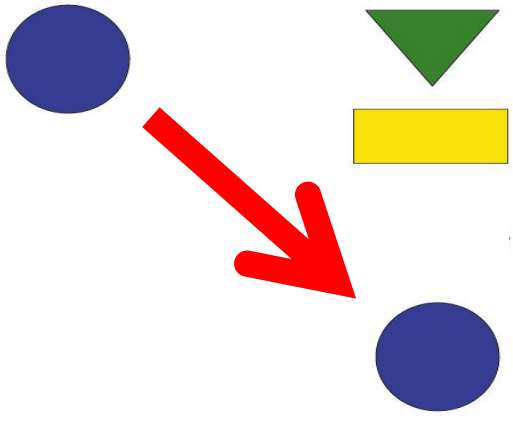
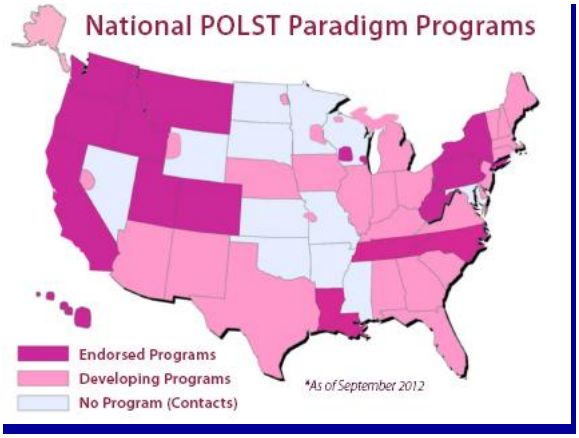






113TH CONGRESS
1ST SESSION

H. R. 1173

To amend the Social Security Act to provide for coverage of voluntary advance care planning consultation under Medicare and Medicaid, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MARCH 14, 2013

Mr. BLUMENAUER (for himself, Mr. HANNA, Mr. ROE of Tennessee, Mr. REED, Ms. SCHWARTZ, Mr. KIND, Mr. GEORGE MILLER of California, Mr. MCDERMOTT, Mr. HERA of California, Ms. SCHAKOWSKY, and Mrs. CAPPS) introduced the following bill, which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

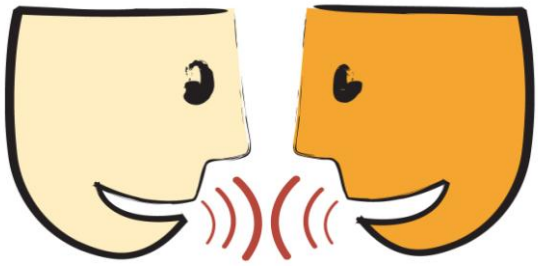
A BILL

To amend the Social Security Act to provide for coverage of voluntary advance care planning consultation under Medicare and Medicaid, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; FINDINGS; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Personalize Your Care Act of 2013".



EOL disclosures (NY, CA, MI, VT)

ASCO® American Society of Clinical Oncology
Making a world of difference in cancer care

Limited effectiveness

Side effects

Options

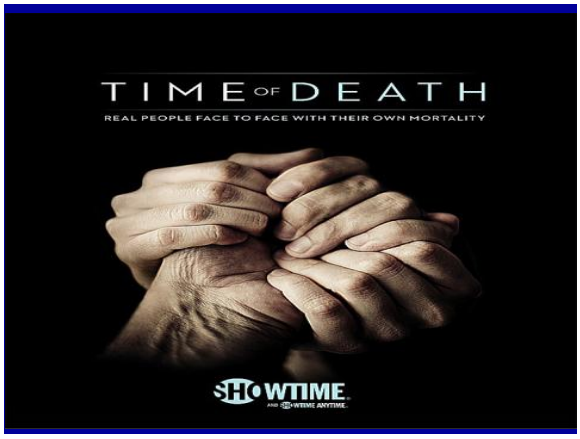
107

Choosing Wisely®

An initiative of the ABIM Foundation

IPDAS

International Patient Decision Aid Standards Collaboration



Limits to Prevention

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PewResearchCenter

NUMBERS, FACTS AND TRENDS SHAPING THE WORLD

NOV. 21, 2013

Views on End-of-Life Medical Treatments

Growing Minority of Americans Say Doctors Should Do Everything Possible to Keep Patients Alive

30%

113

18-29	15%
30-49	33%
50-64	38%
65-74	61%
75+	58%

Pew Research Center, November 2013, "Views on End-of-Life Medical Treatments"

114

Consensus

115

1. Negotiation & Mediation
2. Transfer
3. New Surrogate

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Negotiation

Mediation

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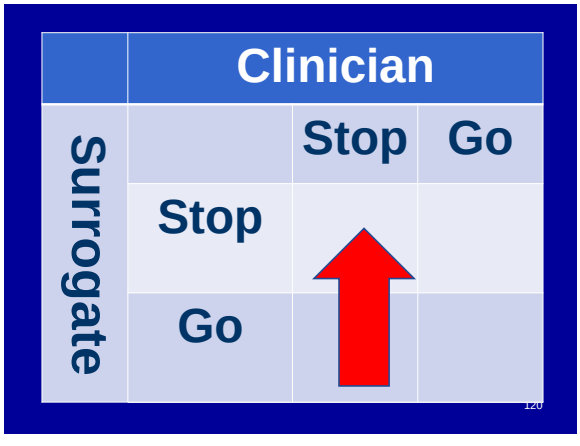
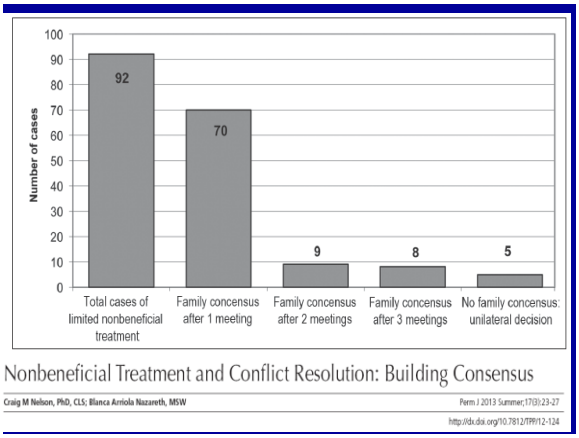


120

95%

121



Prendergast (1998)

