Non-beneficial Treatment
Development of a working hospital policy

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PCQN Monthly teleconference

Bates D. Moses, MD, FHM, FAAHPM
Palliative Medicine, Dept. of Cont. Care
Physician co-chair, KP Riv. Bioethics Cmte
Bates.d.moses@kp.org
Objectives

- Historical overview of non-beneficial treatment
- Review of various opinions (community consensus)
- Review of various California facility policies
- Review Southern California Kaiser’s experience and development of a policy
Presidential Commissions

- 1974-78 National Commission for the Protection of Human Subjects...
- 1978-83 Presidential Commission for the Study of Ethical Problems in Medicine...
  - 1981 Report “Defining Death” led to the Uniform Determination of Death Act
  - 1983 Report on Foregoing life-sustaining treatment
- 1994-95 Advisory committee on human radiation experiments
- 1996-2009 National Bioethics Advisory Committee (cloning, stem cells)
- 2001-2009 President's Council on Bioethics (stem cells, human enhancement)
- 2009-Present Presidential Commission for the Study of Bioethical Issues (emerging technologies, whole genome sequencing, protecting human participants in research)
Policies on Orders Not to Resuscitate. Pioneering policies on "No Code" orders ("code" being the shorthand term for the emergency summoning of a "resuscitation team" by the announcement of "Code Blue" over a hospital's public address system) or "DNR orders" (for "Do Not Resuscitate") were published by several hospitals in 1976. The policies followed the recognition by professional organizations that non-resuscitation was appropriate when well-being would not be served by an attempt to reverse cardiac arrest. For example, the 1974 version of the "Standards for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiac Care (ECC)" of the American Heart Association and the National Academy of Sciences states, "Cardiopulmonary resuscitation is not indicated in certain situations, such as in cases of terminal irreversible illness where death is not unexpected." A growing number of hospitals are now developing such policies while those with policies are already updating them.
Deciding to Forego Life-Sustaining Treatment - 1983

**Table 2:** Resuscitation (CPR) of Competent Patients—Physician’s Assessment in Relation to Patient’s Preference

<table>
<thead>
<tr>
<th>Physician’s Assessment</th>
<th>Patient Favors CPR</th>
<th>No Preference</th>
<th>Patient Opposes CPR</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPR Would Benefit Patient</td>
<td>Try CPR</td>
<td>Try CPR</td>
<td>Do not try CPR: review decision**</td>
</tr>
<tr>
<td>Benefit of CPR Unclear</td>
<td>Try CPR</td>
<td>Try CPR</td>
<td>Do not try CPR</td>
</tr>
<tr>
<td>CPR Would Not Benefit Patient</td>
<td>Try CPR: review decision**</td>
<td>Do not try CPR</td>
<td>Do not try CPR</td>
</tr>
</tbody>
</table>

* Based on an adequate understanding of the relevant information.
** Such a conflict calls for careful reexamination by both patient and physician. If neither the physician’s assessment nor the patient’s preference changes, then the competent patient’s decision should be honored.

**Table 3:** Resuscitation (CPR) of Incompetent Patients—Physician’s Assessment in Relation to Surrogate’s Preference

<table>
<thead>
<tr>
<th>Physician’s Assessment</th>
<th>Surrogate Favors CPR</th>
<th>No Preference</th>
<th>Surrogate Opposes CPR</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPR Would Benefit Patient</td>
<td>Try CPR</td>
<td>Try CPR</td>
<td>Try CPR until review of decision**</td>
</tr>
<tr>
<td>Benefit of CPR Unclear</td>
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</tr>
</tbody>
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** See p. 54 et al.
An intended goal was to define ‘futility’ to enable a ‘clearer discussion’ of issues.

Definition: “Treatments should be defined as futile only when they will not accomplish their intended goal.”

“…treatments may be classified into four categories: a) treatments that have no beneficial physiologic effect; b) treatments that are extremely unlikely to be beneficial; c) treatments that have beneficial effect but are extremely costly; and d) treatments that are of uncertain or controversial benefit.”

