Central Valley Regional Bioethics Conference

Sponsored by the Central Valley Regional Bioethics Committee

Friday, October 17, 2025 | 8:30 a.m. - 4:30 p.m.

Valley Children's Hospital
9300 Valley Children's Place, Madera, CA

1

1:00 - 2:00

2

Strategies for Resolving Care Conflicts in the ICU & Beyond

3

Thaddeus Mason Pope

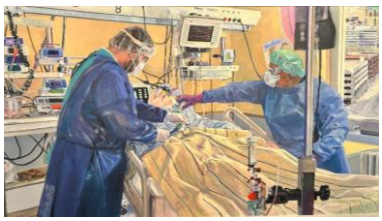
JD, PhD, HEC-C

4

disclosure

Wolters Kluwer royalties for UPTODATE

5



6

catastrophically critically ill

7

lacks decision making capacity

8

clinicians often recommend **CMO**

9

surrogates often **agree**

10

not always

11

12

clinician	surrogate
CMO	LSMT

13

typical response

14

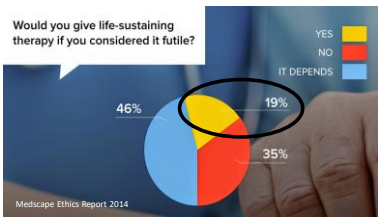
cave-in

15

16

2014

17



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2022

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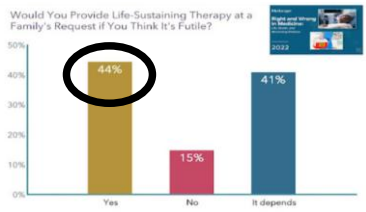

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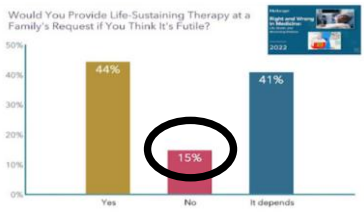

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22

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

23

"follow … SDMs **instead** … what they feel is appropriate"

24

CALIFORNIA MEDICAL ASSOCIATION

25

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

26

"**common** for physicians … provide … non-beneficial … treatments … **against** their best medical judgment"

27

why?

28

29

"almost all cited a **lack of legal support**"

30

McErlean et al. BMC Medical Ethics (2025) 26:65
https://doi.org/10.1186/s12910-025-01224-2

RESEARCH

Ethics, orthodoxies and defensive practice: a cross-sectional survey of nurse's decision-making surrounding CPR in deceased inpatients without Do Not Resuscitate orders

Gemma McErlean[1,2*], Suzanne Bowdler[2], Joanne Cordina[2], Heidi Hull[3], Edwina Licht[3,4]

31

nomo-phobia
fear of law

32

no mopho phobia

33

34

"**ethically** … comfortable removing life support … but … lingering **concerns about being sued**"

35

"**even** a case that … eventually gets thrown out is a major **stressor, time drain, and hassle**"

36

"remove the __, and I will **sue you**"

37

38

39

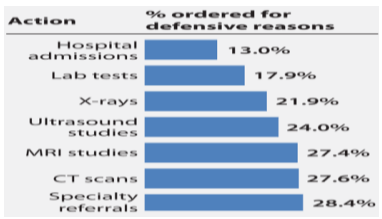
40

physicians round off

nurses bear brunt

41

42



43

here **too**

44

status quo

= cave in

45

46

47

SO…

48

better responses

49

50

low risk

51

few cases brought

52

almost **none** even **want** to sue

53

54

even if surrogate wants to sue, attorneys **decline**

55

unlikely to win
immunity
judicial deference

56

damages **too low**
< $300,000

57

few cases brought

58

in rare instances cases filed,
providers win

59

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

CALIFORNIA MEDICAL ASSOCIATION

60

"**no successful legal suits** against physicians and institutions who … appropriately invoked [NBT] policies"

61

"**appropriately** invoked such policies"

62

providers lose
one type lawsuit
re unilateral WD

63

infliction of emotional distress

64

secretive

insensitive

outrageous

65

not liable for withdrawing but for

how

66

67

slow code

show code

Hollywood code

68

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)

69

consultation expected

distress foreseeable

70

71

72

THE RECAP

73

risk ≠ 0

74

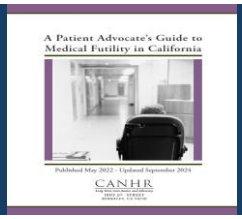
risk > 0

75

San Francisco Chronicle

76

77



78

little patient or family can do

79

"virtually **no limits**"

"remarkable law, written **for physicians**"

80

most likely legal action

81

82

not about liability

not about the merits

83

84

preserve **status quo**
until gather & assess
evidence & argument

85

must **continue** LSMT

until court resolves whether you have a duty to continue LSMT

86

THE RECAP

87

88

89

90

prevalence NBT conflicts

causes NBT conflicts

prevention NBT conflicts

91

92

93

have a conflict

94

what are your **options**

95

4 options

96

consensus

97

new surrogate

98

new hospital

99

if **none** of that works …

100

withdraw LST **without** consent

101

102

103

104

this is only legal **information**

not legal **advice**

105

see your **own** OGC or RM

106

path 1 of 4

107

consensus

108

most hospital policies

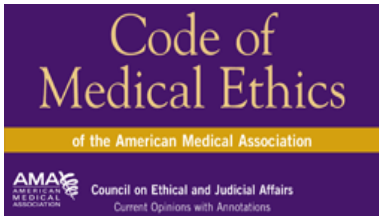
most society guidelines

109

negotiation

mediation

110



111

4 of 7 steps

112

1. earnest attempts … deliberate … **negotiate**

2. **joint** decision making … maximum extent

113

3. attempts … **negotiate** … reach resolution

4. involve … **ethics committee**

114

why?