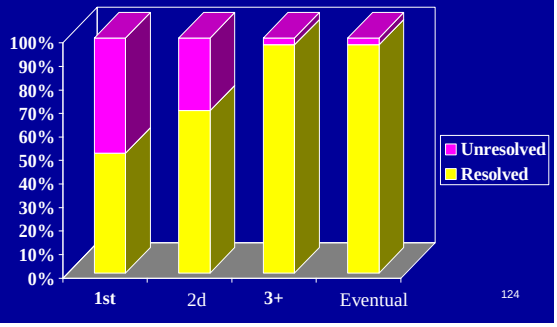
57% agree immediately

90% agree within 5 days

96% agree after more meetings

123

Garros et al. (2003)



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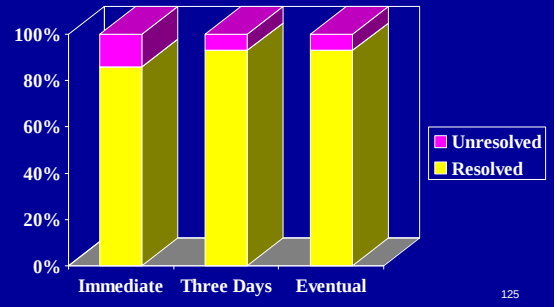
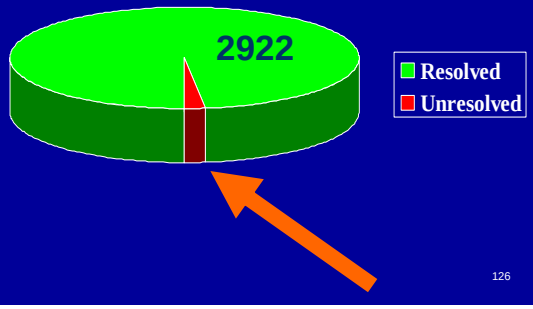
Fine & Mayo (2003)



125

Hooser (2006)



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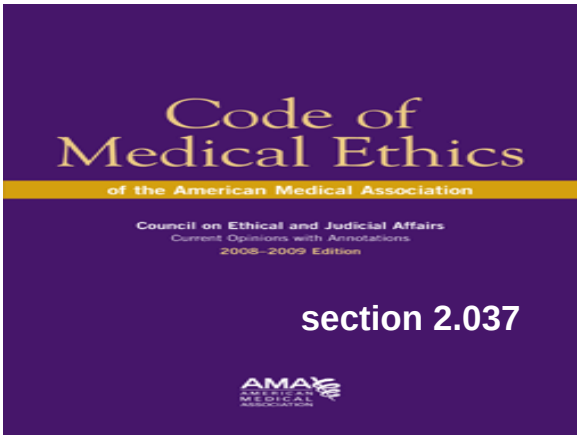

1. Earnest attempts . . .
   deliberate . . .
   negotiate . .
2. **Joint** decision-making
   . . . maximum extent . .

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3. Attempts . . .
   negotiate . . .
   reach resolution . . .
4. Involvement . . .
   ethics committee . . .

129

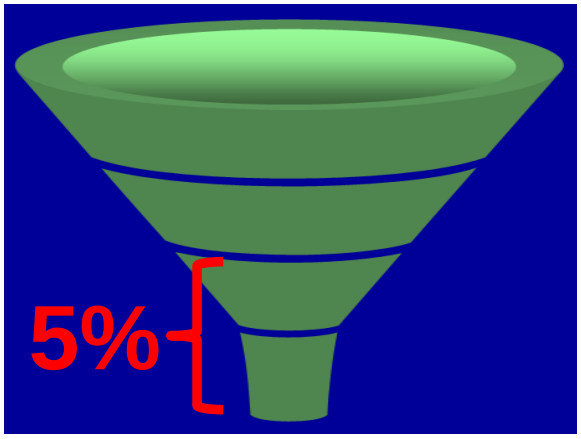
95%

131

Consensus

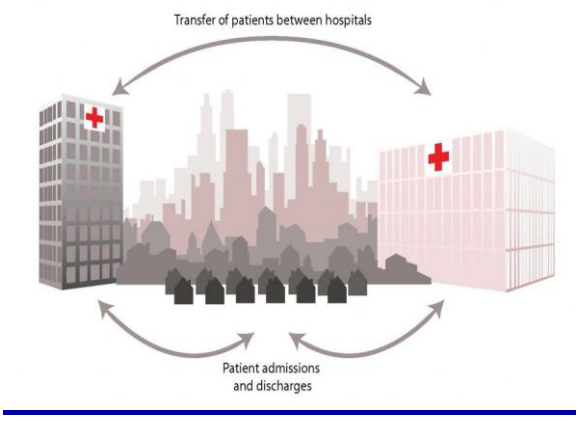
Intractable

132



Transfer

135



	Clinician	
Surrogate	Stop	Go
Stop		
Go		

137

Rare, but possible

138

Replace Surrogate

139

	Clinician		
		Stop	Go
Surrogate	Stop		
	Go		

140

Substituted judgment

Best interests

141

Cal. Prob. Code 4684, 4714

"... in accordance ... health care instructions ... and other wishes ... otherwise, ... in accordance with ... best interest."

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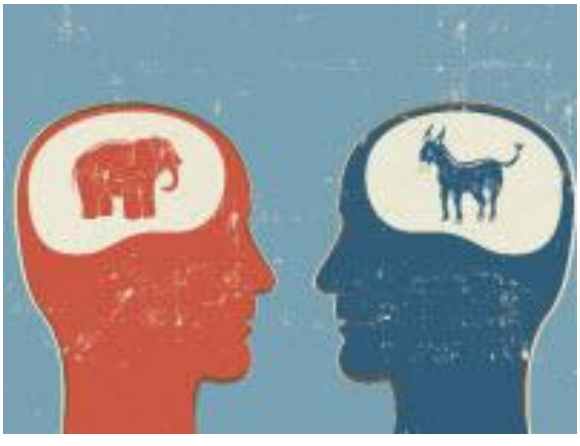


