1

Responding to Requests for Non-Beneficial Treatment: Ethics and Law

2

Thaddeus Mason Pope

JD, PhD, HEC-C

3

disclosure

Wolters Kluwer royalties for UPTODATE

4

learning objectives

1. Explain how the California Probate Code authorizes clinicians and hospitals to withhold or withdraw life-sustaining treatment contrary to patient or surrogate direction when the requested treatment is medically ineffective or contrary to generally accepted health care standards.

2. Recognize that most medico-legal concerns about writing unilateral orders to withhold or withdraw treatment are misplaced and not evidence-based. In fact, California laws legally protect clinicians who follow specified dispute resolution procedures.

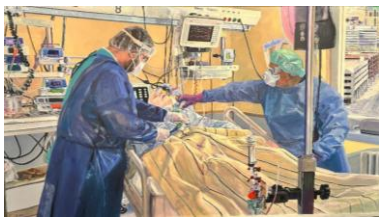
3. Describe widely recognized best practices for resolving disputes concerning medically ineffective or non-beneficial treatment (aka medical futility conflicts).

5

description

California clinicians increasingly confront medical futility conflicts. Typically, in these disputes the incapacitated patient's legally authorized decision maker requests life-sustaining treatment that clinicians judge potentially inappropriate or non-beneficial. Most of these conflicts are resolved with mediation, transfer, or surrogate selection. For the subset that remain intractable, California laws provide a fair dispute resolution pathway that legally protects clinicians and hospitals who refuse to administer interventions determined medically ineffective or contrary to generally accepted healthcare standards.

6



7

catastrophically critically ill

8

lacks decision making capacity

9

clinicians often recommend **CMO**

10

surrogates often **agree**

11

not always

12

13

clinician	surrogate
CMO	LSMT

14

typical response

15

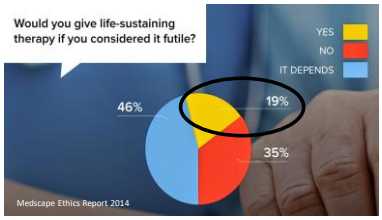
cave-in

16

17

2014

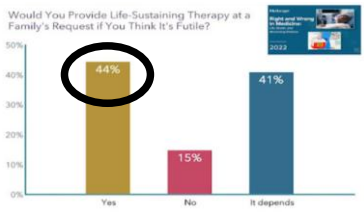
18



19

2022

20



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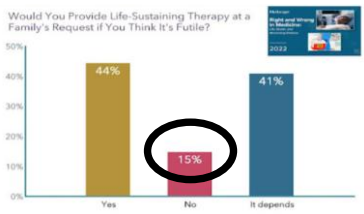


22

23

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

24

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

25

CALIFORNIA MEDICAL ASSOCIATION

26

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

27

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

28

why?

29

30

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

31

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 Hul[2], Edwina Light[3,4]

32

most nurses would commence CPR in patients with **clear signs of death** in the absence of a DNR order

33

nomo-phobia

fear of law

34

no mopho phobia

35

36

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

37

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

38

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

39

40

41

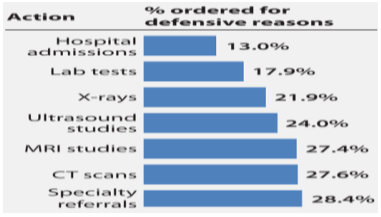
42

physicians round off

nurses bear brunt

43

44



45

here **too**

46

status quo
= cave in

47

48

49

so…

50

better responses

51

52

low risk

53

few cases brought

54

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

55

56

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

57

unlikely to win
immunity
judicial deference

58

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

59

few cases brought

60

in rare instances cases filed,
providers win

61

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

62

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

63

"**appropriately** invoked such policies"

64

providers lose **one type** lawsuit re unilateral WD

65

infliction of emotional distress

66

secretive

insensitive

outrageous

67

not liable for withdrawing but for

how

68

69

slow code

show code

Hollywood code

70

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)

71

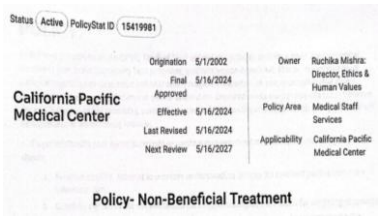
consultation expected

distress foreseeable

72

73

74



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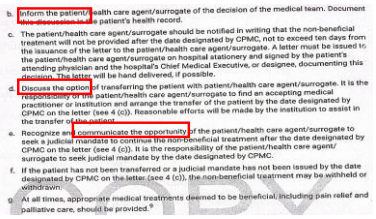

b. Inform the patient/health care agent/surrogate of the decision of the medical team. Document this discussion in the patient's health record.