115

116

95%

117

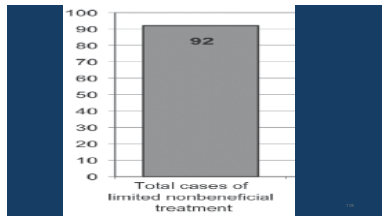
KAISER PERMANENTE

Nonbeneficial Treatment and Conflict Resolution: Building Consensus

Craig M Nelson, PhD, CCS; Blanca Arriola Nazareth, MSW

Perm J 2013 Summer; 17(3):23-27.

118



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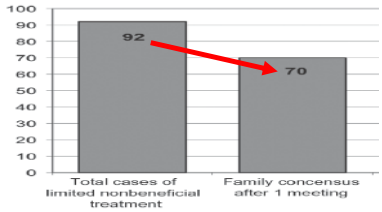

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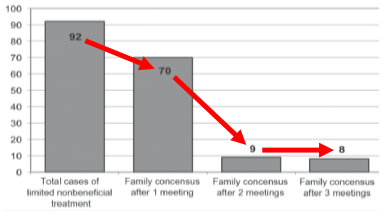

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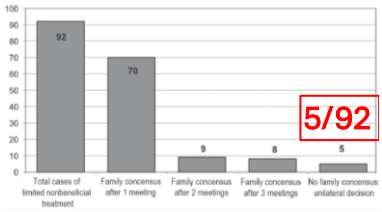

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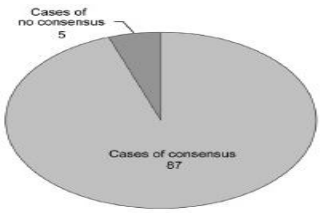

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124

Am J Respir Crit Care Med. 1997 Jan;155(1):15-20.

Increasing incidence of withholding and withdrawal of life support from the critically ill.

Prendergast TJ, Luce JM.

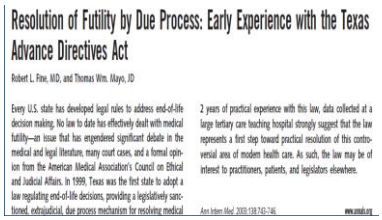
125

57% agree immediately

90% agree within 5 days

96% agree after more meetings

126



Resolution of Futility by Due Process: Early Experience with the Texas Advance Directives Act

Robert L. Fine, MD, and Thomas Wm. Mayo, JD

Every U.S. state has developed legal rules to address end-of-life decision making. No law to date has effectively dealt with medical futility—an issue that has engendered significant debate in the medical and legal literature, many court cases, and a formal opinion from the American Medical Association's Council on Ethical and Judicial Affairs. In 1999, Texas was the first state to adopt a law regulating end-of-life decisions, providing a legislatively sanctioned, extrajudicial, due process mechanism for resolving medical

2 years of practical experience with this law, data collected at a large tertiary care teaching hospital strongly suggest that the law represents a first step toward practical resolution of this controversial area of modern health care. As such, the law may be of interest to practitioners, patients, and legislators elsewhere.

Ann Intern Med. 2003;138:743-746. www.annals.org

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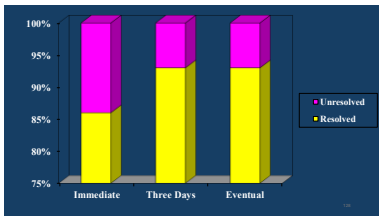

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Circumstances Surrounding End of Life in a Pediatric Intensive Care Unit

Daniel Garros, MD*; Rhonda J. Rosychuk, PhD†; and Peter N. Cox, MD*

PEDIATRICS Vol. 112 No. 5 November 2003

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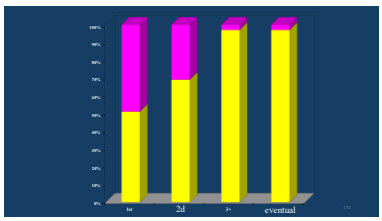

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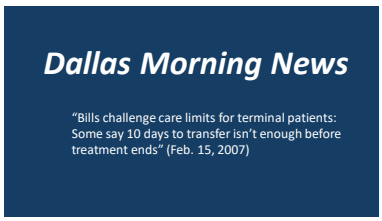
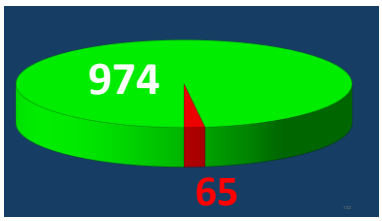


