

Harvard Pediatric Bioethics Certificate Program

October 1, 2026

1

Circumscribing Parental Authority in the ICU

Futile, Non-Beneficial, & Potentially Inappropriate Treatment

2

Thaddeus Pope

JD, PhD, HEC-C

3



Dr. Truog
brain death
09/17/26

4



lots of conflicts – one type looks like this

5

Clinician - “Your child is dead. We must **stop** technologic support.”

Parents - “**No**. Please **continue** technologic support.”

6



7

similar sort of conflict
but
patient is still **alive**

8



9

catastrophically
critically ill

10

clinicians often
recommend **CMO**

11

parents
often **agree**

12

but

13

not always

14



15

clinician

CMO

16

parents

LSMT

prevalent

17

intensivists

or

ethicists

18

intensivists

measures

19

“conflict . . .
in ICUs . . .
epidemic
proportions”



20

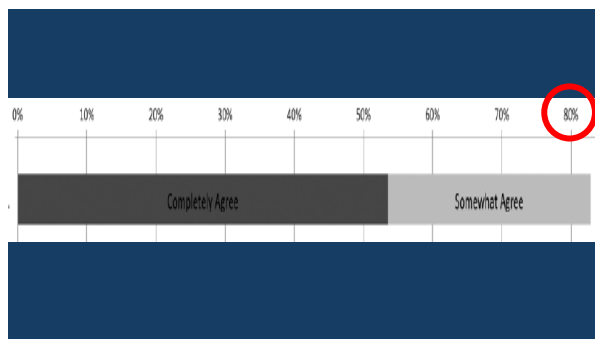
700
acute care
clinicians



21

“NBT is a
problem”

22



23

“NBT is **common**
among **my**
inpatients”

24



25



26

The Frequency and Cost of Treatment Perceived to Be Futile in Critical Care

20%

Thanh N. Huynh, MD, MSHS; Eric C. Klerup, MD; Joshua F. Wiley, MA; Terrance D. Savitsky, MBA, MA, PhD;
Diana Guse, MD; Bryan J. Garber, MD; Neil S. Wenger, MD, MPH *JAMA Intern Med.* 2013;173(20):1887-1894.

27

ethicists

measures

28

“top healthcare challenge”



BMC Med. Ethics (2005)

29

13%

ethics
consults



MEMORIAL SLOAN-KETTERING
CANCER CENTER

J. Oncology Practice (June 2013)

30

16% ethics
consults

HEC Forum
DOI: 10.1007/s10730-015-9293-5

**What Ethical Issues Really Arise in Practice
at an Academic Medical Center? A Quantitative
and Qualitative Analysis of Clinical Ethics
Consultations from 2008 to 2013**

Katherine Wasson^{1,3} · Emily Anderson¹ ·

31

15% ethics
consults



32

33% ethics
consults



Physician Executive Journal (37 no. 6)

33

2 futility
cases
per month



Courtwright, 2015 J Crit Care 30(1):173-77

34

Independent review: Disagreements in the care of critically ill children

NUFFIELD
COUNCIL ON
BIOETHICS

Healthcare professionals' perspectives

*Some findings from our survey for healthcare professionals with experience of disagreements
between families and healthcare teams in the care of critically ill children in England**

35

*How often do new
disagreements arise?*



52%
said **monthly**
or more often*

36

14%

TYPE Original Research
PUBLISHED 18 January 2024
DOI 10.3389/fped.2024.1272648

Check for updates

OPEN ACCESS

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Sabrina Derrington,
Children's Hospital of Los Angeles,
United States

Perceived potentially
inappropriate treatment in the
PICU: frequency, contributing
factors and the distress it triggers

Amrita Sarpal^{1,2*}, Michael R. Miller^{3,2}, Claudio M. Martin^{3,4},
Robert W. Sibbald^{4,5} and Kathy N. Speechley^{3,7}

37



38

PewResearchCenter

NUMBERS, FACTS AND TRENDS SHAPING THE WORLD

NOV. 21, 2013

Views on End-of-Life Medical Treatments

*Growing Minority of Americans Say
Doctors Should Do Everything
Possible to Keep Patients Alive*

39

Doctors and nurses should do
everything possible to save the life
of a patient in all circumstances

40

1990 15%

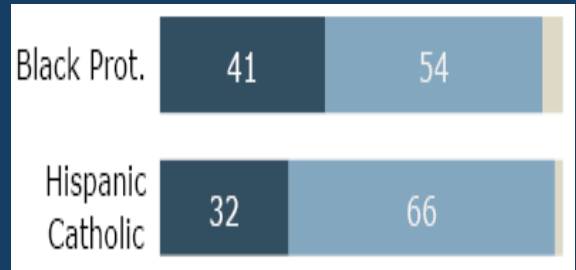
41

2005 22%

42

1990 15%
2005 22%
2013 31%

43



44



45

conflicts
over NBT
are **common**

46

causes

47



48

why
parents
demand

why
clinicians
resist

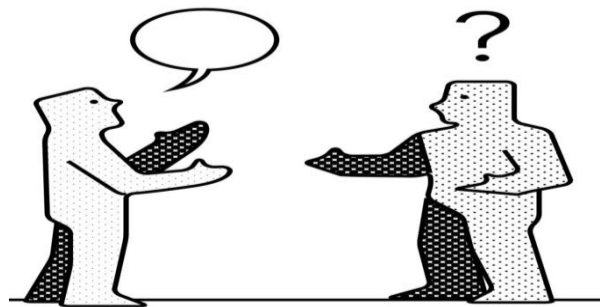
49

parental
demand

50

misunderstanding

51



52

confusion

53

iatrogenic

inadequate communication

uncoordinated, conflicting

54

Association between shared decision-making during family meetings and surrogates' trust in their ICU physician



55

“at least 1 of 5 core elements of shared decision making ... **missing** from **95%** ... family meetings”

56

explain patient's medical condition/**prognosis**

elicit or assess **understanding**

57

mistrust

58

Views and Experiences of Aging & End-of-Life Care in the US

Conducted September 2022

Conducted by:



M-RCENCE
CREATIVITY FOR THE COMMON GOOD

Funded by:



59

31%

Trust the US
healthcare system

60



61

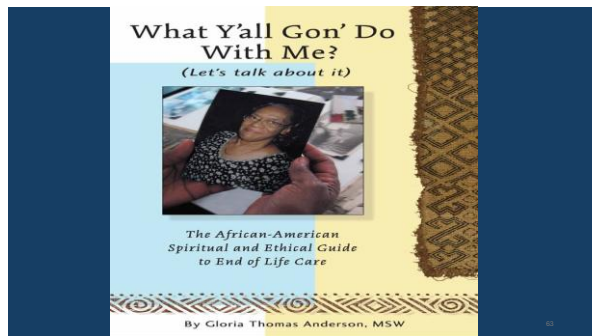


Home News Travel Money Sports Life Tech

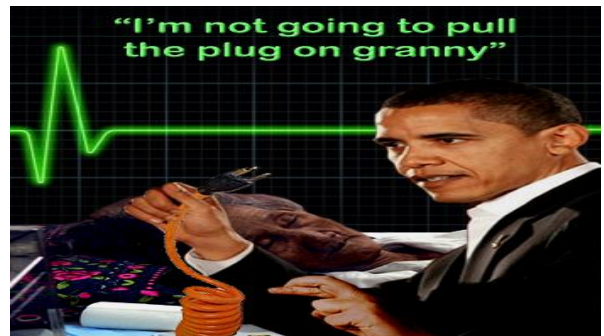
News » Health & Behavior Fitness & Nutrition Your Health: Kim Painter Swine Flu

More 'empowered' patients question doctors orders

62



63



64

emotional barriers

65



66



67



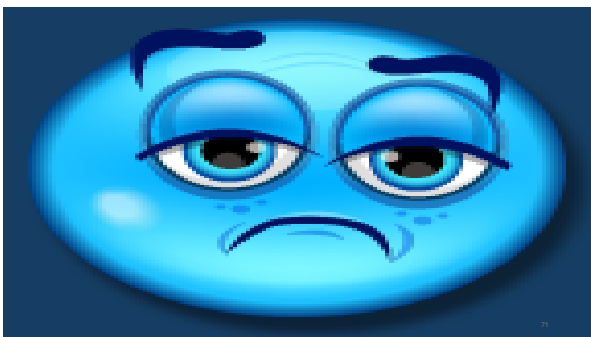
68



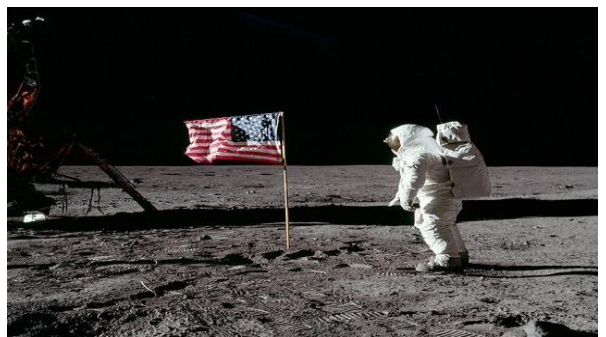
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72



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74



75



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77



78



79

Trauma Death

Views of the Public and Trauma Professionals on Death and Dying From Injuries

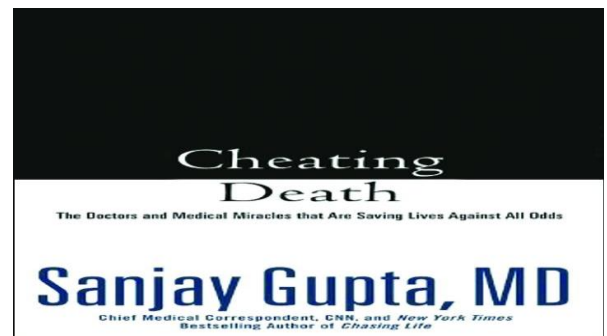
Lenworth M. Jacobs, MD, MPH; Karyl Burns, RN, PhD; Barbara Bennett Jacobs, RN, MPH, PhD, CHPN

Arch Surg. 2008;143(8):730-735

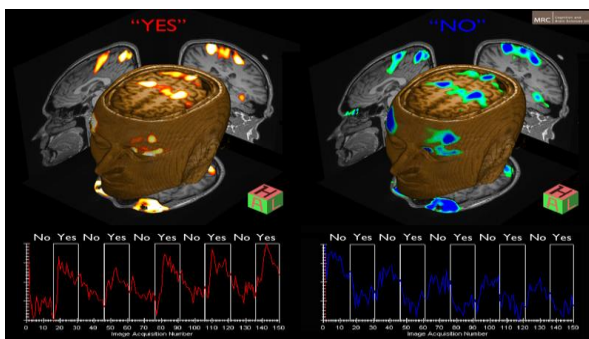
80

Question and Responses ^a	Public, % (n=1006)	Professionals, % (n=774)
If the doctors treating your family member said futility had been reached, would you believe that <u>divine intervention by God</u> could save your family member?		
Yes	57.4	19.5
No	35.5	61.1