Defined hospital policies that were reviewed as either ‘definitional’ and/or ‘procedural’
Advocates for a fair process approach

Does not attempt to define futility

- However it does give possible example:

  - "When the physician’s primary purpose of the treatment seems to be to prolong the dying process without much benefit to the patient or others with legitimate interest, this will be taken into account among fairly heard perspectives, and may become determinative but only if all available physicians in all institutions share this perspective”

Recommended that all health care institutions (of any size) develop policies based on a fair process approach.
AMA 1999
Medical Futility in End-of-Life Care: Report of the Council on Ethical and Judicial Affairs
BANEC 1999

Non beneficial or futile medical treatment: conflict resolution guidelines for the San Francisco Bay Area

Clearly defines nonbeneficial treatment

- Cannot reasonable be expected to be experience by the patient as beneficial... and/or harms > benefits
- Irreversibly unconscious
- No realistic chance of survival outside of an ICU
TADA 1999
Texas Advance Directives Act

- Clear process defined in legal statute
- 1. The family must be given written information concerning hospital policy on the ethics consultation process.
- 2. The family must be given 48 hours' notice and be invited to participate in the ethics consultation process. Family members may consult their own medical specialists and legal advisors if they wish.
- 3. The ethics consultation process must provide a written report to the family of the findings of the ethics review process.
- 4. If the ethics consultation process fails to resolve the dispute, the hospital, working with the family, must try to arrange transfer to another provider physician and institution who are willing to give the treatment requested by the family and refused by the current treatment team.
- 5. If after 10 days, no such provider can be found, the hospital and physician may unilaterally withhold or withdraw the therapy that has been determined to be futile.
- 6. The party who disagrees may appeal to the relevant state court and ask the judge to grant an extension of time before treatment is withdrawn. This extension is to be granted only if the judge determines that there is a reasonable likelihood of finding a willing provider of the disputed treatment if more time is granted.
- 7. If either the family does not seek an extension or the judge fails to grant one, futile treatment may be unilaterally withdrawn by the treatment team with immunity from civil or criminal prosecution.
VA 2000
Do-Not-Resuscitate Orders and Medical Futility

Focuses on unilateral DNR orders, provides a fair process and concludes that:

- Entering a DNR order over the objection of a patient or surrogate should be reserved for exceptionally rare and extreme circumstances after thorough attempts to resolve disagreements have failed.

Does not attempt to define non beneficial treatment:

- The term “medical futility” refers to a physician’s determination that a therapy will be of no benefit to a patient, and therefore should not be prescribed. But physicians use a variety of methods to make these determinations and may not arrive at the same conclusions.

Clarifies the then current VA DNR protocol:

- The intent of the policy is clear: VA physicians are not permitted to write a DNR order over the objection of the patient or surrogate, but they are permitted to withhold or discontinue CPR based on bedside clinical judgment at the time of cardiopulmonary arrest.
Shared Decision-Making in the Appropriate Initiation of and Withdrawal from Dialysis
Withholding and withdrawing non beneficial medical interventions position statement

- Does not attempt to define non beneficial medical interventions

- Withholding or withdrawing the intervention is appropriate “when consistent with the patient’s goals of care.”
  - “Clinicians should not implement therapies that cannot accomplish the patient’s goals of care.”

- Strong statements regarding the process and focuses on enhanced communication
  - Consider the disease, social, familial, psychological and spiritual dimensions of the patient’s situation, including burdens and benefits.
  - Clinicians should recognize and seek to understand cultural, religious, and psychological rationales provided by patients and families.
  - Surrogates should be instructed to keep the focus on the patient’s preferences and best interests rather than the surrogates.
Definition:

- Generally, medically ineffective or non-beneficial treatment is any treatment or study that, in a physician's professional judgment, produces effects that cannot reasonably be expected to be experienced by the patient as beneficial or to accomplish that patient's expressed and recognized medical goals, or has no realistic chance of returning the patient to a level of health that permits survival outside of the acute care setting.

Reaffirms legal standing

- Under California statute, when acting in good faith and in accordance with generally accepted health care standards, a physician or health care institution who declines to give treatment that is medically ineffective or non-beneficial is immune from civil or criminal liability and disciplinary action. (CA Probate Code §4740.)
- Including when declining to honor a POLST that may order medically ineffective treatment or is contrary to generally accepted health care standards.
CMA 2012
CMA Model Policy: Responding to Requests for Non-Beneficial Treatment

Rationale for a statewide model policy provided:
- While existing law and policy allow and protect physicians and health care institutions who decline to comply with a patient's or surrogate decision-maker's request for medically ineffective or non-beneficial treatment if certain procedures are followed (Probate Code §§4654, 4734, 4735, 4736, 4740), many physicians are either unaware of these legal protections or face institutional opposition to invoking them.

Provides a 7-step process-based approach
- Acknowledges that “any member” of the healthcare team that “in his or her professional judgment” identifies as non-beneficial, then the steps outlined should be followed. It then defers to the physician to facilitate conversation and consensus (among the healthcare team) first.