Dallas Morning News

"Bills challenge care limits for terminal patients: Some say 10 days to transfer isn't enough before treatment ends" (Feb. 15, 2007)

131



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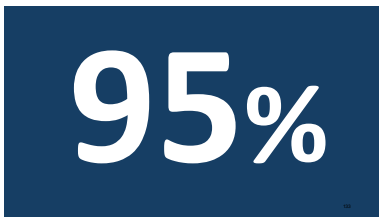

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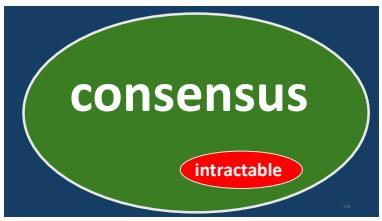


134

135

tried reach consensus

136

intensive communication

mediation

137

still no consent

138

139

		clinician	
		stop	go
surrogate	stop		
	go	X	

140

path 2 of 4

141

new surrogate

142

sometimes surrogates should be **challenged**

143

sometimes surrogate should even be **replaced**

144

145

act **consistently** with patient's known desires

146

otherwise, act in patient's **best interest**

147

148

but

149

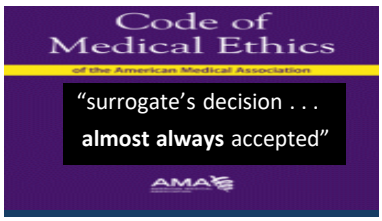
150

~ 60% accurate

151

more aggressive treatment

152



153

154

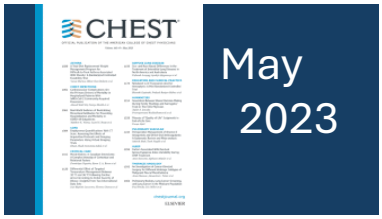
educate

support

155

ensure surrogate understands Pt **prognosis**

156



May 2023

157

158

"**missing** from **95%** … family meetings"

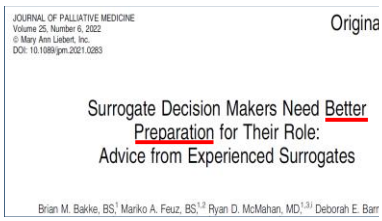
159

in addition to helping surrogate understand Pt situation

160

ensure surrogate understands **role** of surrogate

161



162

163

5

164

surrogate lacks **capacity**

165

surrogate has material **COI**

166

167

AD →

← surrogate

168

known wishes →

← surrogate

169

"dad would not have wanted X"

"but **I**, just can't let go"

170

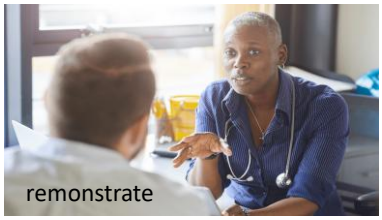
if **no** AD or known wishes

171

best interest →

← surrogate

172



173

174

clinicians should **not** follow "bad" surrogates

175

surrogate replacement **works**

176

177

but

178

limits
to surrogate replacement

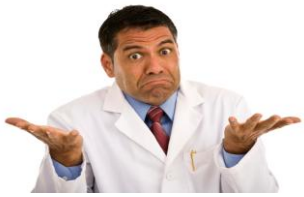
179

1 limit

180

clinicians **cannot** show deviation

181



182

2 limit

183

surrogates get benefit of doubt

184

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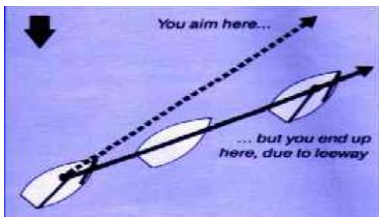

186

SO…

187

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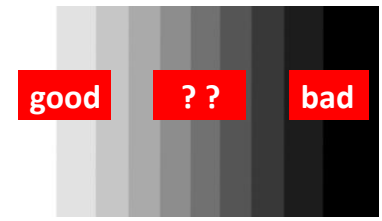

189

3 limit

190

surrogates are **faithful**

191

192

3 limits

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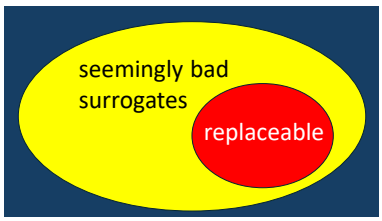


194

195

no consensus

no new surrogate

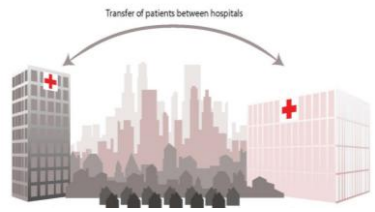
196

path 3 of 4

197

new hospital

198



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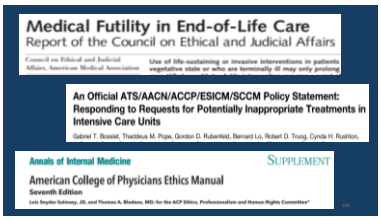

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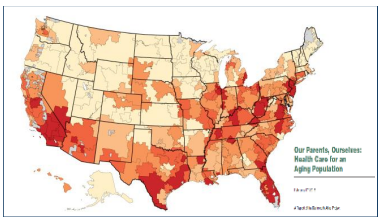


207

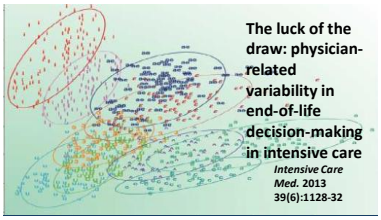
ICU days last 6 mo.

