

<b>Subject</b> Decision-making and Dispute Resolution for Medical Interventions Considered to be Harmful, Non-beneficial or Futile	<b>Attachments</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>Key words</b> Medical futility	<b>Number</b> <b>RH-RI-PC-10-28</b>
<b>Category</b> Ethics, Rights & Responsibilities (RI)	<b>Effective Date</b> <b>December 2009</b>
<b>Manual</b> Patient Care Manual	<b>Last Review Date</b> <b>December 2012</b>
<b>Issued By</b> Ethics Committee	<b>Next Review Date</b> <b>December 2015</b>
<b>Applicable</b> All Regions Employees	<b>Origination Date</b> <b>November 2009</b>
	<b>Retired Date</b>
<b>Review Responsibility</b> Ethics Committee, Medical Executive Committee	<b>Contact</b> Ethics Committee

**I. PURPOSE**

To provide a process by which decisions can be made when there is disagreement regarding whether a medical intervention is harmful, non-beneficial or futile.

**II. POLICY**

**A. Introduction**

When patients are extremely ill, patients, families, and health care providers always hope that interventions are available to help the patient. Most often, that is the case. Occasionally the patient / surrogate or the health care team may come to the conclusion that some interventions do not help or actually harm the patient. When that happens, discussion between the patient / family and team usually leads to agreement about what is best for the patient.

In rare instances when agreement is not reached, it is essential to have a clear process of discussion about the treatment plan and how it affects the patient. This document outlines a process for those rare instances when agreement is not reached about whether an intervention is harmful, non-beneficial or futile. Views on whether an intervention is non-beneficial, harmful, or futile often depend on how the benefits and burdens are defined. These issues reflect deeply held beliefs and values on the part of the patient / surrogate and health care providers.

Recognizing that everyone is pursuing what they believe is best for the patient, complete and open discussion of all aspects of treatment is essential to achieve the best interest of the patient. This is best done through a clear process that all people involved know in advance. Even when complete and open discussion has occurred, disagreement may continue. This policy outlines a process by which these disagreements may be resolved.

**B. Assumptions**

1. A basic commitment of health care is that all patients receive care that ensures their comfort and dignity. Comfort care is always a goal of treatment, especially when curative

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- intervention is no longer possible.
  2. Guidelines informing the provision of care must be explicit and equitable, and not to the disadvantage of the disabled, poor, or uninsured. They should also recognize the diversity of individual values and goals.
  3. The principle of respect for persons grounds patients' or their surrogates' right to accept, refuse, or limit medical interventions. An advanced health care directive is one expression of this right.
  4. Medical professionals are part of a tradition and practice devoted to the goals of promoting health, preventing illness, restoring function and relieving suffering and pain. They are committed to maintaining their integrity consistent with their standards of practice.
  5. Health care institutions balance obligations to their patients and professional staff with their commitments to the communities of which they are a part.
  6. Disputes regarding harmful, non-beneficial or futile interventions often reflect tensions between the values of individual autonomy, professional integrity, and institutional commitments. They may also reflect different beliefs regarding what counts as a benefit or burden of medical interventions, as well as differing conceptions of communal goods.
  7. Good faith efforts to resolve disputes regarding the provision of harmful, non-beneficial or futile interventions will always be made by the health care team. All appropriate institutional resources are to be offered to the patient / surrogate and health care team, e.g., social worker, chaplain, patient representative, ethics committee representative, palliative care team, etc. If disagreements about interventions can not be resolved, the institution will cooperate with the patient / surrogate in attempts to transfer the patient in a timely and expedient manner.
  8. If these efforts do not lead to resolution of the dispute, then the process described in this policy will be followed.

C. Policy

Members of the health care team collaborate with patients or their surrogate decision-makers to develop treatment goals and a care plan that reflects patient preferences and appropriate medical goals. When the patient / surrogate or the health care team identify that an intervention may be harmful, non-beneficial or futile, they immediately identify that to the other party. In rare instances, there may be unresolved disagreement about whether a medical intervention benefits the patient or is harmful or even medically futile. Disputes may arise regarding whether new interventions ought to be provided and / or current interventions withdrawn. All relevant institutional resources are to be used to resolve the dispute including care conferences, second opinions, discussions with support teams such as chaplains, social work, pain and palliative care, and ethics consultation.

If these attempts are unsuccessful, a formal process of dispute resolution as outlined in this document will be undertaken. If agreement on a shared plan of care is reached at any time, that plan will be implemented. If disagreement continues, a review panel will be established, and based on procedures outlined in this document will resolve the disagreement. If the review panel finds the intervention to be harmful, non-beneficial, or futile, that intervention will be withheld or withdrawn. This means that the patient / surrogate cannot be forced to accept interventions advocated by the health care team, and the health care team can not be forced to provide interventions requested by the patient / surrogate.

This process may be used at the request of either the patient / surrogate or the attending physician / health care team.

III. **PROCEDURE(S)**

- A. The formal process for identification of concerns that a medical intervention is harmful, non-beneficial, or futile involves the following steps that should all be included as part of the formal dispute resolution process:

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1. Initial recognition by the patient / surrogate or the health care team that the intervention may be harmful, non-beneficial or futile.
  2. Communication and discussion between the patient / surrogate and the health care team regarding this concern.
  3. If not already completed, formal ethics consultation should be convened with the patient / surrogate and the health care team, including written findings communicated to all parties.
  4. If not already completed, formal, independent second opinion(s) from appropriate physician(s) are obtained and the information is shared with both the patient / surrogate and the health care team, and a care conference with the patient / surrogate and health care team is held to discuss the second opinions.
  5. If there is still disagreement, establishment of a Review Panel to evaluate and reach a decision about whether the intervention is harmful, non-beneficial, or futile.
  6. The Review Panel Chair
    - a. Informs patient / surrogate and health care team of the next step in the process.
    - b. Assures relevant information for the patient / surrogate and the health care team will be presented to the Review Panel.
    - c. Assures that the institution's Risk Manager is aware of the procedure.
  7. Formal meeting of the Review Panel with patient / surrogate, their advisors, and the health care team at a time mutually accepted by all parties. If the invited parties choose not to attend, the meeting will still be held. The Review Panel gathers information from all parties and then develops a written decision regarding whether the intervention is harmful, non-beneficial, or futile.
  8. The decision of the Review Panel will be to either:
    - a. Provide the intervention in question; or
    - b. Continue to withhold the intervention in question, or, if the intervention in question is currently being provided, to withdraw it no later than ten days after this decision. The ten day period begins at the time the written decision is directly given to or sent by certified mail to the patient / surrogate and the health care team.
  9. The chair of the Review Panel will make reasonable efforts to communicate the decision of the Review Panel to all parties involved, including:
    - a. Attempts to communicate directly to each party in person or by phone.
    - b. Providing the written decision of the review panel directly and by certified mail to the patient / surrogate, the health care team, and the institution's administration, and assuring the written decision is in the patient's electronic health record (EHR).
  10. Compassionate assistance to attempt to locate another health care provider and arrange for transfer is provided by the institution if requested.
  11. After the ten day period interventions determined to be harmful, non-beneficial or futile are withdrawn.

**B. Review Panel Description and Role**

1. The Review Panel consists of three Health Partners Medical Group Ethics Committee members and two appropriate physician peers, members of the institution's Medical Staff without previous involvement or direct interest in the patient's care. The chair of the Review Panel is one of the HPMG Ethics Committee members and is appointed by the Chair of the HPMG Ethics Committee (or his / her designee) and the Chief Medical Officer (or his / her designee). The other members of the Review Panel are chosen by the Review Panel chair with the advice and consent of the chair of the HPMG Ethics Committee and the Chief Medical Officer (or their designees). Consideration will be given to including members of the HPMG Ethics Committee who have not previously been involved with the case, and to including a community member who is not employed by the institution or on the institution's medical staff.
2. The goals of the Review Panel are to:
  - a. Schedule a time at which the patient / surrogate and the members of the health care team can meet to review the situation and invite their participation, clarifying that the

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- meeting will be held even if one of the parties chooses not to attend.
  - b. Establish an atmosphere of respectful discussion of the issue.
  - c. Identify the specific intervention (s) which are possibly harmful, non-beneficial or futile, and the reasons the intervention (s) are considered to be so.
  - d. Review the current situation including:
    - i. Information from the patient / surrogate.
    - ii. Information from the health care team.
    - iii. The patient's medical, psychosocial, and personal history, and any expressed wishes regarding intervention.
    - iv. Previous attempts at discussion and resolution of disputes.
    - v. Additional information relevant to the decision.
  - a. Examine alternate viewpoints regarding the intervention (s) in question.
  - b. Reach a unanimous conclusion about whether the intervention(s) are harmful, non-beneficial, or futile. To determine that the intervention is harmful, non-beneficial, or futile requires a unanimous conclusion by the Review Panel.
  - c. The chair will make reasonable efforts to communicate the decision of the review panel to all parties involved (see Procedures #9).
  - d. Establish the next step in the process for each party.
  - e. Assure documentation of the decision of the Review Panel in the EHR.

#### IV. **DEFINITIONS**

- A. *Harmful intervention*: An intervention is considered harmful if it causes injury, pain, or suffering without likelihood of proportionate benefit.
- B. *Non-beneficial intervention*: An intervention is considered non-beneficial if it does not improve the patient's health status.
- C. *Futile intervention*: An intervention is considered futile if it will not achieve its intended short or long term physiological goal, or has no realistic chance of achieving the medical goal of returning the patient to the level of health that permits survival outside the acute care setting.
- D. *Life-sustaining intervention*: An intervention that, based on reasonable medical judgment, sustains the life of a patient and without which the patient will die. The term includes both life-sustaining medications and technological support, such as mechanical ventilators, renal dialysis equipment, artificial nutrition and hydration, and cardiopulmonary resuscitation. This term does not include the administration of pain management medication or any other medical care provided to alleviate a patient's pain or suffering.
- E. *Review Panel*: The group appointed to review, meet with the patient / surrogate and health care team, and make a decision about whether an intervention or set of interventions is harmful, non-beneficial, or futile.
- F. *Healthcare team*: All professional caregivers who have been involved in and have an appropriate role in the decision-making process regarding a patient's care.
- G. *Surrogate decision-maker*: The person identified, either in a health care directive, healthcare facility policy, or by standard of practice, to be authorized to make health care decisions for a patient who is decisionally incapacitated.

#### V. **COMPLIANCE**

Failure to comply with this policy or the procedures may result in disciplinary action.

#### VI. **ATTACHMENTS** NOT APPLICABLE

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**VII. OTHER RESOURCES**

*Internal*

PC-02-15 Criteria for the Determination of Brain Death by Physicians

PC-10-27 Principles and Guidelines for Limiting Treatments

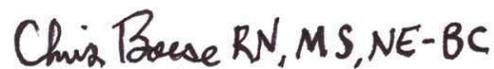
PC-15-90 End of Life / Comfort Care

**VIII. APPROVAL(S)**



Ken Holmen, MD

Vice-President Medical Affairs



Chris Boese, RN, MS, NE-BC

Vice President Patient Care Services

**IX. ENDORSEMENT**

HealthPartners Ethics Committee: September 2012

Ethics Consult Team: October 2012

Medical Executive Committee: December 2012

Quality, Practice & Education Council: December 2012

Patient Care Committee: December 2012