c. The patient/health care agent/surrogate should be notified in writing that the non-beneficial treatment will not be provided after the date designated by CPMC, not to exceed ten days from the issuance of the letter to the patient/health care agent/surrogate. A letter must be issued to the patient/health care agent/surrogate on hospital stationery and signed by the patient's attending physician and the hospital's Chief Medical Executive, or designee, documenting this decision. The letter will be hand delivered, if possible.

d. Discuss the option of transferring the patient with patient/health care agent/surrogate. It is the responsibility of the patient/health care agent/surrogate to find an accepting medical practitioner or institution and arrange the transfer of the patient by the date designated by CPMC on the letter (see 4 (c)). Reasonable efforts will be made by the institution to assist in the transfer of the patient.

e. Recognize and communicate the opportunity of the patient/health care agent/surrogate to seek a judicial mandate to continue the non-beneficial treatment after the date designated by CPMC on the letter (see 4 (c)). It is the responsibility of the patient/health care agent/surrogate to seek judicial mandate by the date designated by CPMC.

f. If the patient has not been transferred or a judicial mandate has not been issued by the date designated by CPMC on the letter (see 4 (c)), the non-beneficial treatment may be withheld or withdrawn.

g. At all times, appropriate medical treatments deemed to be beneficial, including pain relief and palliative care, should be provided.[9]

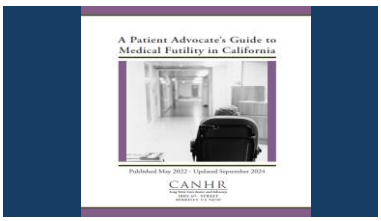
76

77

78

79

80



81

little patient or family can do

82

"virtually **no limits**"

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

83

most likely legal action

84

85

not about liability

not about the merits

86

87

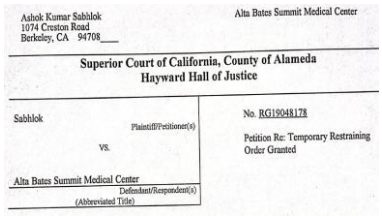
preserve **status quo** until gather & assess evidence & argument

88

89

18 days

90


Ashok Kumar Sabhlok
1074 Creston Road
Berkeley, CA 94708

Alta Bates Summit Medical Center

Superior Court of California, County of Alameda
Hayward Hall of Justice

Sabhlok
Plaintiff/Petitioner(s)
vs.
Alta Bates Summit Medical Center
Defendant/Respondent(s)
(Abbreviated Title)

No. RG19048178

Petition Re: Temporary Restraining Order Granted

91

must **continue** LSMT

until court resolves whether you have a duty to continue LSMT

92

93

94

95

prevalence NBT conflicts

causes NBT conflicts

prevention NBT conflicts

96

97

98

have a conflict

99

what are your **options**

100

4 options

101

consensus

102

new surrogate

103

new hospital

104

if **none** of that works …

105

withdraw LST **without** consent

106

107

108

109

this is only legal **information**

not legal **advice**

110

see your **own** OGC or RM

Sutter Health

SOUND PHYSICIANS

111

path 1 of 4

112

consensus

113

most hospital policies

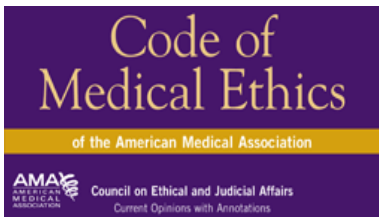
most society guidelines

114

negotiation

mediation

115



116

4 of 7 steps

117

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

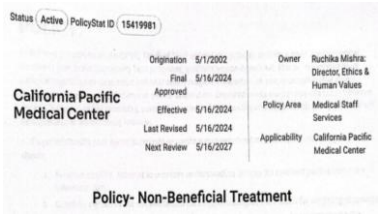
2. **joint** decision making … maximum extent

118

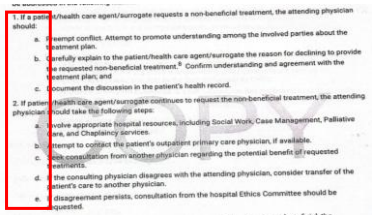
3. attempts … **negotiate** … reach resolution

4. involve … **ethics committee**

119



120


1. If a patient/health care agent/surrogate requests a non-beneficial treatment, the attending physician should:
   a. Preempt conflict. Attempt to promote understanding among the involved parties about the treatment plan.
   b. Carefully explain to the patient/health care agent/surrogate the reason for declining to provide the requested non-beneficial treatment.[6] Confirm understanding and agreement with the treatment plan; and
   c. Document the discussion in the patient's health record.
2. If patient/health care agent/surrogate continues to request the non-beneficial treatment, the attending physician should take the following steps:
   a. Involve appropriate hospital resources, including Social Work, Case Management, Palliative Care, and Chaplaincy services.
   b. Attempt to contact the patient's outpatient primary care physician, if available.
   c. Seek consultation from another physician regarding the potential benefit of requested treatments.
   d. If the consulting physician disagrees with the attending physician, consider transfer of the patient's care to another physician.
   e. If disagreement persists, consultation from the hospital Ethics Committee should be requested.