~ 60%

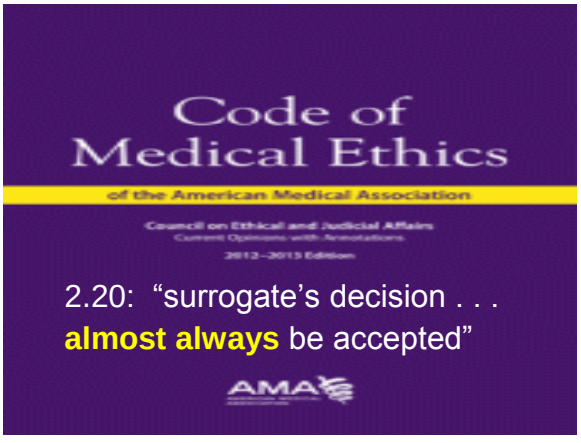
accuracy

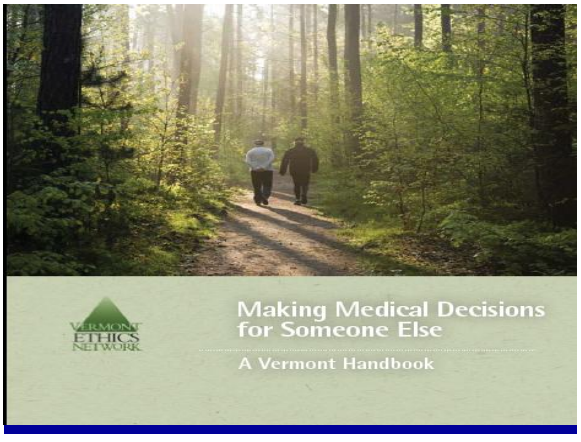
More

aggressive treatment

146

Improve Surrogate Accuracy





Cal. Prob. Code 4766(c)

"petition . . . whether . . . agent or surrogate . . . **consistent** . . . patient's desires . . . best interest."

151

Cal. Prob. Code 4740(b)

"Declining to comply with a health care decision of a person based on a belief that the person then **lacked authority**."

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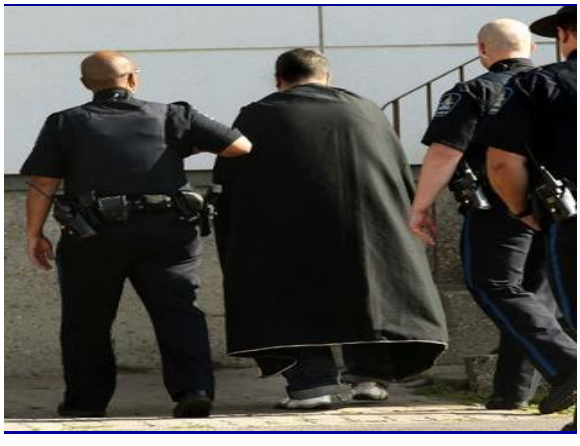
Reasons to Replace

154



Surrogate	Advance directive
GO	STOP

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State of Minnesota

County of Hennepin

FILED
11 FEB -4 PM 1:32
BY: PROBATE/MENTAL HEALTH
FOURTH DISTRICT COURT

District Court
Probate Division
Judicial District: Fourth
Court File No. 27-GC-PR-111-16

In Re: Emergency Guardianship of

Albert N. Barnes,
Respondent

Order Appointing Emergency Guardian

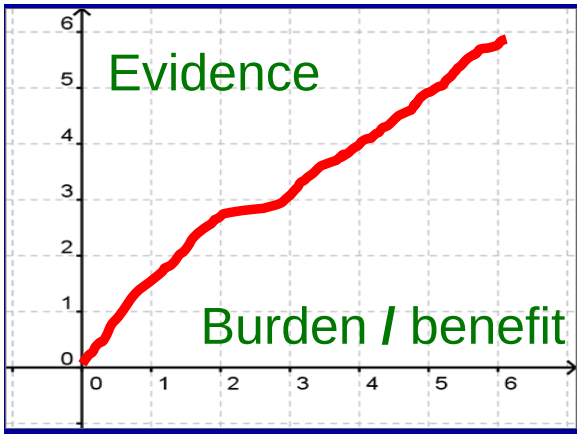
This matter came on for hearing on February 2, 2011 before the District Court on a petition seeking an emergency appointment of a guardian for the Respondent named above. The matter, having been considered by the Court and the Court being duly advised in the premises now makes the following:

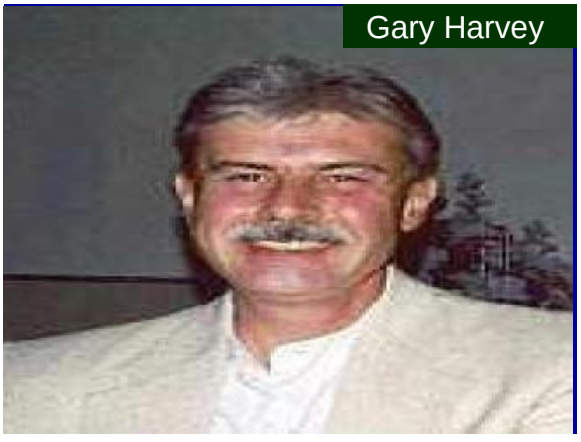
FINDINGS OF FACT

Bernstein v. Superior Court of Ventura County (Feb. 2, 2009).

Surrogate	Best interests
GO	STOP

164





"failed to follow medical advice"

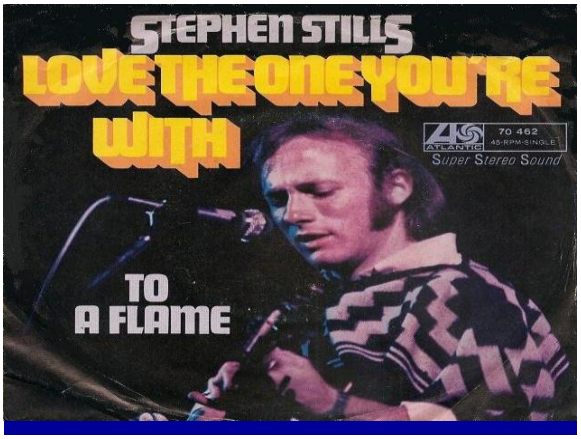
"failed to use good judgment"

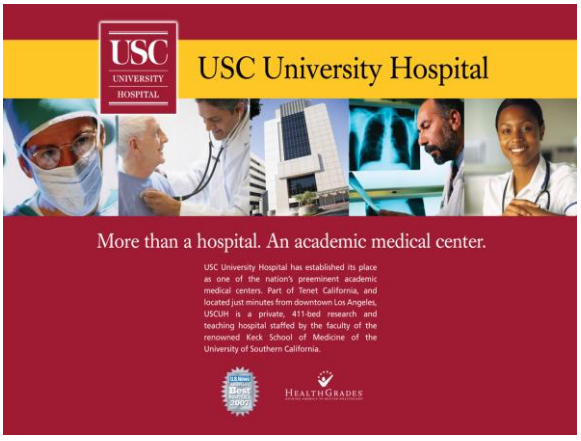
Your own personal issues are “impacting your decisions”

“Refocus your assessment”

Option

Duty





Plascentia McDonald, 74yo

Advance directive:

1. Bobby is agent
2. Cynthia is alternate
3. “Do No prolong life if incurable condition”

Aug. 14

Surgery
thoracoabdominal aneurysm

Post-op infections

Aug. 30

Sepsis, non-cognitive

Continued LSMT

3 additional surgeries

Disagrees w/ brother

USC: Probate Code 4740 immunizes providers who "in good faith comply with a health care decision made by one whom they believe authorized."