81



82



83

some reasons
surrogates
demand NBT

84

cognitive
psychological
emotional
religious
mistrust

85



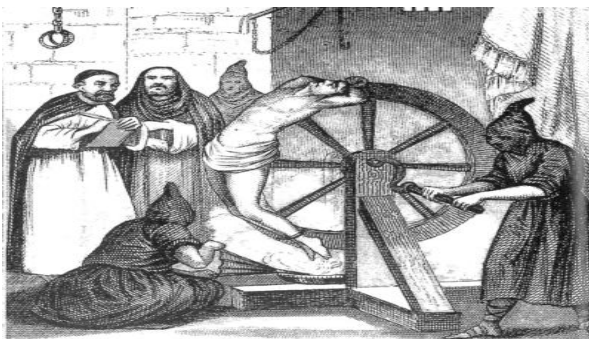
86

clinicians
resist

87

avoid patient
suffering

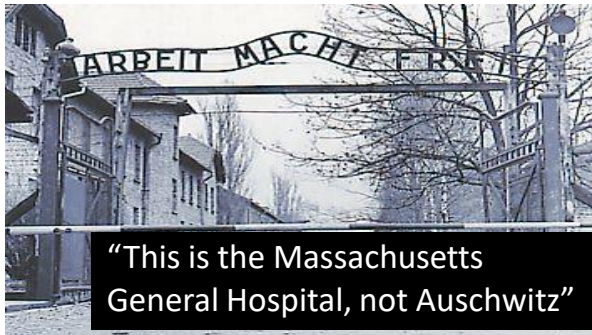
88



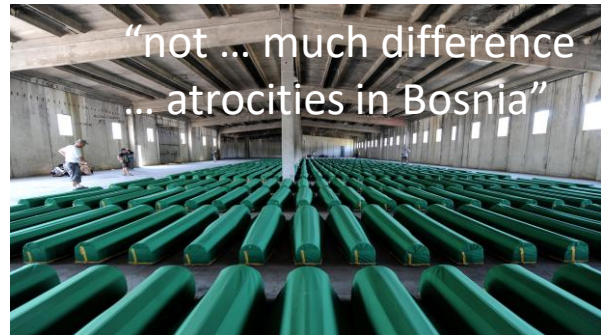
89

quotes from
actual cases

90



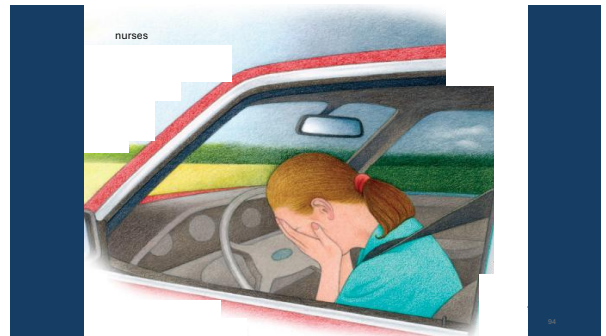
91



92

avoid moral
distress

93



94



95



96

integrity of
profession

97



98



99

stewardship

100



101

distrust
parent

102

protect Pt from
their own parent

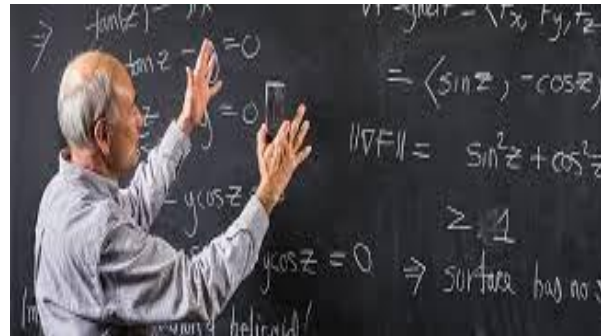
103

some reasons
clinicians
resist NBT

104



105



106

Trauma Death

Views of the Public and Trauma Professionals on Death and Dying From Injuries

Lenworth M. Jacobs, MD, MPH; Karyl Burns, RN, PhD; Barbara Bennett Jacobs, RN, MPH, PhD, CHPN

Arch Surg. 2008;143(8):730-735

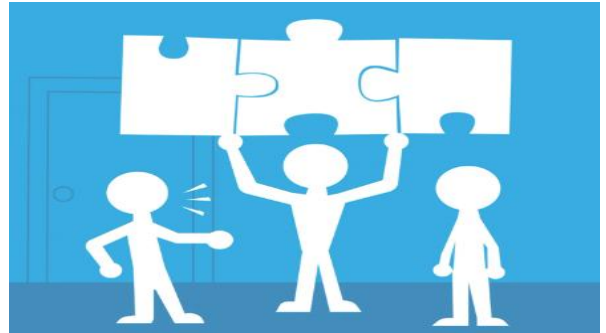
107

Question and Responses ^a	Public, % (n=1006)	Professionals (n=774)
If doctors believe there is <u>no hope</u> of recovery, which would you prefer?		
All efforts should continue <u>indefinitely</u>	20.6	2.5

108



109



110



111



112



113



114

6 **easier**
cases

115

harder & more
common cases

116

starting
axioms

117

axiom 1

118

clinicians must
have **consent**
to treat

119

touching a Pt
without consent
is a **battery**

120

even if patient
clinically
benefits

121

who can
provide that
consent?

122

axiom **2**

123

minors **rarely**
may consent to
their own Tx

124

**EXCEPTION TO
THE RULES**

125

1. emancipated minors
2. mature minors
3. regular minors for certain Tx (e.g., STI)

126

n/a for today's
discussion

127

ICU patients
typically **lack**
capacity anyway

128

axiom **3**

129

parents are
medical decision
makers for their
children

130

axiom **4**

131

parents get
substantial
deference in
determining Tx

132



133

Parham v. J.R.

442 U.S. 584 (1979)

Troxel v. Granville

530 U.S. 57 (2000)

134

“Due Process Clause of the 14th Amendment protects the **fundamental right of parents** to make decisions concerning the care ... of their children”