121

why?

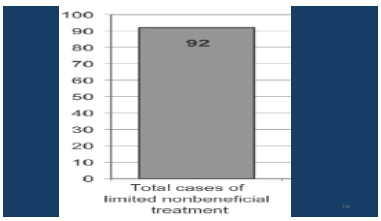
122

123

95%

124

125



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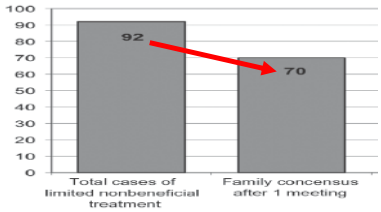

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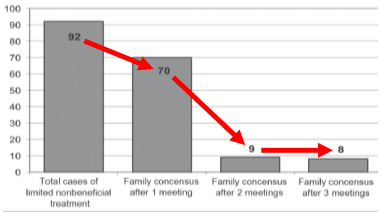
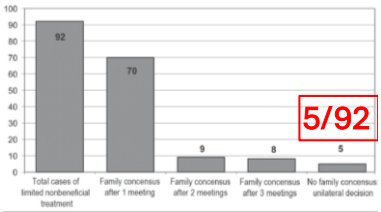


128



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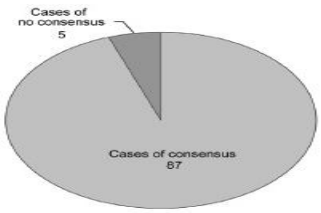


130

131

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.

132

57% agree immediately

90% agree within 5 days

96% agree after more meetings

133

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

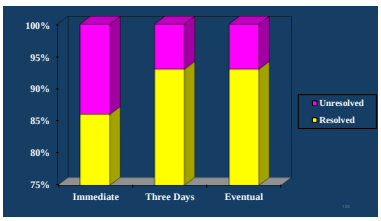
Robert L. Fine, MD, and Thomas Wm. Mayo, JD

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. 2001;134:1262-1268. www.annals.org

134



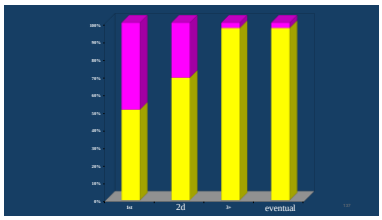
135

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

136

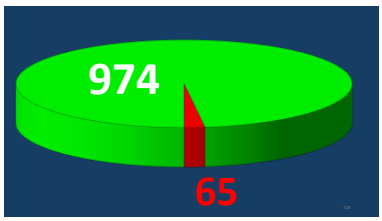


137

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)

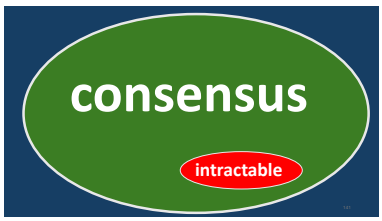
138



139

95%

140



141

but

142

tried reach consensus

143

intensive communication

mediation

144

still no consent

145

146

	clinician		
		stop	go
surrogate	stop		
	go	X	

147

path 2 of 4

148

new surrogate

149

sometimes surrogates should be **challenged**

150

sometimes surrogate should even be **replaced**

151

152

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

153

otherwise,
act in patient's
best interest

154

155

but

156

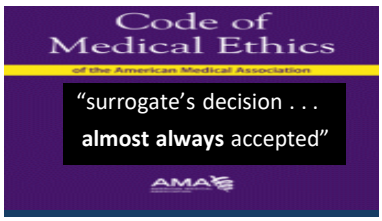
157

~ 60%
accurate

158

more
aggressive
treatment

159



160

161

educate
support

162

ensure surrogate understands Pt **prognosis**

163

May 2023

164

"at least 1 of 5 core elements of shared decision making … **missing** from **95%** … family meetings"