Court: "Compliance with agent's decision . . . **at odds** with the patient's own . . . AHCD . . . **not** qualify as in good faith."

Agent **not** authorized to depart from AD

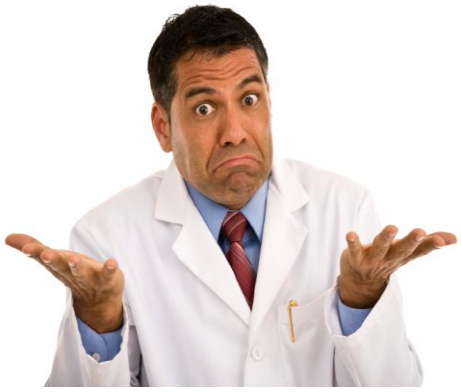
USC should have known that

Limits of surrogate replacement

180

1

Providers cannot show deviation



2

Surrogates get benefit of doubt

Cal. Prob. Code 4733

"provider . . . **shall comply** . . . instruction . . . decision"

184

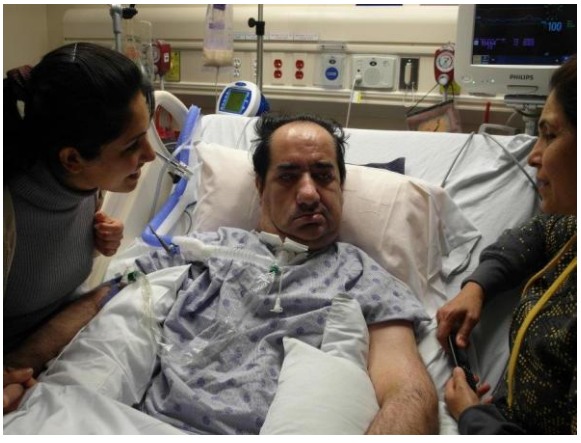
3

Surrogates are faithful

Ontario

Consent and Capacity Board

188



Intractable Conflict

192

1. Covert
2. Cave-in
3. Unilateral stop

Covert

194

Without legal support to w/d or w/h openly and transparently, some do it covertly.

PROPORTION OF PHYSICIANS (n = 726) WHO WITHHELD LIFE-SUSTAINING TREATMENT ON THE BASIS OF MEDICAL FUTILITY

Consent Status	n (%)
Without the written or oral consent of the patient or family	219 (25%)
Without the knowledge of the patient or family	120 (14%)
Despite the objections of the patient or family	28 (3%)

D. Asch, ***Am. J. Resp. Crit. Care Med.*** (1995)

Providers have **won almost every single** damages case for unilateral w/h, w/d

198

IIED

199

Secretive

Insensitive

Outrageous

200

"provider . . . that declines to comply . . . **shall . . . promptly so inform** . . ."

Prob. Code § 4736

201

Cave-in

202

Perceptions of "futile care" among caregivers in intensive care units

Robert Sibbald MSc, James Downar MD, Laura Hawryluck MD MSc

CMAJ 2007;177(10):1201-8

"Why they follow the . . . SDMs instead of doing what they feel is appropriate, almost all cited a **lack of legal support."**

203

"Remove the ___, and I will **sue you**."