135

axiom 5

136



137

while parental discretion is wide,
it has **limits**

138



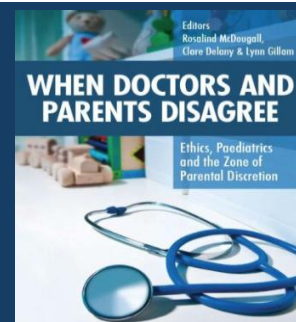
139

we'll discuss
those **limits**

140

one useful
framing

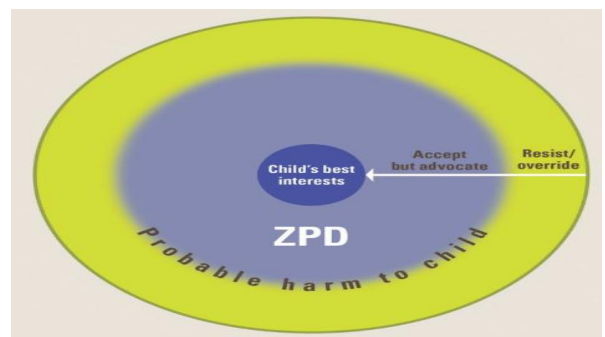
141



142

zone of
parental
discretion

143



144



145

when are
we **outside**
the ZPD

146

when have
parents **crossed**
the line

147

contrast faith
healing parents

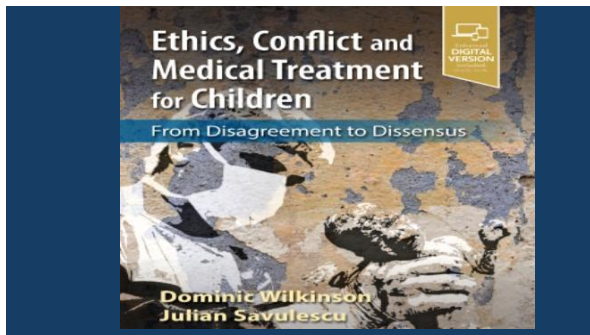
148



149

got **too little**
healthcare for
their child

150



151

request
too much
healthcare

152



153



154

appropriate inappropriate

155

advisable inadvisable

156

proportionate

disproportionate

157

beneficial

non-
beneficial

158

effective

ineffective

159

neglect
to stop Tx

abuse
to continue

160

consistent

with
reasonable
medical
standards

contrary

to
reasonable
medical
standards

161

therapeutically
obstinate

not
therapeutically
obstinate

162



163

those are our
**starting
axioms**

164

**6 easier
cases**

165

2 concern the
parties to the
dispute

166

4 concern the
type of
disputed **Tx**

167

easier case 1

168

rogue
parents

169

ZPD assumes
parents determine
best interest in
good faith

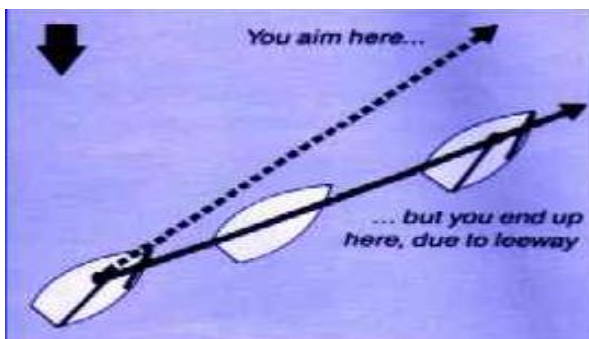
170

no good faith
→ no ZPD

171



172



173

but

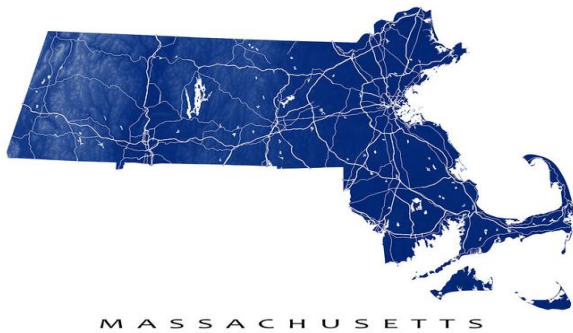
174



175

examples

176



177



Haleigh
Poutre

178

clinician

CMO

parents

LSMT

179



stepfather
Jason
Strickland
says "no"

180

but

181



182

parent has
material **COI**

183



184



185



186

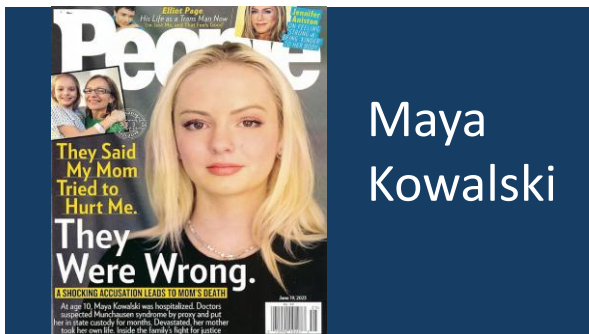
Family Of Olivia Gant Notifies Children's Hospital Colorado Of Intent To Sue For Up To \$25M

November 25, 2020 / 11:25 PM MST / CBS Colorado

187



188



189

Maya
Kowalski

\$213,000,000

190

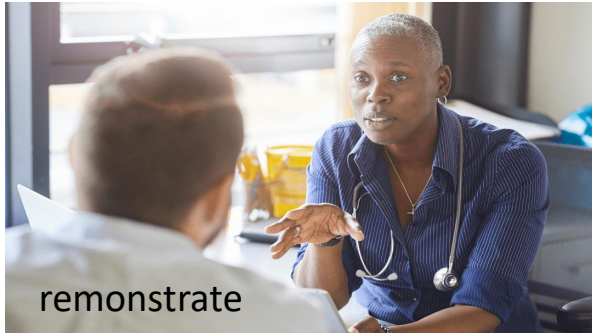


191

when you
see a red
flag



192



193



194



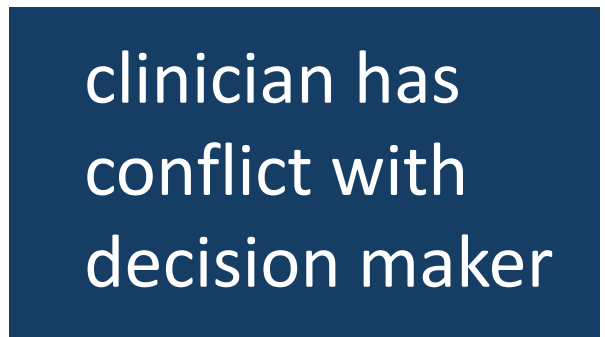
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196



197



198

clinician

CMO

199

parents

LSMT



200

get a **new**
decision maker

201

easier
case

2

202

CBO

203

clinicians **may refuse**
participation with
healthcare that violate
their moral, ethical, or
religious beliefs

204

personal
not professional
reasons

205

assuming no
CBO & parents
act good faith

206

4 types of
cases **easier**
to resolve

207

brain death
physiological futility
proscribed Tx
discretionary Tx

208

easier
case **3**

209

**brain
death**

210



211



212



213

core question
must clinicians get
consent to
test/evaluate BD

214



215

once death is
determined →
rules settled

216

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**”

217



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”

218

Guidelines for Physicians: Forgoing Life-Sustaining
Treatment for Adult PatientsJoint Committee on Biomedical Ethics
of the
Los Angeles County Medical Association
and
Los Angeles County Bar AssociationApproved 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”