165

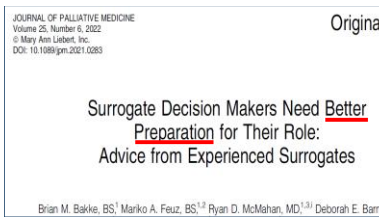
166

in addition to helping surrogate understand Pt situation

167

ensure surrogate understands **role** of surrogate

168



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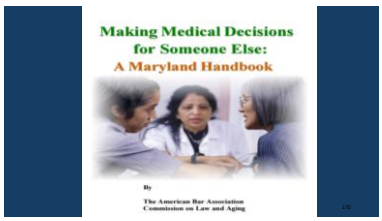


170

5

171

surrogate lacks **capacity**

172

surrogate has material **COI**

173

174

AD →

← surrogate

175

known wishes →

← surrogate

176

"dad would not have wanted X"

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

177

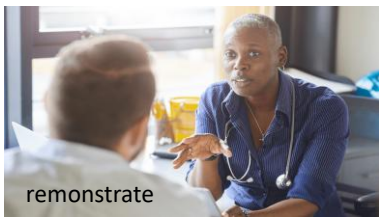
if **no** AD or known wishes

178

best interest →

← surrogate

179



180

181

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

182

surrogate replacement **works**

183

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION SIX

SCOT BERNSTEIN,

Petitioner,

v.

THE SUPERIOR COURT OF VENTURA COUNTY,

Respondent;

ILYA BERNSTEIN, CONSERVATOR OF THE PERSON OF KARL BERNSTEIN, et al.,

2d Civil No. B212067
(Super. Ct. No. P076953)
(Ventura County)

OPINION AND ORDER DENYING PETITION FOR WRIT OF MANDATE

184

how?

185

5 types of surrogates in CA

186

default surrogates

agents

orally designated surrogates

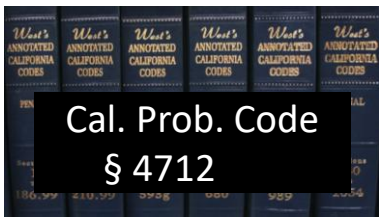
parents

guardians

187

default surrogates

188



189

"health care provider … **may choose** a surrogate to make health care decisions on the patient's behalf"

190

choose new (better) surrogate

191

319 Cal.Rptr.3d 400

Mark HARROD, Plaintiff and Respondent,

v.

COUNTRY OAKS PARTNERS, LLC, et al., Defendants and Appellants.

S276545

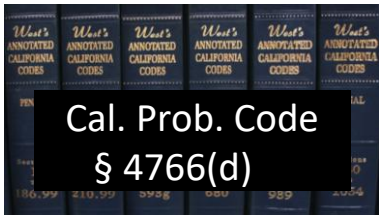
Supreme Court of California.

March 28, 2024

192

agents

193



194

"petition may be filed … declaring … authority of an agent … **terminated**"

195

THE RECAP

196

you **can** replace "bad" surrogates

197

you **must** replace "bad" surrogates

198

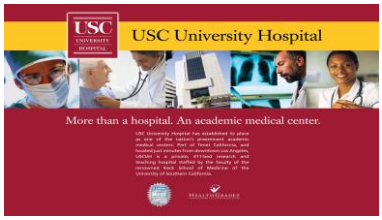
incongruent

patient wishes

or

patient best interests

199



200

Plascentia McDonald

74yo

201

advance directive

1. Bobby is agent
2. Cynthia is alternate
3. "do not prolong life if incurable condition"

202

Aug. 14

surgery – thoracoabdominal aneurysm

post-op infections

203

Aug. 30

sepsis, non-cognitive

continued LST

3 additional surgeries

204

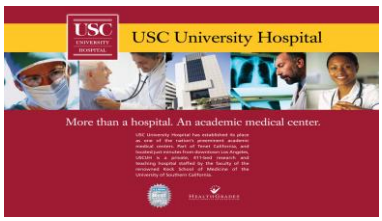
Cynthia **opposes** this

"not what mom wanted"

but … she is **not** the agent

205

206



207

"good faith **comply with** a health care decision made by one whom they believe authorized"

208

209

"no"

210

"compliance with agent's decision … **at odds** with … patient's … AD … **not** … good faith"

211

agent **not** authorized to depart from AD

USC should have known that

212

The New York Times

The Patients Were Saved. That's Why the Families Are Suing.