204

Easier to cave-in

- Patient will die soon
- Provider will round off
- Nurses bear brunt

207

Civil liability

- Battery
- Medical malpractice
- Informed consent
- State HCDA
- EMTALA

209

Licensure discipline

Criminal liability

- *e.g.* homicide

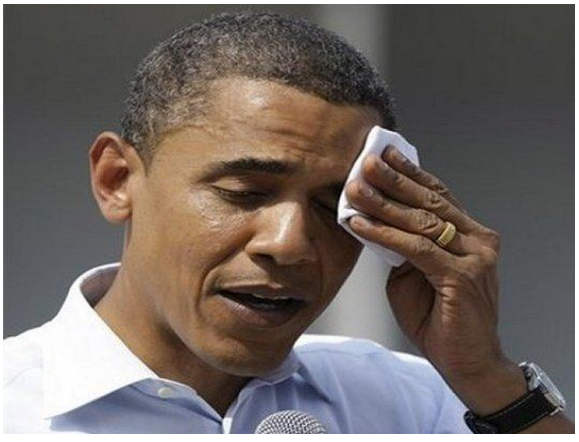
210

Legal Risk

211

Few cases

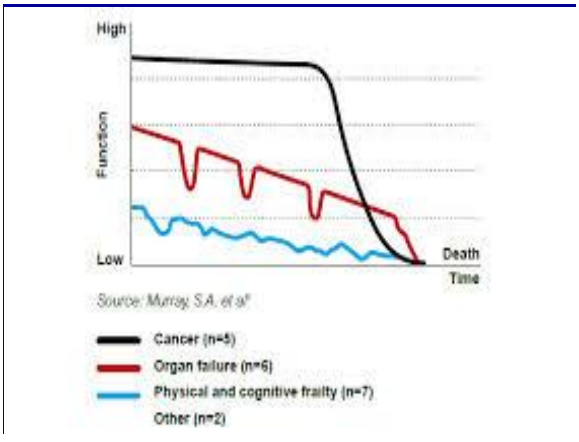
212

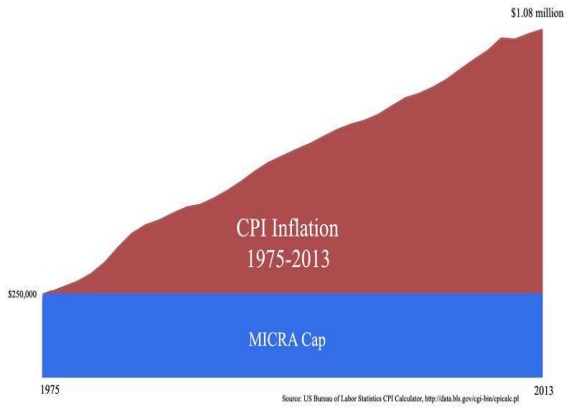


214

$250,000

215





Nov. 2014

218

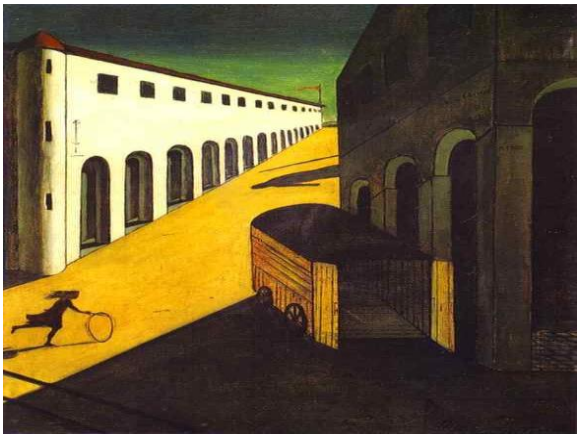
Few successful

219

A thorough and accurate medical record is evidence that the doctor provided appropriate care and can be strong evidence that the physician complied with the standard of care.

BUT

221



Risk > 0

223

Manning (Idaho 1992)
Rideout (Pa. 1995)
Bland (Tex. 1995)
Wendland (Iowa 1998)
Causey (La. 1998)

224

ALLIANCE DEFENSE FUND
Defending Our First Liberty

226

Liability averse

Litigation averse

227

Process = punishment

Even prevailing parties pay **transaction costs**

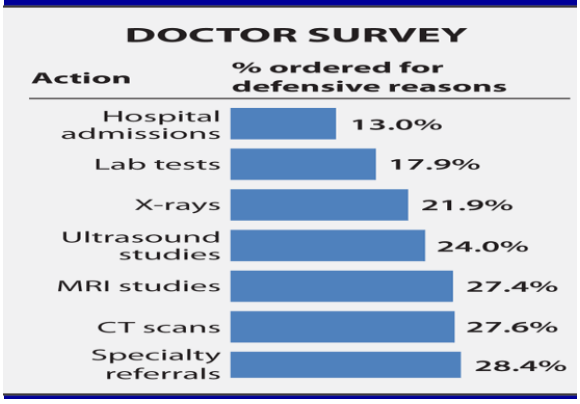
- Time
- Emotional energy

228

Defensive Medicine

229

Mass. Med. Society (Nov. 2008)



Bad law

231

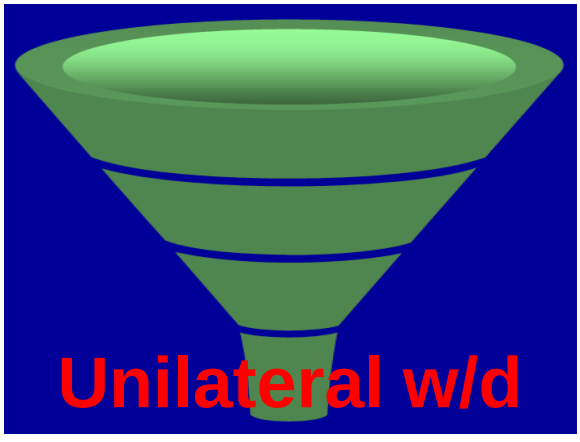
Safe Harbor®

"in the medical environment . . . practically everything is regulated; regulation is the default, and only what is regulated is considered safe and acceptable."

234

Stop without consent

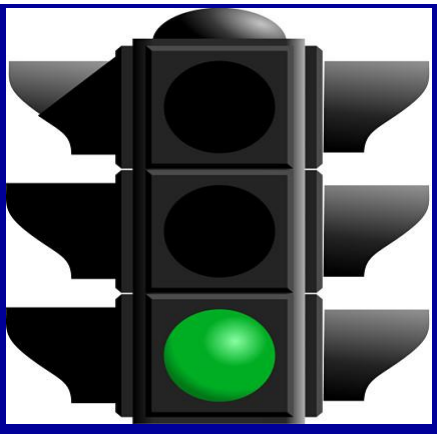
235



239

Green

240

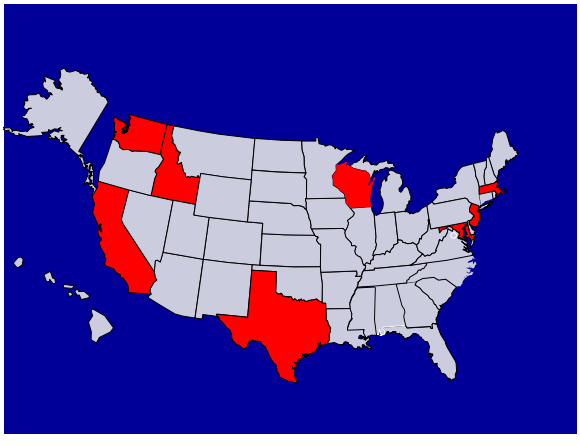


You may stop LSMT for **any reason**

- with immunity
- if your HEC agrees

Tex. H&S 166.046

1. 48hr notice
2. HEC meeting
3. Written decision
4. 10 days to transfer
5. Unilateral WH/WD



Resolution 505-08 TITLE: LEGAL SUPPORT FOR NONBENEFICIAL TREATMENT DECISIONS

Author: H Hugh Vincent, MD; William Andereck, MD

Introduced by: District 8 Delegation

Endorsed by: District 8 Delegation

CA

Reference Committee E

October 4-6, 2008

WASHINGTON STATE MEDICAL ASSOCIATION
HOUSE OF DELEGATES

WA

Resolution: C-5 (A-09)