219

consent
is **not**
required

220

easier
case **4**

221

physiological
futility

222



223

AMERICAN THORACIC SOCIETY DOCUMENTS

An Official ATS/AACN/ACCP/ESICM/SCCM Policy Statement:
Responding to Requests for Potentially Inappropriate Treatments in
Intensive Care Units

224



225



226



227



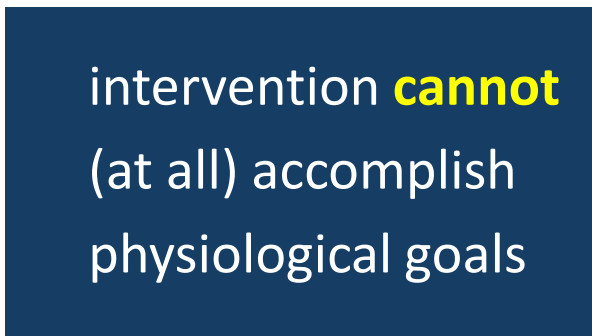
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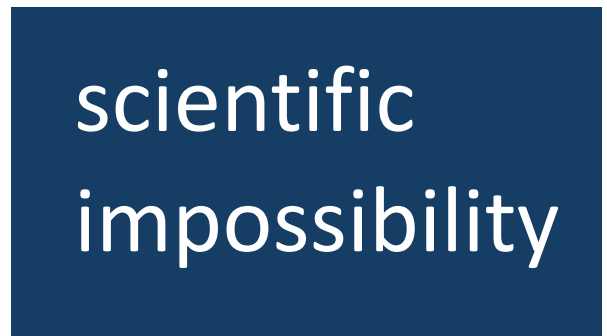
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230



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232



233



234

example 1

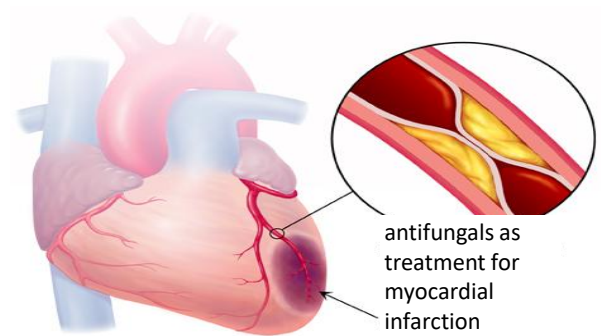
235



236

example 2

237



238

example 3

239



240

example 4

241



242

example 5

243



244

value free
objective

245



246

chance of working

0.00%

247

may the
clinician
stop LSMT?

248

“futile”

249

may & should
refuse

250



Charlie Gard

251

“prospect ... treatment
having any benefit ...
close to zero as makes
no difference”

252

all these cases
are called
medical futility
conflicts

253

but treatment
at issue is **rarely**
really “futile”

254

easier
case **5**

255

proscribed
treatment

256

treatment **might**
accomplish effect
desired by surrogate

257

>0%

258

not
“futile”

259

but

260

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

261

example 1

262



263

might “work”
but illegal

264



Houston transplant doctor indicted for making false statements in patients' medical records

Thursday, February 5, 2026

265

example 2

266



267

example 3

268



269

if treatment request is legally **proscribed** →

270

may & should
refuse

271

easier
case 6

272

discretionary
treatment

273

opposite of
proscribed

274



275



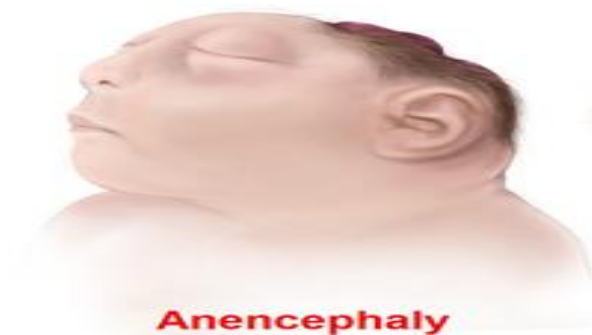
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laws, judicial precedent,
or policies give
physicians **permission**
to refuse to administer

277

example 1

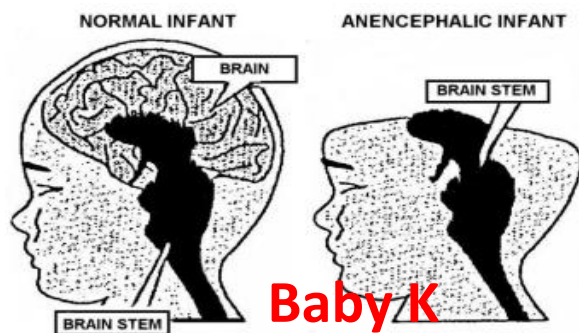
278



279

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;
20. triploidy;
21. trisomy 13;
22. trisomy 16 (full);
23. trisomy 18;
24. trisomy 22; and

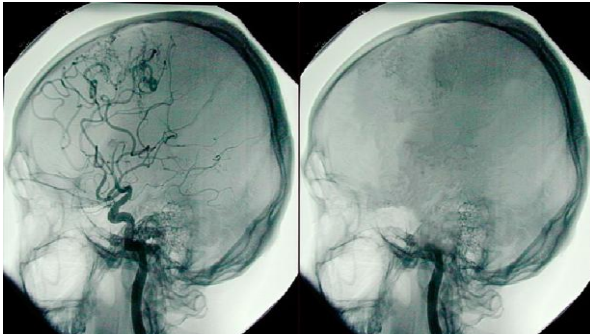
280



281

example 2

282



283

may the
clinician
stop LST?

284

legally
discretionary

285

may & should
refuse

286



287

while easier
these 6 types
cases **rare**

288

harder
cases

289

AMERICAN THORACIC SOCIETY
DOCUMENTS

An Official ATS/AACN/ACCP/ESICM/SCCM Policy Statement:
Responding to Requests for Potentially Inappropriate Treatments in
Intensive Care Units

290

potentially
inappropriate
treatment

291

some chance of
accomplishing the
effect sought by
parent

292

not “futile”
because
might “work”

293

examples

294

dialysis for
permanently
unconscious

295

MV for widely
metastatic
cancer

296

we **call** these
“futility disputes”

297

but

298

disputed Tx
might keep
patient alive

299

~~0.00%~~

300

not asking
“will it **work**”

301

asking “is it in
the patient’s
best interest”

302



303

is that chance
or outcome
worthwhile

304

not a
medical
judgment

305

value
judgment

306

“potentially”

307

vet & confirm
your judgment

308

3 options

309

consensus

310

new
hospital

311

if **none** of
that works ...