208

physician

variability

209



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What does "futility" mean? An empirical study of doctors' perceptions

Ben White et al
Med J Aust 2016; 204 (8):318
doi: 10.5694/mja15.01103

211

1 Elements in 96 doctors' definitions of futility

Element of futility	Number of doctors
Nature of patient benefit	96 (100%)
Level of benefit	89 (93%)
Burdens outweigh benefits	75 (78%)
No benefit (will not work)	59 (61%)
Insignificant benefit (not sustained, not meaningful)	42 (44%)
Type of benefit	84 (88%)
Inadequate quality of life (independent of quantity of life)	76 (79%)
Does not provide quantity or quality of life	40 (42%)
No gain in physical functioning or symptom control	20 (21%)
Does not lengthen life (independent of quality of life)	14 (15%)

212

Overall outcome	81 (84%)
Death is imminent	66 (69%)
Would not address underlying terminal condition or change ultimate outcome	60 (63%)
Not reversible	28 (29%)
Investigation would not change management	5 (5%)
Does not achieve a goal of treatment (patient, family, doctor)	45 (47%)
Benefit generally (not further defined)	27 (28%)
Prospect of patient benefit	70 (73%)
Insignificant or low chance of benefit	59 (61%)
No chance of benefit	31 (32%)
Below numeric threshold of success for specific cases (range of answers, < 0.1% to 10%)	18 (19%)
Below numeric threshold of success applicable to all cases (range of answers, < 0.1% to 10%)	4 (4%)
Not worth the resources	17 (18%)

213

April 2025

214

hospital

variability

215

Hospital Culture and Intensity of End-of-Life Care at 3 Academic Medical Centers

Elizabeth Dzeng, MD, PhD, MPH[1,2,3]; Jason N. Batten, MD, MA[4,5]; Daniel Dohan, PhD[2]; et al

Author Affiliations

JAMA Intern Med. Published online July 3, 2023. doi:10.1001/jamainternmed.2023.2450

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[Humanities in CHEST Medicine Original Research] CHEST

Hospital Policy Variation in Addressing Decisions to Withhold and Withdraw Life-Sustaining Treatment

Gina M. Piscitello, MD; Patrick G. Lyons, MD; Valerie Gutmann Koch, JD; William F. Parker, MD, PhD;

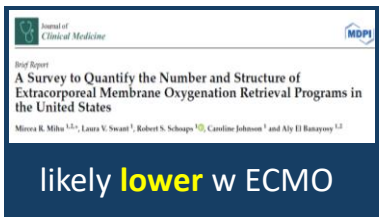
217

can find & make transfers

218

that's based on experience with trad. **LST**

219


Journal of Clinical Medicine MDPI

Brief Report

A Survey to Quantify the Number and Structure of Extracorporeal Membrane Oxygenation Retrieval Programs in the United States

likely **lower** w ECMO

220

but

221

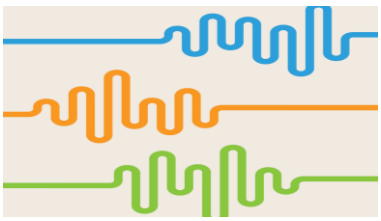

how **long** to look for transfer

222

what constitutes a **reasonable** time depends on custom & practice

223

224



225

source	days
San Diego Med Soc	3
Torrance	5
Glendale	10 B
SoCal Bioethics model	10

226

source	days
Utah UHCDA	10
Virginia law	14
Delaware UHCDA	15
Texas law	25

227

10 days is common

228

THE RECAP

229

no consent
no new surrogate
no transfer

230

path 4 of 4

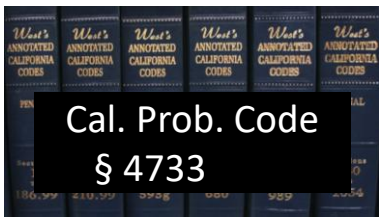
231

withdraw LSMT w/o consent

232

normally, clinicians must **follow** patient & surrogate decisions

233



234

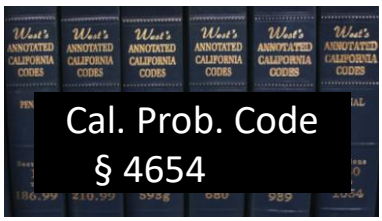
"provider … **shall … comply** with a … decision … made by a person then authorized"

235

but

236

237



238

"**not … require** … health care contrary to generally accepted health care standards"