Subject: Legal Protection for Physicians When Treatment is Considered Futile

Introduced by: King County Medical Society Delegation

Referred to: Reference Committee C

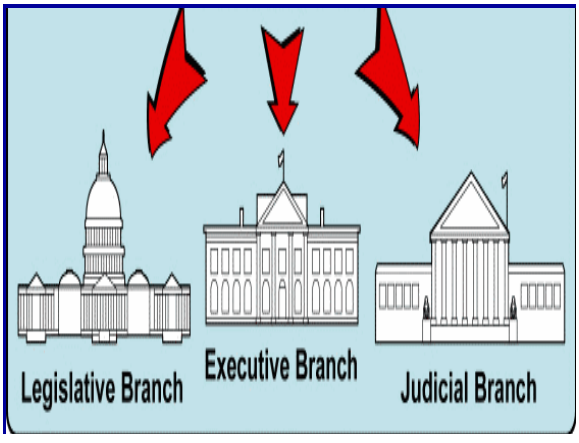
RESOLUTION 1 - 2004
(read about the *action* taken on this resolution)

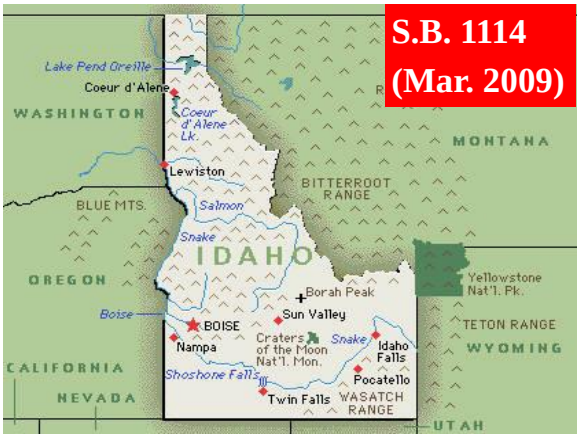
WI

Subject: Futility of Care

Introduced by: Michael Katzoff, MD and the Medical Society of Milwaukee County

RESOLVED, That the Wisconsin Medical Society, concurrent with a recommendation of the American Medical Association, Medical Futility in End-of-Life Care policy E-2.037, supports the passage of state legislation which establishes a legally sanctioned extra-judicial process for resolving disputes regarding futile care, modeled after the Texas Advanced Directives Act of 1999.

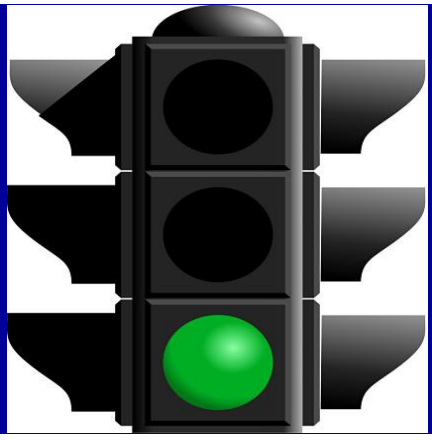




S.B. 1114 (Mar. 2009)

NJHA
NEW JERSEY HOSPITAL ASSOCIATION

MSNJ
MEDICAL SOCIETY OF NEW JERSEY
Est. 1766



255

Treat
'til
transfer

257

Miss. Code § 41-107-3

258

L.B. 564 (2013)

41

Mich. S.B. 136 (2013)

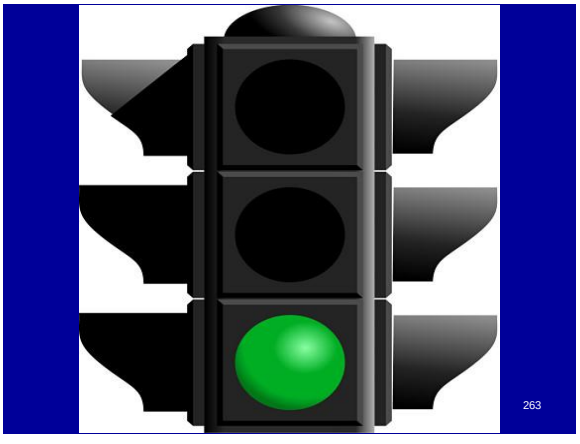
42

H.B. 279 (2013) (over veto)

40

Okla. H.B. 2460 (2012)

262



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HIPAA PERMITS DISCLOSURE OF COLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

DNR/COLST
CLINICIAN ORDERS
for DNR/CPR and OTHER LIFE SUSTAINING TREATMENT

Patient Last Name
Patient First/Middle Initial
Date of Birth

FIRST follow these orders, **THEN** contact **Clinician**.

(If patient/resident has no pulse and/or no respirations)

A

DO NOT RESUSCITATE (DNR)

☐ **DNR/Do Not Attempt Resuscitation (Allow Natural Death)**

CARDIOPULMONARY RESUSCITATION (CPR)

☐ **CPR/Attempt Resuscitation**

For patient who is breathing and/or has a pulse, GO TO SECTION B – G, PAGE 2 FOR OTHER INSTRUCTIONS. CLINICIANS MUST COMPLETE SECTIONS A-1 THROUGH A-5

A-1 Basis for DNR Order
Informed Consent - Complete Section A-2
Futility - Complete Section A-3

A-2 Informed Consent
Informed Consent for this DO NOT RESUSCITATE (DNR) Order has been obtained from:

Name of Person Giving Informed Consent (Can be Patient)

Relationship to Patient (Write "self" if Patient)

A-3 Futility (required if no consent)

☐ I have determined that resuscitation would not prevent the imminent death of this patient should the patient experience cardiopulmonary arrest. Another clinician has also so determined:

MM 2 2012 Page 1 of 2

Maryland Medical Orders for Life-Sustaining Treatment (MOLST)

Patient's Last Name, First, Middle Initial	Date of Birth	☐ Male ☐ Female

This form includes medical orders for Emergency Medical Services (EMS) and other medical personnel regarding cardiopulmonary resuscitation and other life-sustaining treatment options for a specific patient. It is valid in all health care facilities and programs throughout Maryland. This order form shall be kept with other active medical orders in the patient's medical record. The physician or nurse practitioner must accurately and legibly complete the form and then sign and date it. The physician or nurse practitioner shall select only 1 choice in Section 1 and only 1 choice in any of the other Sections that apply to this patient. If any of Sections 2-9 do not apply, leave them blank. A copy or the original of every completed MOLST form must be given to the patient or authorized decision maker within 48 hours of completion of the form or sooner if the patient is discharged or transferred.

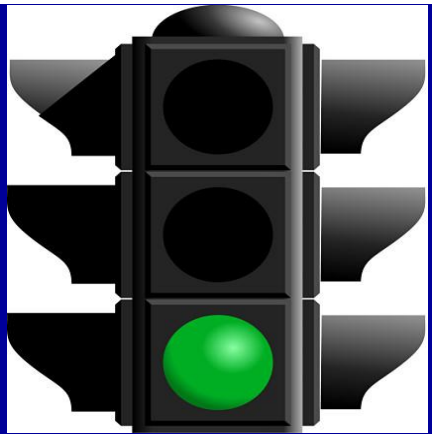
CERTIFICATION FOR THE BASIS OF THESE ORDERS: Mark any and all that apply.