Paula Span

THE NEW OLD AGE APRIL 10, 2017

213

duty to challenge

214

but

215

limits to surrogate replacement

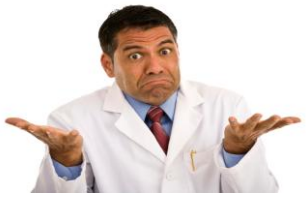
216

1 limit

217

clinicians **cannot** show deviation

218



219

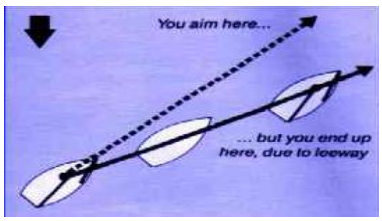
2 limit

220

surrogates get benefit of doubt

221

222

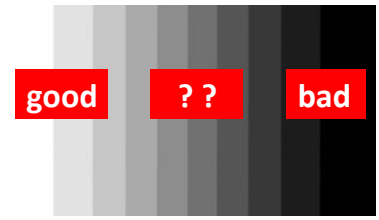


223

SO…

224

225



226

3 limit

227

surrogates
are **faithful**

228

229

THE RECAP

230

no consensus
no new surrogate

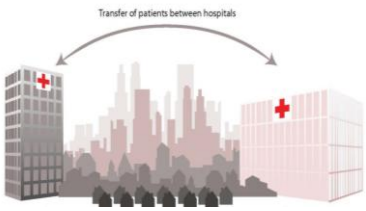
231

path 3 of 4

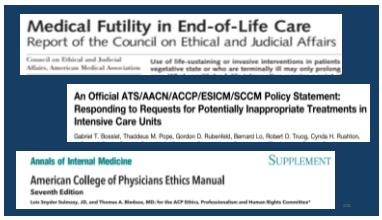
232

new hospital

233



234



235

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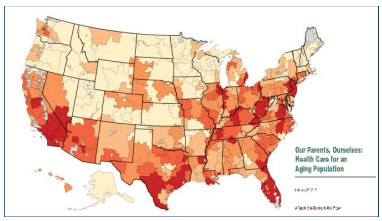
240

241



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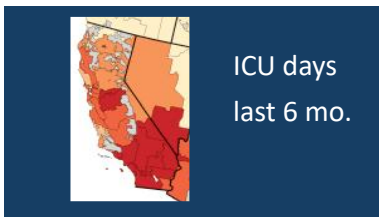
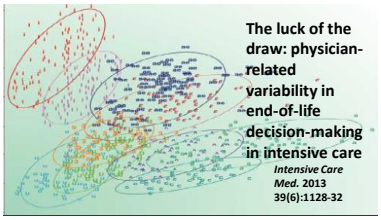


243

physician

variability

244



The luck of the draw: physician-related variability in end-of-life decision-making in intensive care

Intensive Care Med. 2013 39(6):1128-32

245

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

246

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%)

247

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%)

248

April 2025

AJOB Empirical Bioethics

Whether to Offer Interventions at the End of Life: What Physicians Consider and How Clinical Ethicists Can Help

JPSM

249

hospital

variability

250

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

251

[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;

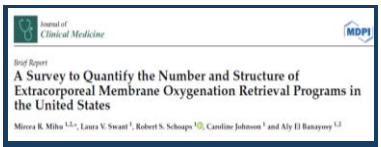
252

can find & make transfers

253

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

254



likely **lower** w ECMO

255

THE RECAP

256

no consent
no new surrogate
no transfer

257

path 4 of 4

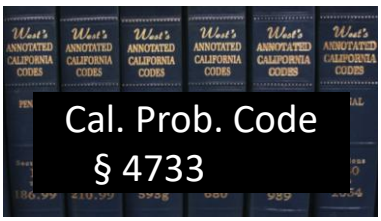
258

withdraw LSMT w/o consent

259

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

260



261

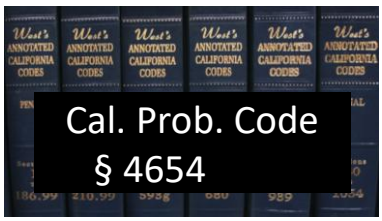
"provider … **shall … comply** with a … decision … made by a person then authorized"

262

but

263

264



265

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

266

267

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

268

either

269

"**medically ineffective** health care"