239

240

"provider … **may decline to comply** with … decision that … requires"

241

either

242

"**medically ineffective** health care"

243

or

244

"health care **contrary** to generally accepted health care **standards**"

245

plus

246

legal immunity

247

248

"**not subject** to civil **or** criminal liability **or** to discipline for unprofessional conduct"

249

250

may stop LSMT **without** consent

251

with legal **immunity**

252

contrary to GAHCS

253

medically ineffective

254

255

you want to **decline to comply** with a health care decision

256

3 questions

257

with **whose** decisions may you decline to comply

258

with **what** decisions may you decline to comply

259

when may you decline to comply with those decisions

260

whose decisions

261

262

"decline to comply with … **instruction** or … **decision**"

263

instruction

264

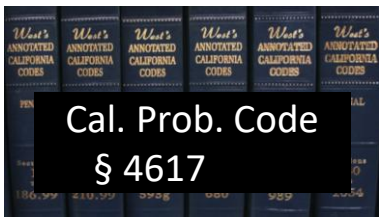
265

"**patient's written or oral direction** concerning a health care decision"

266

decision

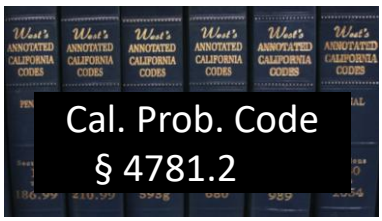
267



268

"means a decision made by a **patient** or … **agent, conservator,** or **surrogate**"

269



270

applies to POLST

271

so…

272

you **may decline** to comply with request for LSMT

273

patient with capacity

274

or

275

advance directive POLST

276

or

277

agent
conservator
surrogate

278

279

you **may decline** to comply with request for LSMT

280

no matter **who** makes it

281

no matter **how** they make it

282

what decisions

283

284

"including … **provide, withhold, or withdraw** … all … forms of health care"

285

surrogate asks to **start** dialysis

286

you **may decline** to start

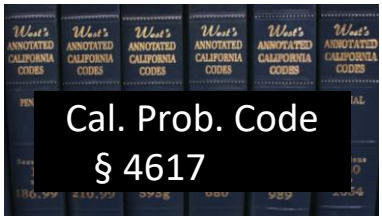
287

surrogate asks to **continue** dialysis

288

you **may decline** to continue

289



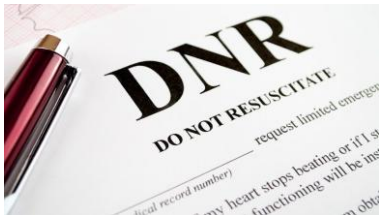
290

"directions to provide … CPR"

291

SO…

292



293

IN OTHER WORDS

294

4735 permits overriding surrogate

295

4735 **permits** clinicians to

296

withhold ***or*** withdraw

297

omit
or
cease

298

any
treatment

299

Physician Certification of Medically Ineffective Treatment Maryland form

The Physician Certification of Medically Ineffective Treatment must be completed by the attending physician and a second physician prior to withholding or withdrawing life sustaining treatment (including CPR) on the basis that the treatment would be medically ineffective.

(Place √ by treatments deemed medically ineffective):

☐ CPR / Defibrillation	☐ TPN
☐ Endotracheal Intubation and Mechanical Ventilation	☐ Tube feeding
☐ BiPAP or cPAP	☐ Antibiotics
☐ Reintubation	☐ Dialysis
☐ IV Vasoactive Drugs	☐ Labs / Including fingersticks
☐ IV Anti-arrhythmic Drugs	☐ Surgery/Invasive procedure
☐ Cardioversion	☐ Fluid boluses
☐ Blood Products	☐ Automatic cardiac defibrillator
☐ Other ___	

300

301

may decline to follow request for LSMT

302

no matter the **type** of LSMT

303

no matter **who** makes the decision

304

no matter **how** they make it

305

but

306

only if that request for LSMT is

307

contrary to GAHCS

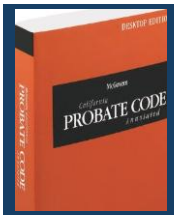
308

or

309

medically ineffective

310



what do these words **mean**

311

312

contrary to GAHCS

313

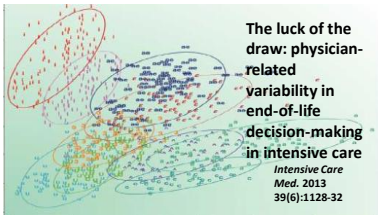
GAHCS **S**

314

standard of care **S**

315

316



317

318

medically ineffective

319

"not offer any **significant benefit**"

320

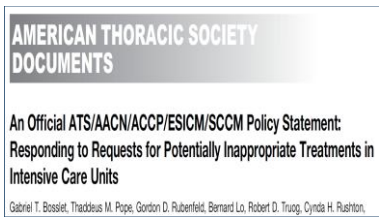
321

easier cases

322

start with vocabulary

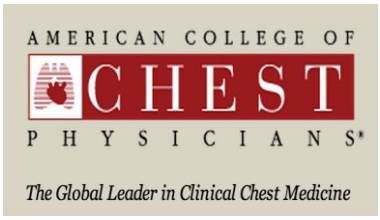
323



324

325

326



327

328

329

4 terms

330

- futile
- legally proscribed
- legally discretionary
- potentially inappropriate