I hereby certify that these orders are entered as a result of a discussion with and the informed consent of:

_____ the patient; or
_____ the patient's health care agent as named in the patient's advance directive; or
_____ the patient's guardian of the person as per the authority granted by a court order; or
_____ the patient's surrogate as per the authority granted by the Heath Care Decisions Act; or
_____ if the patient is a minor, the patient's legal guardian or another legally authorized adult.

Or, I hereby certify that these orders are based on:

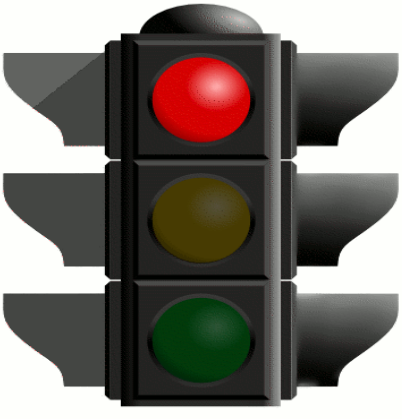
_____ instructions in the patient's advance directive; or
_____ other legal authority in accordance with all provisions of the Health Care Decisions Act. All supporting documentation must be contained in the patient's medical records.



266

Red

268



269

Consent and Capacity Board

270

"If surrogate directs [LST] . . . provider that does not wish to provide . . . **shall nonetheless comply** . . . ."

273

Discrimination in Denial of Life Preserving Treatment Act

274

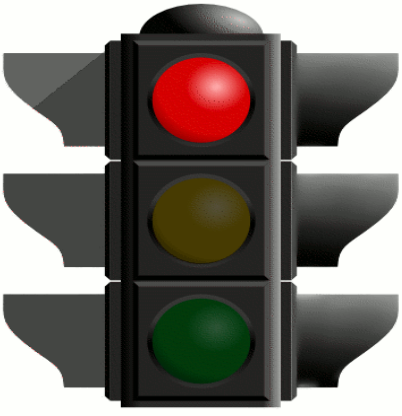
"Health care . . . **may not be** . . . **denied** if . . . directed by . . . surrogate"

275

SB 172, HB 309 (2012)

277

SDM	Red Light
Agent / POA	Yes
Default surrogate	No; Maybe
Guardian	No; Maybe



280

"I . . . come in . . . and use the law to say stop"

Life & death stakes

Unclear facts

Unclear law

TRO

Yellow

287

Not
red

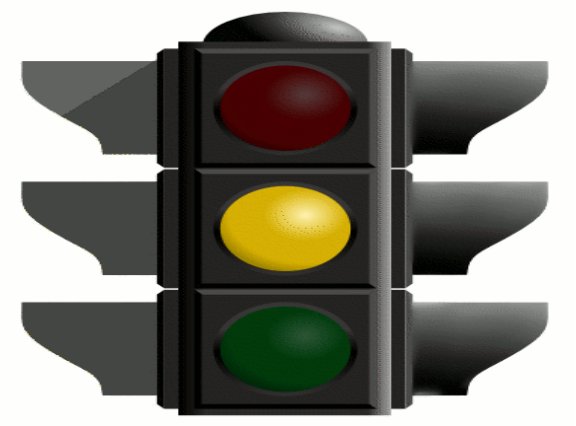
289

Not
green
either

290

Yellow

291

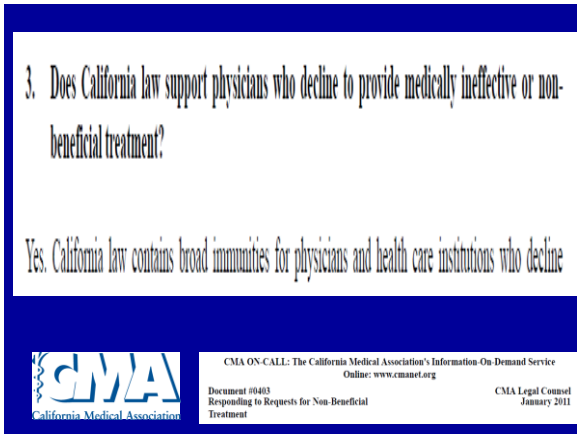


"provider . . . **may decline** to comply . . . contrary to generally accepted health care standards . . ."

4735

"provider . . . acting in good faith and in accordance with generally accepted health care standards . . . **not subject to civil or criminal liability** or to discipline. . . "

4740



When

How

296

How

"Provide continuing care . . . until a transfer can be accomplished **OR** until it **appears** that a transfer **cannot** be accomplished."

See Prob. Code 4736(c)

Want to refuse

↓

Try to transfer

No transfer

↓

Comply until transfer looks impossible

"[If] decline . . . provide continuing care . . . **until a transfer can be effected**

16 Del. Code 2508(g)(2)

Want to refuse

↓

Try to transfer

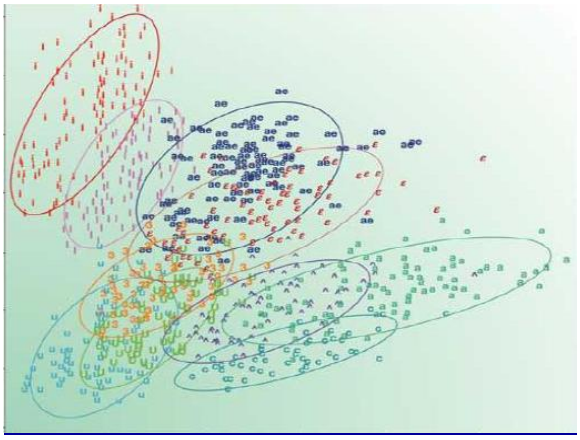
No transfer

↓

Must comply

When

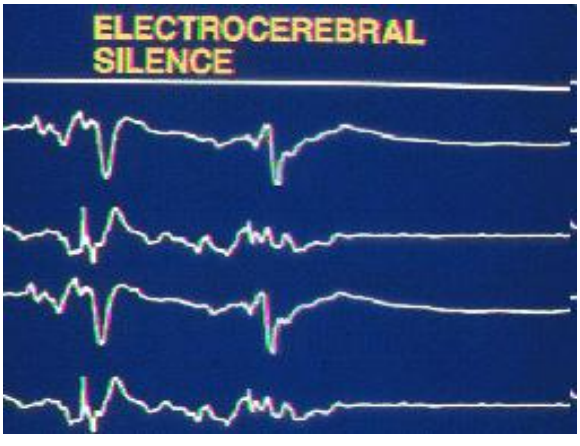
"generally accepted health care standards"