270

or

271

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

272

plus

273

legal immunity

274

275

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

276

277

may stop LSMT **without** consent

278

with legal **immunity**

279

contrary to GAHCS

280

medically ineffective

281

282

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

283

3 questions

284

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

285

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

286

when may you decline to comply with those decisions

287

whose decisions

288

289

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

290

instruction

291

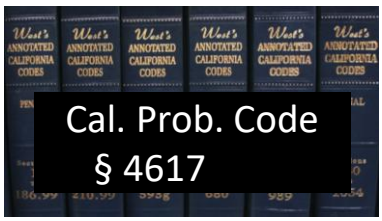
292

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

293

decision

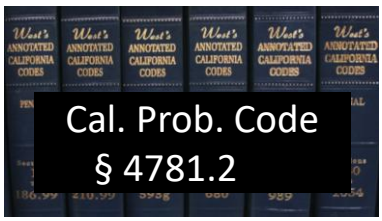
294



295

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

296



297

applies to POLST

298

so…

299

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

300

patient with capacity

301

or

302

advance directive POLST

303

or

304

agent
conservator
surrogate

305

306

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

307

no matter **who** makes it

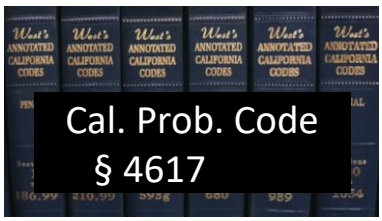
308

no matter **how** they make it

309

what decisions

310



311

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

312

surrogate asks to **start** dialysis

313

you **may decline** to start

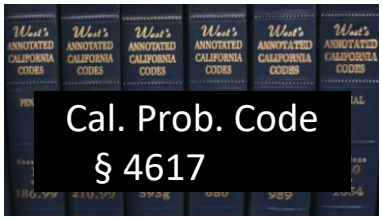
314

surrogate asks to **continue** dialysis

315

you **may decline** to continue

316



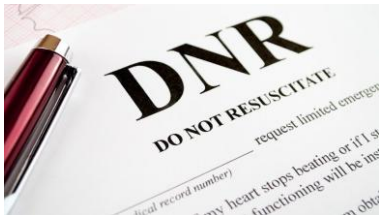
317

"directions to provide … CPR"

318

SO…

319



320

321

4735 permits overriding surrogate

322

4735 **permits** clinicians to

323

withhold ***or*** withdraw

324

omit
or
cease

325

any
treatment

326

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

327

328

may decline to follow request for LSMT

329

no matter the **type** of LSMT

330

no matter **who** makes the decision

331

no matter **how** they make it

332

but

333

only if that request for LSMT is

334

contrary to GAHCS

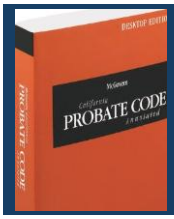
335

or

336

medically ineffective

337



what do these words **mean**

338

339

contrary to GAHCS

340

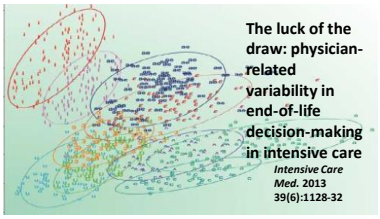
GAHCS **S**

341

standard of care **S**

342

343



344

GAHCS

345

medically ineffective

346

"not offer any **significant benefit**"

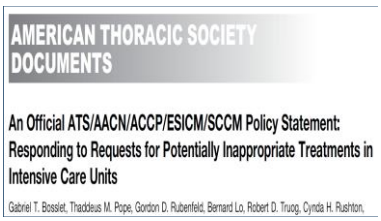
347

easier cases

348

start with vocabulary

349



350

AMERICAN THORACIC SOCIETY · 1905 · ATS
We help the world breathe
PULMONARY · CRITICAL CARE · SLEEP

351

Society of Critical Care Medicine
The Intensive Care Professionals

352

AMERICAN COLLEGE OF CHEST PHYSICIANS
The Global Leader in Clinical Chest Medicine

353

AACN

354

ESICM
EUROPEAN SOCIETY OF INTENSIVE CARE MEDICINE

355

4 terms

356

- futile
- legally proscribed
- legally discretionary
- potentially inappropriate

357

futile

358

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

359

scientific impossibility

360

361

362

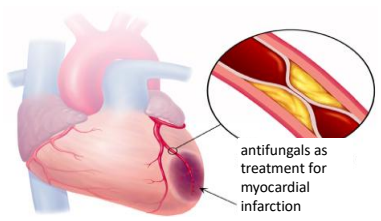
example 1

363

364

example 2

365



366

example 3

367

368

example 4

369

370

example 5

371

372

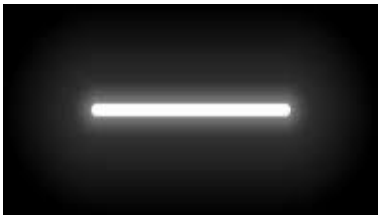
"futile"

373

value free

objective

374



375

may the clinician stop LSMT?