331

futile

332

intervention **cannot** (at all) accomplish physiological goals

333

scientific impossibility

334

335

336

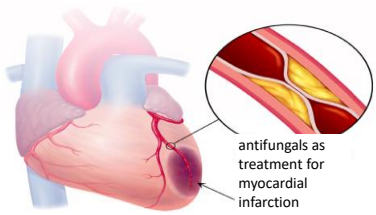
example 1

337

338

example 2

339



340

example 3

341

342

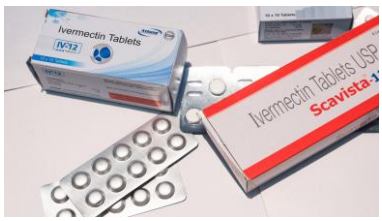
example 4

343

344

example 5

345



346

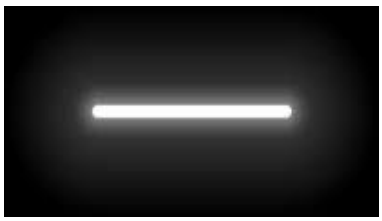
"futile"

347

value free

objective

348



349

chance of working

0.00%

350

may the clinician stop LSMT?

351

“futile”

352

may & should refuse

353

354

“futile” treatment
is
“medically ineffective”

355

~~futile~~
legally proscribed
legally discretionary
potentially inappropriate

356

legally proscribed

357

treatment **may accomplish** effect desired by the patient

358

>0%

359

not “futile”

360

prohibited by applicable laws, judicial precedent, or widely accepted public policies

361

example 1

362

363

might "work" but illegal

364

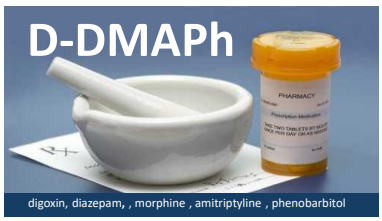
example 2

365

366

example 3

367



368

if treatment request is legally **proscribed** →

369

may & should refuse

370

371

"proscribed" treatment
is
"contrary to GAHCS"

372

~~futile~~

~~legally proscribed~~

legally discretionary

potentially inappropriate

373

legally discretionary

374

opposite of proscribed

375

376

377

laws, judicial precedent, or policies give physicians **permission** to refuse to administer them

378

example 1

379

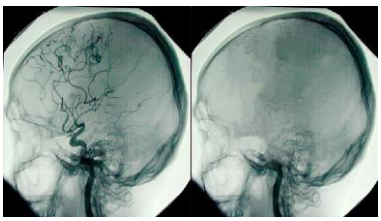
380

1. achondrogenesis;
2. anencephaly;
3. acardia;
4. body stalk anomaly;
5. campomelic dysplasia;
6. craniorachischisis;
7. dysencephalia splanchnocystica (M
8. ectopia cordis;
9. exencephaly;
10. gestational trophoblastic neoplasia
11. holoprosencephaly;
12. hydrops fetalis;
13. iniencephaly;
14. perinatal hypophosphatasia;
15. osteogenesis imperfecta (type 2)
16. renal agenesis (bilateral);
17. short rib polydactyly syndrome;
18. sirenomelia;
19. thanatophoric dysplasia;
2. triploidy;
21. trisomy 13;
22. trisomy 16 (full);
23. trisomy 18;
24. trisomy 22; and

381

example 2

382



383

Annals of Internal Medicine

American College of Physicians Ethics Manual

Sixth Edition

Lois Snyder, JD, for the American College of Physicians Ethics, Professionalism, and Human Rights Committee*

"after a patient . . . brain dead . . . medical support should be **discontinued**"

384

Views & Reviews

Really, most SINCERELY dead

Policy and procedure in the diagnosis of death by neurologic criteria

D.M. Shaner, MD; R.D. Orr, MD; T. Drought, PhD, RN; R.B. Miller, MD; and M. Siegel, MD

"once death … diagnosed … **discontinue** support"

385

Guidelines for Physicians: Forgoing Life-Sustaining Treatment for Adult Patients

Joint Committee on Biomedical Ethics of the Los Angeles County Medical Association and Los Angeles County Bar Association

Approved by the Los Angeles County Medical Association February 15, 2006
Approved by the Los Angeles County Bar Association March 22, 2006

"all medical interventions should be **withdrawn**"

386

consent **not** required

387

may the clinician stop LST?

