San Diego County Model Policy on Non-beneficial Treatment Requests

Introduction: Patients have the right to receive quality care including medically effective and beneficial Treatment that meets the standard of care. However, physicians are not obligated to provide medical treatments that are outside the standard of care, including treatments that, in the physician's professional judgment, are not expected to benefit the patient. This includes determinations that the burden of suffering and intrusiveness is disproportionate to the benefits. When disagreements arise about a particular treatment, all parties involved are best served by a fair and explicit process that acknowledges and respects the views of all parties, patient autonomy and dignity, as well as the rights and professional obligations of physicians and other members of the medical team.

The Process: To promote an atmosphere of respect and understanding, [the Medical Staff of health care facility] adopt this Policy as a fair and explicit process for resolution of disagreements between physicians and patients or their Legally Recognized Health Care Decisionmakers (LRHCD) concerning the appropriateness of specific medical treatments, diagnostic procedures, or other interventions. This policy is intended to facilitate communication and recognize and respect both shared values and areas of disagreement. Thorough communication with the patient or LRHCD at each step in the process is vital and each step in this process should be documented in the patient's medical record. Working through the steps outlined in this policy will often lead to resolution of the situation well before the final stages of this process are reached.

Scope/ Coverage: (optional if applicable in health care system)

Definitions: The following definitions apply to the noted terms and phrases throughout the policy:

1. "Cardiopulmonary Resuscitation (CPR)" refers to therapeutics provided in the event of cardiac or respiratory arrest. Therapeutics include electroshock, chest compressions, medications, and artificial ventilation.

2. "Consulting Physician" means a physician who is not a part of the medical team and who is consulted to render a second opinion regarding whether a treatment is non-beneficial. The consulting physician is not the physician primarily responsible for the patient's care and treatment.

3. “Coordinating Physician” means the physician who, in accordance with the Medical Staff bylaws, institutional policy, local or state laws and regulations, or custom and practice, has the authority and is expected to assess the medical condition, health status and goals of care of the Patient and, in the exercise of their professional judgment, to make decisions and recommendations regarding the Patient’s Treatment plan. This physician is responsible for coordinating the efforts of the various medical consultants and ancillary practitioners according to defined goals of care. Depending on the institution,

health care setting and circumstances, this physician may be known as the Patient's primary care physician, attending physician, treating physician, physician of record, or similar term.

4. "Decision Making Capacity" is a person's ability to understand the nature of their condition and consequences of a decision, to make and communicate a decision, and includes in the case of proposed health care, the ability to understand its significant benefits, risks, and alternatives

5. "Ethics Committee" offers assistance in addressing ethical issues that arise in patient care and facilitate sound decision making that respects participants' values, concerns, and interests.

6. "Ethics Consultation Service" means that service provided by the hospital to examine and reflect upon ethical issues or conflicts involved in the care of a patient.

7. "Legally Recognized Health Care Decisionmaker" ("LRHCDM") means an Agent, Surrogate, Conservator or other person who the Coordinating Physician believes in good faith has authority to make health care decisions on behalf of a Patient which includes the following:

a. "Agent" means an individual appointed by the patient in a legal document (for example, a durable power of attorney for health care or advance health care directive) to make health care decisions for the patient, and includes a successor or alternate agent.

b. "Conservator" means a court-appointed person granted authority to make health care decisions for a patient.

c. "Power of Attorney for Health Care" means a written instrument designating an Agent to make health care decisions for the Patient.

d. "Surrogate" means an adult 18 years of age or older with decision making capacity who is appointed to make health care decisions on behalf of the patient.

8. "Life-Sustaining Treatment" in this policy refers to all medical interventions that have the potential to sustain life in situations where death otherwise is expected to occur excluding cardiac or pulmonary arrest. Life-sustaining treatments may include but are not limited to mechanical ventilation, dialysis, antibiotics, artificial nutrition and hydration, anti-arrhythmics, blood pressure support medications, blood and blood products, and other medications and procedures that are capable of sustaining life.

9. "Medical Team" means a group of health care professionals, including the Coordinating Physician or their designee, and other health care professionals working together as a unit to provide a particular medical service. Examples include a surgical team, the organ transplantation team, the intensive care unit team, and the rehabilitation team.

10. "Non-Beneficial Treatment" is any medical Treatment, intervention, or diagnostic procedure that the Coordinating Physician determines, in the exercise of their professional judgment, either: 1) will be ineffective for producing the physiological effect that the Patient or LRHCDM desires or expects of the medical Treatment; 2) will produce no effects that can reasonably be expected to be experienced by the Patient as beneficial for accomplishing the Patient's expressed and medically obtainable goals; (3) will more likely cause harm than benefit for the Patient; (4) has no realistic chance of returning the Patient to

a level of health that permits survival outside of a general acute care hospital as defined in Health and Safety Code section 1250(a); or (5) would serve only to maintain the patient's life in a permanently unconscious state. (Note that Non-Beneficial applies to specifically defined Treatments or interventions. Care itself is never non-beneficial.) No health care professional has an ethical obligation to provide or participate in the provision of a Non-Beneficial Treatment.

11. "Patient" means an adult or a minor authorized to give legal consent to medical Treatment whose health care is under consideration, or a minor whose health care is under consideration as represented by the minor's parent(s) or legal guardian(s) who makes health care decisions on behalf of the minor.

12. "Treatment" includes any diagnostic study or procedure, medical study, intervention or procedure, and any surgical intervention or procedure.