376

"futile"

377

may & should refuse

378

379

"futile" treatment

is

"medically ineffective"

380

~~futile~~

legally proscribed

legally discretionary

potentially inappropriate

381

legally proscribed

382

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

383

>0%

384

not "futile"

385

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

386

example 1

387

388

might "work"

but illegal

389

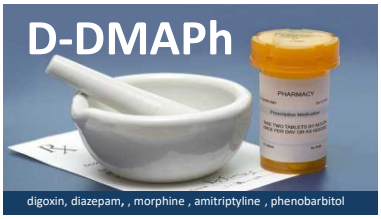
example 2

390

391

example 3

392



393

if treatment request is legally **proscribed** →

394

may & should refuse

395

396

"proscribed" treatment
is
"contrary to GAHCS"

397

~~futile~~

~~legally proscribed~~

legally discretionary

potentially inappropriate

398

legally discretionary

399

opposite of proscribed

400

401

402

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

403

example 1

404

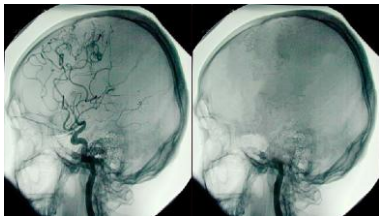
405

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

406

example 2

407



408

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**"

409

CMA California Medical Association

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"

410

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**"

411

consent **not** required

412

may the clinician stop LST?

413

legally discretionary

414

may & should refuse

415

416

"discretionary" treatment
is
"contrary to GAHCS"

417

surrogate

appropriate medicine

418

~~futile~~

~~legally proscribed~~

~~legally discretionary~~

potentially inappropriate

419

futile
proscribed
discretionary

→ refuse

420

harder cases

421

potentially inappropriate treatment

422

some chance of accomplishing the effect sought by patient or surrogate

423

not “futile” because **might** “work”

424

examples

425

dialysis for permanently unconscious

426

MV for widely metastatic cancer

427

we call these “futility disputes”

428

but

429

disputed Tx **might** keep patient alive

430

431

is that chance or outcome **worthwhile**

432

not a medical judgment

433

value judgment

434

"potentially"

435

vet & confirm your judgment

436

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.

437

2nd opinion

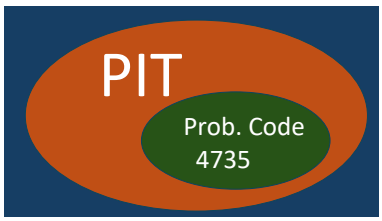
interdisciplinary institutional committee

438

helps consensus

assures carefully considered

439



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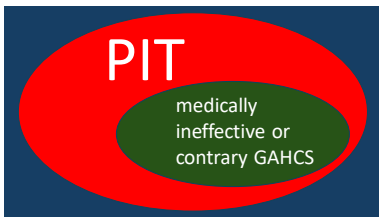


441

3 situations

442

imminent death

irreversible coma

Rs outweigh Bs

443

imminent death

444

Sept. 2016

Society of Critical Care Medicine

The Intensive Care Professionals

445

CALIFORNIA MEDICAL ASSOCIATION

446

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

447

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

448

advanced metastatic disease

advanced multi-system organ failure from sepsis

449

active clinical deterioration

450

451

not futile

might be able to restart circulation

452

but

453

454

actively dying

death impending

imminent - hours

455

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

456

court case example

457

Elizabeth Alexander

458

459

70 years old

end-stage pancreatic cancer

460

transferred from SNF

461

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

462

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

463

but

464

POLST

AD

agent (son)

465

"**all** measures to prolong life"

466

cannot replace agent – he's following AD

467

appropriate care committee

468

DNR

469

Alexander died next day

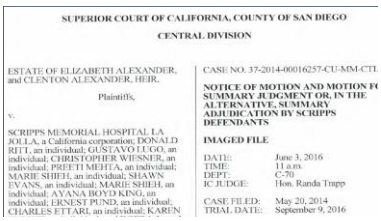
470

471

472

"medically ineffective"

473



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 WEISNER, an individual; PREETI MEHTA, an individual; MARIE SHIEH, an individual; SHAWN EVANS, an individual; MARIE SHIEH, an individual; AYANA BOYD KING, an individual; ERNEST PUND, an individual; CHARLES ETTARI, an individual; KAREN

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

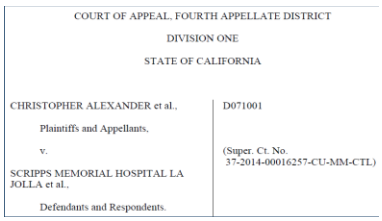
NOTICE OF MOTION AND MOTION FO SUMMARY JUDGMENT OR, IN THE ALTERNATIVE, SUMMARY ADJUDICATION BY SCRIPPS DEFENDANTS