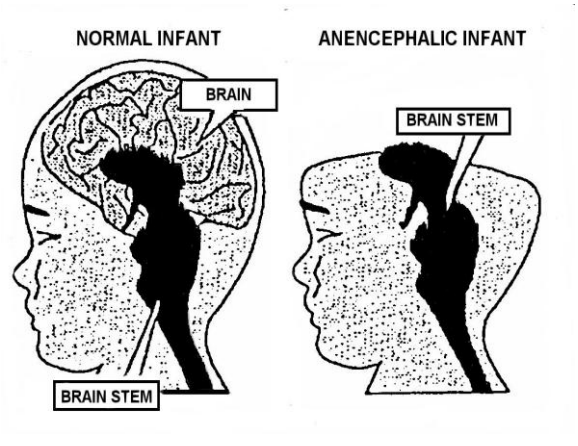


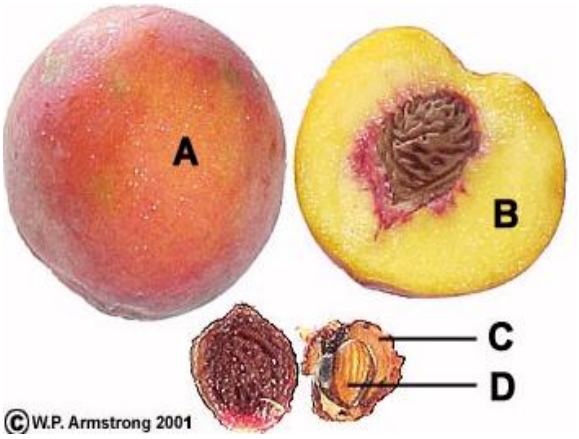
0% → 13%

Lantos, Am J Med 1989

Even if agree cutoff – how to extrapolate from populations to individuals







Safe Harbor®

Safe harbor attributes

- Clear
- Precise
- Concrete
- Certain

316

TX	CA
Measurable procedures	Vague substantive standards

Resolution 505-08 **TITLE:** LEGAL SUPPORT FOR NONBENEFICIAL TREATMENT DECISIONS

Author: H Hugh Vincent, MD; William Andereck, MD
Introduced by: District 8 Delegation

Endorsed by: District 8 Delegation

Reference Committee **E**

October 4-6, 2008

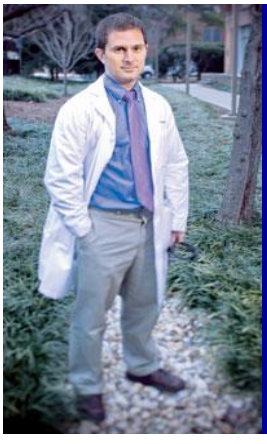
WHEREAS, it is still common for physicians who feel non-beneficial or futile treatments are being provided or considered to feel threatened by legal action by the patient's family or other surrogates, and thus continue to provide such care against their best medical judgment; and

That CMA support legislation or other changes in codes which will support physicians who appropriately invoke and follow accepted policies

320

Worse

321



Not just ambiguity

Providers continue to create the "wrong" standard of care

Dan Merenstein
291 *JAMA* 15 (1994)

Future

326

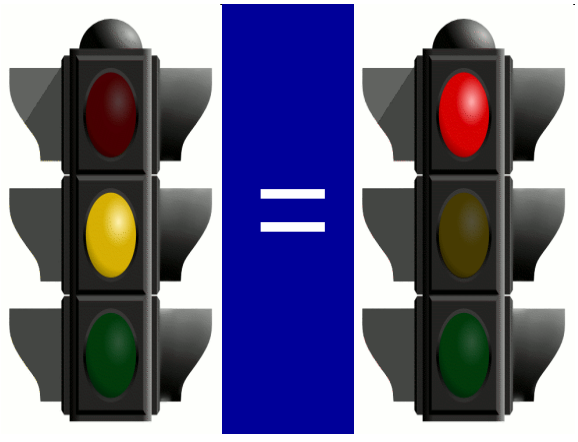
RPA

Renal Physicians Association

School of thought

Parris v. Sands (1993)

Barton v. Owen (1977)



Thaddeus Mason Pope

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F 901-202-7549
E tpope01@hamline.edu
W www.thaddeuspope.com
B medicalfutility.blogspot.com

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References

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Medical Futility Blog

Since July 2007, I have been blogging, almost daily, to **medicalfutility.blogspot.com**. This blog is focused on reporting and discussing legislative, judicial, regulatory, medical, and other developments concerning medical futility and end-of-life medical treatment conflict. The blog has received over 550,000 direct visits. Plus, it is distributed through RSS, email, Twitter, and republishers like Westlaw, Bioethics.net, Wellsphere, and Medpedia.

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END

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Community standards vs. locality rule

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San Diego County Medical Society

"Physicians United for a Healthy San Diego"

Model Policy on "Non-beneficial Treatment"

Lynette Cederquist, MD, July 2009 "San Diego Physician" • Ethics in Medicine medicine)

Penalties for over-treatment

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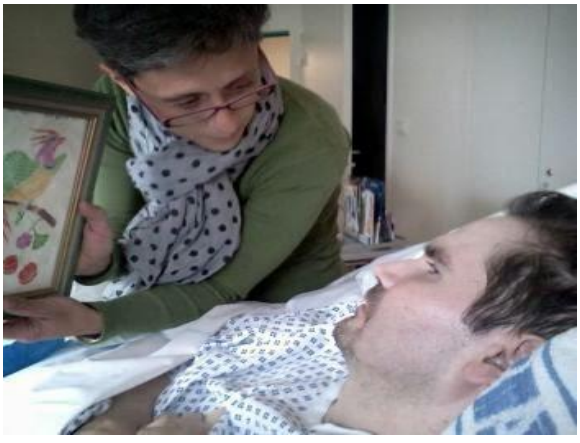

THE UNITED STATES DEPARTMENT of JUSTICE


Questions