Relevant Legal Standards: This Policy is consistent with professional medical standards, professional medical-ethics standards and California law. For a summary description of these relevant standards, see CMA ON-CALL document #3456, "Responding to Requests for Non-Beneficial Treatment."

Step 1: Identify Non-Beneficial Treatment

If a member of the Medical Team receives a request from a Patient or their Legally Recognized Health Care Decisionmaker (LRHCDM) for a specific Treatment that, in his or her professional judgment, is Non-Beneficial, the particular Treatment in question should be clearly identified and the provision of the requested Treatment evaluated using the following steps.

Step 2: Communication within the Medical Team

If the Coordinating Physician or any member of the Patient's Medical Team believes a treatment is non-beneficial, it should be discussed with the medical team. Team consensus is desired as it is best that all Medical Team members move forward with a clear, common understanding of the Patient's goals of care and whether the requested Treatment constitutes non-beneficial treatment. The Coordinating Physician should act to facilitate this consensus and resolve disputes. If consensus within the team cannot be achieved, an Ethics consultation should be requested.

Step 3: Communication with the Patient or LRHCDM regarding the Treatment Plan

The Medical Team will communicate with compassion and patience to the Patient or LRHCDM the medical prognosis and Treatment plan, and that the particular treatment(s) in question will either not be offered or withdrawn, because it has been determined to be non-beneficial. The Coordinating Physician should attempt to reconcile differences between the treating Medical Team and the Patient or LRHCDM and to negotiate solutions to disagreements directly.

The Coordinating Physician should document this communication process in the medical record, including whether it is the patient with decision-making capacity or a LRHCDM who is making decisions on behalf of a patient lacking requisite decision-making capacity the probable diagnoses, probable prognosis, Patient or LRHCDM desired Treatment plan, and the Coordinating Physician's recommended Treatment plan, as well as acceptable alternatives.

Step 4: Seek Second Opinion by Another Physician

If disagreement persists between the Medical Team and the Patient or LRHCDM, seek consultation with another physician to assess whether the existing proposed Treatment meets the definition of non-beneficial treatment. If the Consulting Physician believes the Treatment is beneficial, the treatment should be continued for a time-limited trial as determined by the Coordinating Physician, and reassessed when appropriate.

If the Consulting Physician believes the Treatment is Non-Beneficial, the Consulting Physician should communicate that second opinion to the Patient or LRHCDM. The Medical Team should again attempt to reconcile differences and negotiate solutions. This communication process should be documented in the Patient's medical record.

Step 5: Request an Ethics consultation

If disagreement persists, the Coordinating Physician should consult the Ethics Consultation Service who can facilitate a meeting that includes the Patient or LRHCDM, the Coordinating Physician, and any other involved stakeholders in an attempt to resolve the conflict. If the conflict remains unresolved after ethics consultation, move to Step 6.

Step 6: Ethics Committee or Other Appropriate Body Review Team

If the Ethics Consultation Service is unable to resolve the conflict, the institution's Ethics Committee or Other Appropriate Body Review Team should be consulted to offer a review. The Ethics Committee or Other Appropriate Body Review Team may include a physician member who has not previously been involved in the care of the Patient, a non-physician, and if possible, a community member. Ad hoc individuals from the institution can be included. The purpose of the Ethics Committee or Other Appropriate Body Review is to 1) determine whether the conflict resolution steps outlined in this policy have been implemented and followed correctly, 2) evaluate whether there are additional compelling ethical issues that should be considered, and 3) render an opinion if the treatment(s) in question are ethically justifiable. The review and recommendations offered through Ethics Committee Review are considered advisory. Other Appropriate Body reviews may be considered determinative, and not solely advisory.

If the Ethics Committee Review or Other Appropriate Body Team finds the treatment in question to be ethically justifiable, or is unable to reach consensus, the Coordinating Physician should take into consideration the guidance provided by the review team when deciding whether to offer the treatment.

The findings of the Ethics Committee Review or Other Appropriate Body Review Team should be documented in the electronic health record.

Other institutional bodies can be consulted to review and affirm the justifiability of the proposed treatment plan.

A summary or copy of the institution's Non-Beneficial Treatment Policy may be offered to the patient/ LRHCDM.

Step 7: Transfer of Care

If the Ethics Committee Review (or similar body) offers ethical justification supporting the Coordinating Physician's determination that treatment is non-beneficial, The Patient or LRHCDM must be promptly informed, either verbally or in writing, that the Treatment will not be offered or will be withdrawn if the Patient remains at the institution following an opportunity to arrange transfer. Unless the Patient or LRHCDM does not desire transfer, the physician or institution shall assist in the transfer of the Patient to another health care provider or institution that is willing to comply with the Patient/ LRHCDM's Treatment request. Until transfer can be accomplished, the Medical Team will provide continuing care to the Patient. In all cases, any appropriate pain relief and other palliative care will be continued. The Patient/ LRHCDM should also be notified of the ability to seek judicial review of the Treatment. A reasonable timeframe for the Patient/ LRHCDM to locate a facility willing to accept the patient, as determined by the Coordinating Physician, generally should not exceed 72 hours.

Step 8: If Transfer of Care is NOT Possible or NOT Desired by the Patient or LRHCDM

If transfer of care is not possible or not desired by the Patient or LRHCDM, the Patient or LRHCDM should promptly be informed that the Treatment will not be offered or will be withdrawn after a reasonable period of time for accommodation. This period of time is not longer than the time that it would ordinarily take for family to gather at the bedside. Once conflict resolution process is complete and treatment is determined to be non-beneficial, treatment will not be offered at that hospital.

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