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

474



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)

475

imminent death = medically ineffective or contrary GAHCS

476

irreversible coma

477

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

478

Sept. 2016

Society of Critical Care Medicine

The Intensive Care Professionals

479

CALIFORNIA MEDICAL ASSOCIATION

480

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

481

Torrance Memorial Medical Center

Department: Medical Staff

DRAFT

Policy/Procedure: MEDICALLY INEFFECTIVE TREATMENT

WITHDRAWING OR WITHHOLDING MEDICALLY INAPPROPRIATE LIFE-SUSTAINING TREATMENT HS 1319

UCLA Health

WITHDRAWING OR WITHHOLDING MEDICALLY INAPPROPRIATE LIFE SUSTAINING TREATMENT

482

irreversible coma = medically ineffective or contrary GAHCS

483

risks outweigh benefits

484

Status Active PolicyStat ID 15419981

California Pacific Medical Center

Origination	5/1/2002	Owner	Ruchika Mishra: Director, Ethics & Human Values
Final Approved	5/16/2024		
Effective	5/16/2024	Policy Area	Medical Staff Services
Last Revised	5/16/2024		
Next Review	5/16/2027	Applicability	California Pacific Medical Center

Policy- Non-Beneficial Treatment

485

Torrance Memorial

Department: Medical Staff

Policy/Procedure: MEDICALLY INEFFECTIVE TREATMENT

San Diego County Medical Society

"Physicians United for a Healthy San Diego"

CMA HEALTH LAW LIBRARY

FROM THE CALIFORNIA PHYSICIAN'S LEGAL HANDBOOK

486

487

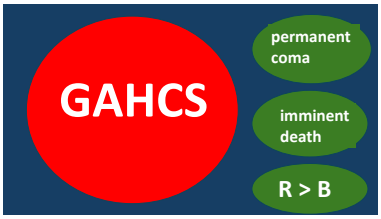
488

may unilaterally withdraw LSMT

489

490

491



492

493

494

common basis for judging LSMT inappropriate

495

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

496

Society of Critical Care Medicine
The Intensive Care Professionals

497

SAN DIEGO COUNTY MEDICAL SOCIETY

498

but

499

federal constraints

500

501

CA law says no duty if medically ineffective contrary GAHCS

502

503

504

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

505

may not base on

age race sex color national origin

506

may not base on

disability

507

508

FEDERAL REGISTER

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

509

effective

July 8, 2024

510

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

511

discriminatory

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

512

so…

513

may not withdraw LSMT based on judgment

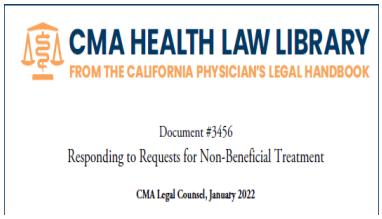
"life ICU is not worth living"

514

515

immunity

516



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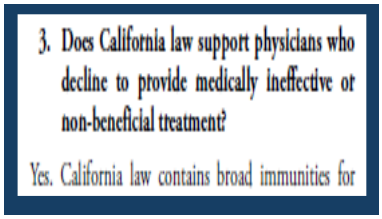

518

519

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

520

6 conditions

521

1

522

"act in good faith"

523

2

524

"act … in accordance with generally accepted health care standards"

525

3

526

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

527

4

528

"make all reasonable efforts to assist in the **transfer**"

529

5

530

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

531

6

532

"continue … appropriate pain relief and palliative care"

533

does it work?

534

Elizabeth Alexander

535

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

536

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)

537

safe harbor immunity **works**

538

but

539

how **long** to look for transfer

540

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

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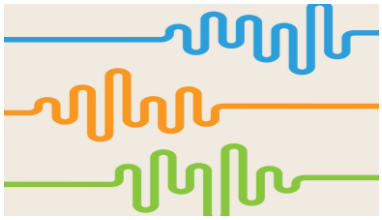

542

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

543

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

544

conclusion

545

clinician

CMO

surrogate

ECMO

546

547

try to **prevent**

w/ better communication
w/ documentation Pt wishes

548

try to reach **consensus**

with more family meetings
with EC, palliative, chaplaincy …

549

no consensus?

550

try **transfer** to another facility

551

try to **replace** surrogate

552

use your fair multidisciplinary review process

553

withdraw LSMT **without** consent

554

when requested LSMT is

555

proscribed
prohibited by laws, rules

556

discretionary
permitted by laws, rules

557

imminent demise
dying hours/days - even with Tx

558

irreversible coma

permanently unconscious

559

risks outweigh

benefits by a lot

560

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