312

withdraw LST
without consent

313

consensus

314

most professional
society guidelines

315

most hospital
policies

316

negotiation
mediation

317

Code of
Medical Ethics

of the American Medical Association



Council on Ethical and Judicial Affairs
Current Opinions with Annotations

318

4 of 7 steps

319

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

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

320

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

4. involve ... **ethics
committee**

321

SENTARA

Procedure: Medically Unnecessary Treatment Not Required – Virginia Only

Manual: Patient Rights	Original Date: 5/19/2006
Section: Ethics	Revision Date: 4/19/2022
Location(s): SCH, SHRH, SLH, SMH, SNGH, SNVMC, SRMH, SOH, SPAH, SVBGH, SWRMC, SASD (VA Locations Only)	
Approved By: Clinical Policy & Procedure Committee	Process Owner: Sentara Center for Healthcare Ethics

Revision Description (Most Recent): Focused and simplified language.

322

“attempts to resolve
... conflict, ... **prior**
to instituting ...
following steps”

323

why?

324



325



326

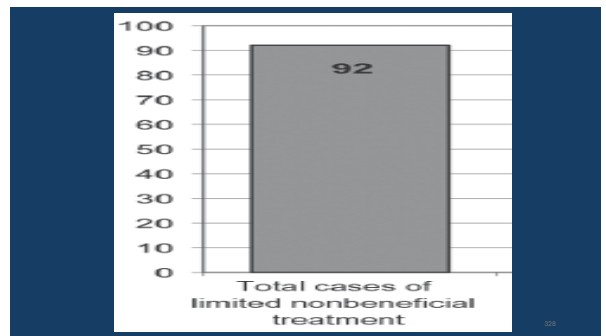
KAISER PERMANENTE

Nonbeneficial Treatment and Conflict Resolution: Building Consensus

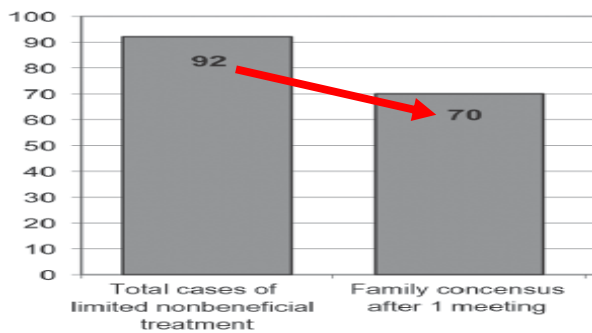
Craig M Nelson, PhD, CJS; Blanca Arriola Nazaretti, MSW

Perni J 2013 Summer (173) 22-27

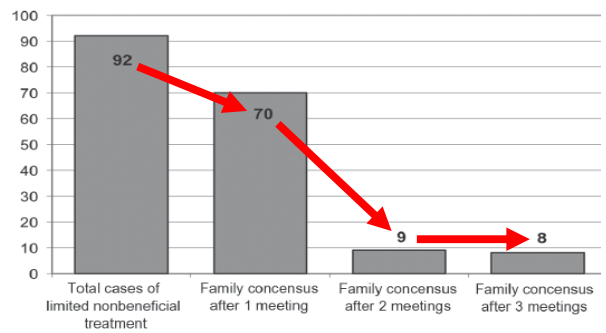
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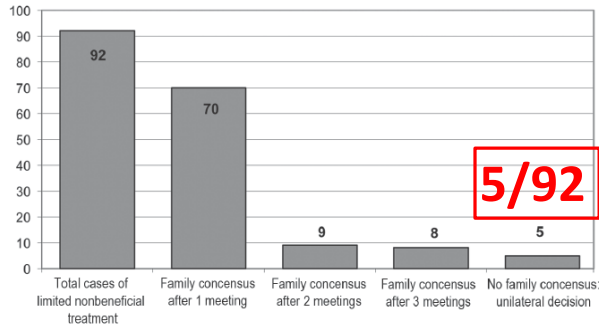
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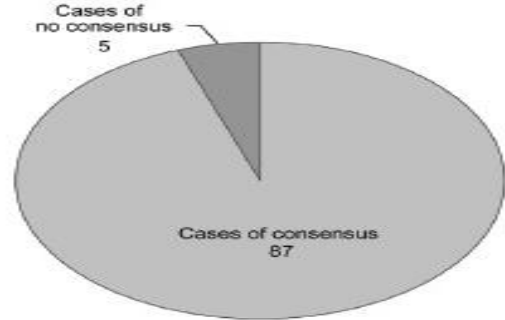
329



330



331



332



333

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 T.J., Luce J.M.

334

57% agree immediately
90% agree within 5 days
96% agree after more meetings

335

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

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

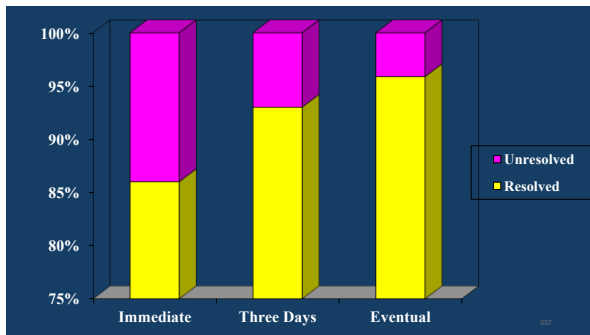
Every U.S. state has developed legal rules to address end-of-life decision making. No law to date has effectively dealt with medical futility—an issue that has engendered significant debate in the medical and legal literature, many court cases, and a formal opinion from the American Medical Association's 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.ama-assn.org