388

legally discretionary

389

may & should refuse

390

391

"discretionary" treatment is "contrary to GAHCS"

392

393

~~futile~~

~~legally proscribed~~

~~legally discretionary~~

potentially inappropriate

394

futile
proscribed
discretionary
→ refuse

395

harder cases

396

potentially inappropriate treatment

397

some chance of accomplishing the effect sought by patient or surrogate

398

not "futile" because **might** "work"

399

examples

400

dialysis for permanently unconscious

401

MV for widely metastatic cancer

402

we call these "futility disputes"

403

but

404

disputed Tx **might** keep patient alive

405

406

is that chance or outcome **worthwhile**

407

not a medical judgment

408

value judgment

409

"potentially"

410

vet & confirm
your judgment

411

Table 4. Recommended Steps for Resolution of Conflict Regarding Potentially Inappropriate Treatments

1. Before initiation of and throughout the formal conflict-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 medical opinion to verify the prognosis and the judgment that the requested treatment is inappropriate.
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 case review by an independent appeals body.

7a. If the committee or appellate body 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.

7b. If the committee agrees with the clinicians' judgment, 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.

412

2nd opinion

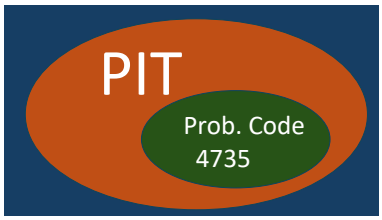
interdisciplinary institutional committee

413

helps consensus

assures carefully considered

414



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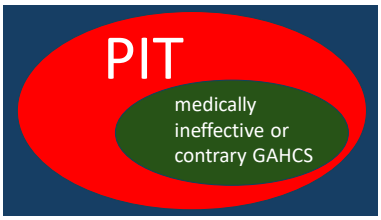


416

417

imminent death
irreversible coma
Rs outweigh Bs

418

imminent death

419

Sept. 2016

Society of Critical Care Medicine

The Intensive Care Professionals

420

CALIFORNIA MEDICAL ASSOCIATION

421

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

422

patient will die
in **hours/days**
even with LSMT

423

advanced metastatic disease

advanced multi-system organ failure from sepsis

424

active clinical deterioration

425

426

not futile

might be able to restart circulation

427

but

428

429

actively dying

death impending imminent - hours

430

cardiac arrest just the **start** of an inexorable dying process that cannot be prevented

431

court case example

432

Elizabeth Alexander

433

434

70 years old

end-stage pancreatic cancer

435

transferred from SNF

436

"clearly an individual who should **not** undergo aggressive resuscitation"

437

"frail, debilitated, ... metastasis ... extensive"

438

but

439

POLST

AD

agent (son)

440

"**all** measures to prolong life"

441

cannot replace agent – he's following AD

442

appropriate care committee

443

DNR

444

Alexander died next day

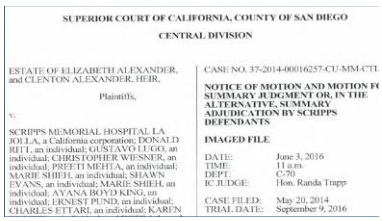
445

446

447

"medically ineffective"

448



SUPERIOR COURT OF CALIFORNIA, COUNTY OF SAN DIEGO

CENTRAL DIVISION

ESTATE OF ELIZABETH ALEXANDER, and CLENTON ALEXANDER, HEIR,

Plaintiffs,

v.

SCRIPPS MEMORIAL HOSPITAL LA JOLLA, a California corporation; DONALD RITT, an individual; GUSTAVO LUGO, an individual; CHRISTOPHER WIESNER, an individual; PREETI MEHTA, an individual; MARIE SHIEH, an individual; SHAWN EVANS, an individual; MARIE SHIEH, an individual; AYANA BOYD KING, an individual; ERNEST PUNB, an individual; CHARLES ETTARI, an individual; KAREN

CASE NO. 37-2014-00016257-CU-MM-CTL

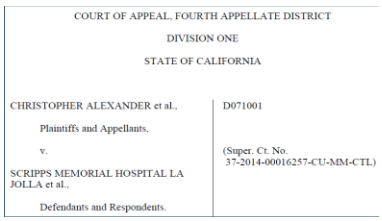
NOTICE OF MOTION AND MOTION FO SUMMARY JUDGMENT OR, IN THE ALTERNATIVE, SUMMARY ADJUDICATION BY SCRIPPS DEFENDANTS

IMAGED FILE

DATE: June 3, 2016
TIME: 11 a.m.
DEPT: C-70
IC JUDGE: Hon. Randa Trapp

CASE FILED: May 20, 2014
TRIAL DATE: September 9, 2016

449



COURT OF APPEAL, FOURTH APPELLATE DISTRICT

DIVISION ONE

STATE OF CALIFORNIA

CHRISTOPHER ALEXANDER et al.,

Plaintiffs and Appellants,

v.

SCRIPPS MEMORIAL HOSPITAL LA JOLLA et al.,

Defendants and Respondents.