336



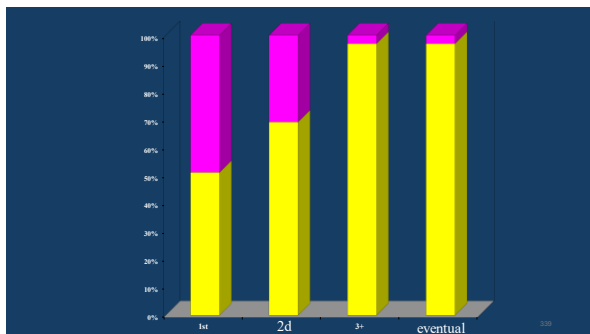
337

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

338

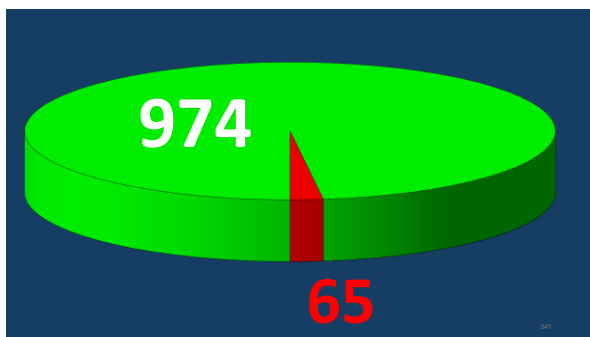


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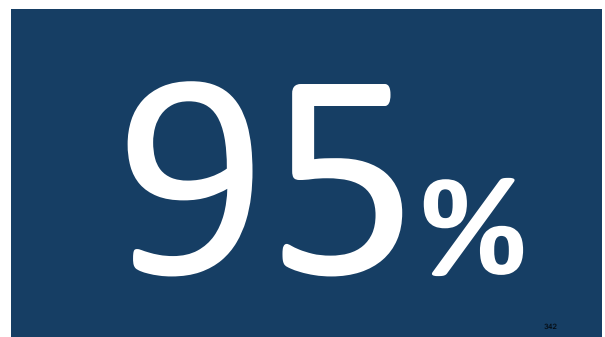
Dallas Morning News

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

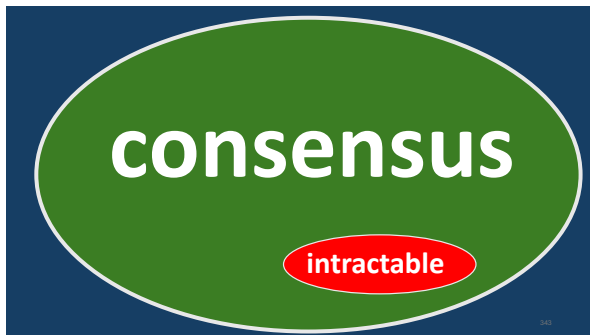
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341



342



343



344



345



346



347



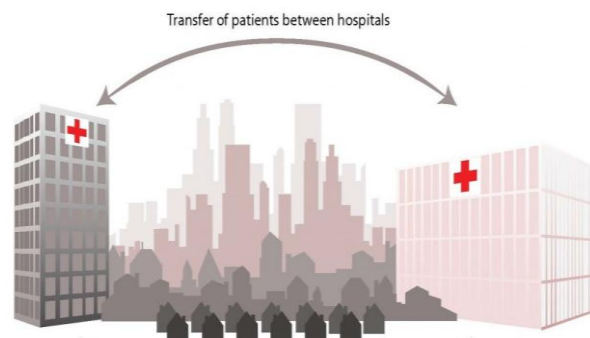
348

	clinician		
parents		stop	go
	stop		
	go	X	

349

**new
hospital**

350



351

Medical Futility in End-of-Life Care
Report of the Council on Ethical and Judicial Affairs

Council on Ethical and Judicial Affairs, American Medical Association

Use of life-sustaining or invasive interventions in patients vegetative state or who are terminally ill may only prolong

**An Official ATS/AACN/ACCP/ESICM/SCCM Policy Statement:
Responding to Requests for Potentially Inappropriate Treatments in
Intensive Care Units**

Gabriel T. Bosslet, Thaddeus M. Pope, Gordon D. Rubenfeld, Bernard Lo, Robert D. Truog, Cynda H. Rushton,

Annals of Internal Medicine SUPPLEMENT

American College of Physicians Ethics Manual
Seventh Edition

Lois Snyder Sulmasy, JD, and Thomas A. Bledsoe, MD, for the ACP Ethics, Professionalism and Human Rights Committee*

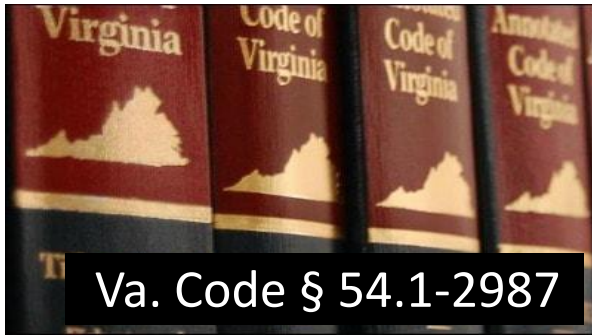
352

**state
laws**

353



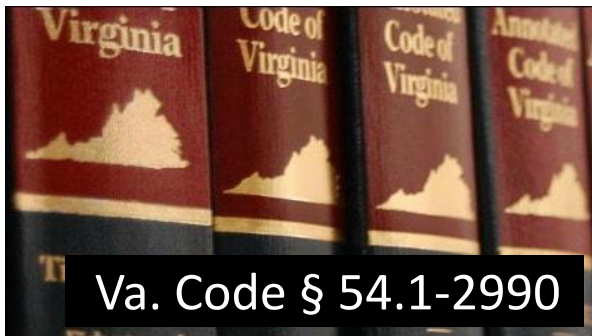
354



355

“physician who
refuses ... shall make
a reasonable effort to
transfer the patient”

356



357

“make a reasonable
effort to **transfer**
the patient”