D071001

(Super. Ct. No. 37-2014-00016257-CU-MM-CTL)

450

Cedars Sinai

451

SUPERIOR COURT OF CALIFORNIA, COUNTY OF LOS ANGELES
Civil Division
Central District, Stanley Mosk Courthouse, Department 54

23STCV09073 — April 30, 2025
SIAMAK PISHVAEE, et al. vs CEDARS-SINAI HEALTH SYSTEM, et al. — 9:00 AM

Judge: Honorable Maurice A. Leiter
Judicial Assistant: A. J. Ortiz
Courtroom Assistant: R. Manzo
CSR: J. Weldon, C.S.R #10098
ERM: None
Deputy Sheriff: None

452

imminent death =
medically ineffective
or contrary GAHCS

453

~~imminent death~~
irreversible coma
Rs outweigh Bs

454

irreversible coma

455

no reasonable expectation neurologic function will improve to allow patient to **perceive the benefits** of treatment

456

Sept. 2016

Society of Critical Care Medicine
The Intensive Care Professionals

457

CALIFORNIA MEDICAL ASSOCIATION

458

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

459

460

irreversible coma =
medically ineffective
or contrary GAHCS

461

~~imminent death~~
~~irreversible coma~~
Rs outweigh Bs

462

risks outweigh benefits

463

464

465

466

may unilaterally
withdraw LSMT

467

GAHCS
ME
Tx

468

when is that

469

GAHCS ME

- discretionary
- proscribed
- futile

470

471

but also

472

GAHCS ME

- PIT

473

GAHCS ME

- permanent coma
- imminent death
- R > B

474

475

GAHCS

- never leave ICU

476

common basis for judging LSMT inappropriate

477

no reasonable expectation patient will improve … to survive **outside the acute care setting**

478

Society of Critical Care Medicine
The Intensive Care Professionals

479

SAN DIEGO COUNTY MEDICAL SOCIETY

480

but

481

federal constraints

482

483

CA law says no duty if medically ineffective contrary GAHCS

484

485

486

"the Laws of the United States … shall be the **supreme Law of the Land** … …Laws of any State … notwithstanding"

487

may not base on

age race sex color national origin

488

may not base on

disability

489

490

FEDERAL REGISTER

Nondiscrimination on the Basis of Disability in Programs or Activities Receiving Federal Financial Assistance

491

effective

July 8, 2024

492

"discrimination is particularly salient in the context of **medical futility**"

493

discriminatory

"deny … treatment … cannot end dependence on intensive … care"

494

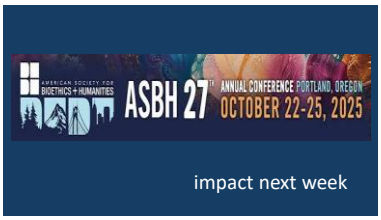
so…

495

may not withdraw LSMT based on judgment

"life ICU is not worth living"

496



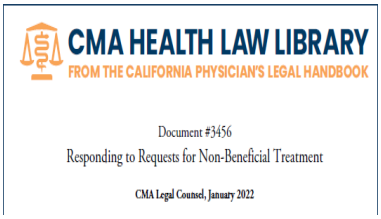
impact next week

497

498

immunity

499



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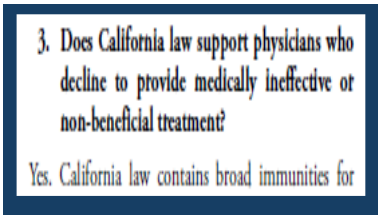

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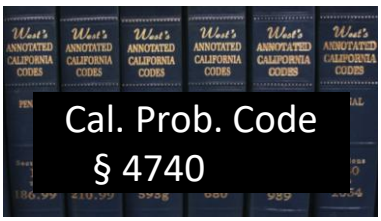


Cal. Prob. Code § 4740

502

"not subject to civil **or** criminal liability **or** to discipline for unprofessional conduct"

503

6 conditions

504

1

505

“act in good faith”

506

2

507

“act … in accordance with generally accepted health care standards”

508

3

509

“**inform** the patient, if possible, and any person then authorized to make health care decisions”

510

4

511

“make all reasonable efforts to assist in the **transfer**”

512

5

513

"provide **continuing care** … until a transfer can be accomplished **or** until it appears that a transfer cannot be accomplished"

514

6

515

"continue … appropriate pain relief and palliative care"

516

does it work?

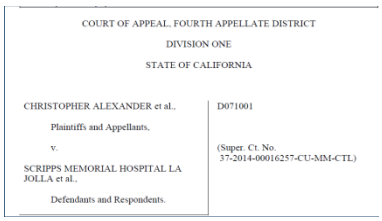
517

Elizabeth Alexander

518

"**immune** from liability under section 4740"

519



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D071001

(Super. Ct. No. 37-2014-00016257-CU-MM-CTL)

520

safe harbor immunity **works**

521

conclusion

522

clinician	surrogate
CMO	LSMT

523

524

try to **prevent**

w/ better communication
w/ documentation Pt wishes

525

try to reach **consensus**

with more family meetings
with EC, palliative, chaplaincy …

526

no consensus?

527

try **transfer** to another facility

528

try to **replace** surrogate

529

if **none** of that works …

530

use your fair multidisciplinary review process

531

withdraw LSMT
without consent

532

when
requested LSMT is

533

futile
will not work **at all**

534

or

535

proscribed
prohibited by
laws, rules

536

or

537

discretionary
permitted by
laws, rules

538

or

539

imminent demise
dying hours/days
- even with Tx

540

or

541

irreversible coma

permanently unconscious

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or

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risks outweigh

benefits by a **lot**

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Thank you!

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