358

rare

359

but
possible

360



361



362



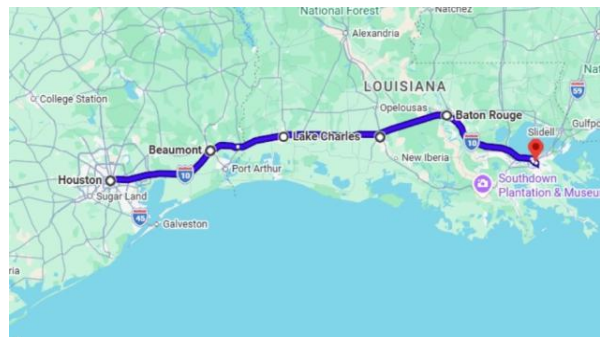
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364



365



366



367

Frequency/Characteristics of Disputes in Virginia – Survey

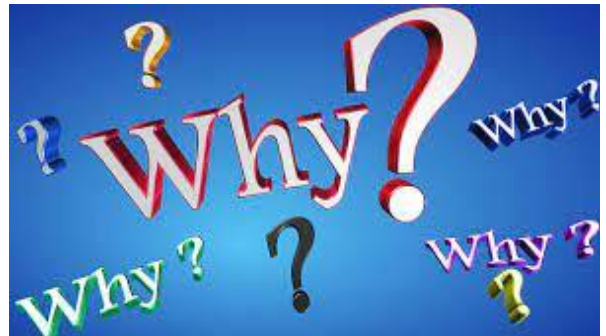
survey, representing 90% (66/73) of general acute care hospitals in Virginia

368

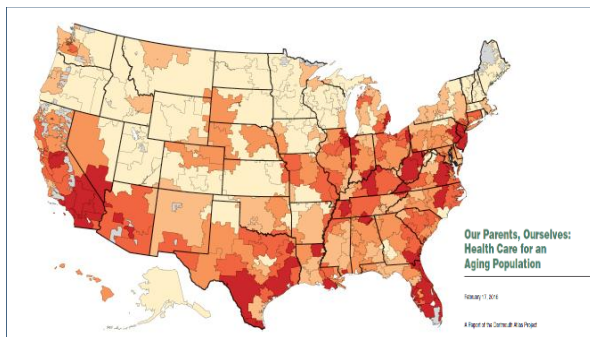
Over 40 cases went through the process in the last 12 months

2% were resolved because the patient was transferred

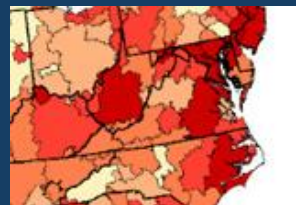
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370



371

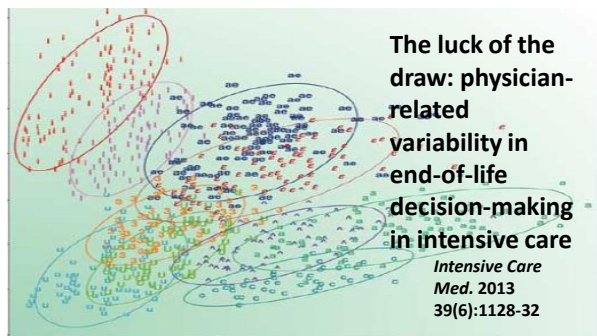


ICU days
last 6 mo.

372

physician variability

373



374

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

Ben White et al
Med J Aust 2016; 204 (8):318



375

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%)

376

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%)

377

AJOB Empirical Bioethics

ISSN: 2329-4515 (Print) 2329-4523 (Online) Journal homepage: www.tandfonline.com/journals/abio21

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

378

hospital variability

379

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, PhD²; et al

» Author Affiliations

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

380

[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;

381

can find &
make transfers

382

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

383

 Journal of
Clinical Medicine 

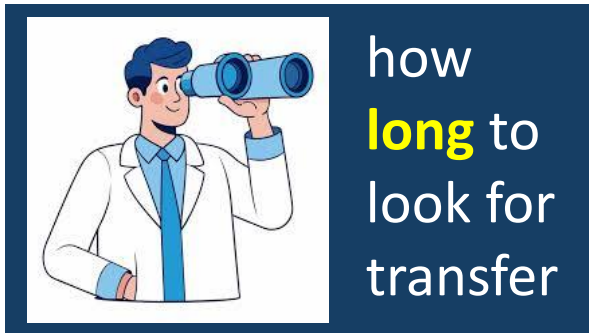
Brief Report

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

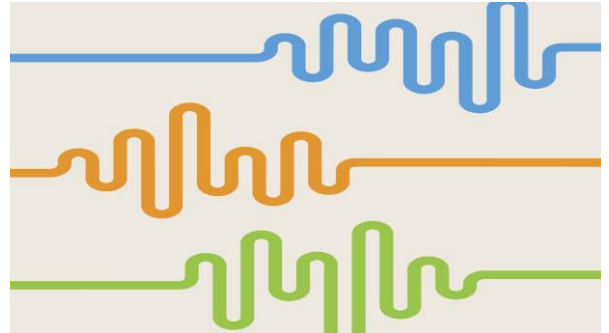
Mircea R. Mihu^{1,2,*}, Laura V. Swant¹, Robert S. Schoaps¹ , Caroline Johnson¹ and Aly El Banayosy^{1,2}

likely **lower** w ECMO

384



385



386



387

THE 
RECAP

388

no consent
no transfer

389

withdraw
LSMT w/o
consent

390

normally,
clinicians must
follow parental
decisions

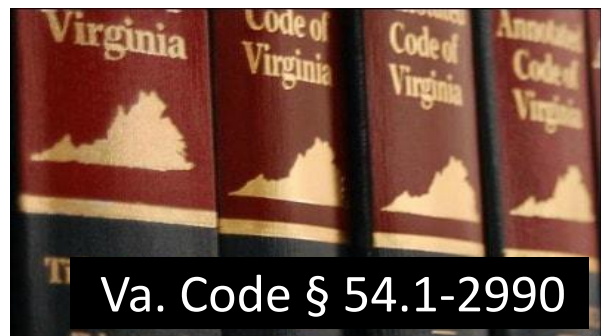
391

but

392

**EXCEPTION TO
THE RULES**

393



394

“**nothing ... requires** a
physician to ... render health
care ... that the physician
determines ... **medically or
ethically inappropriate**”

395

“physician
may cease
to provide ...”

396

“physician **may cease**
to provide ... treatment
... determined to be
medically or ethically
inappropriate”

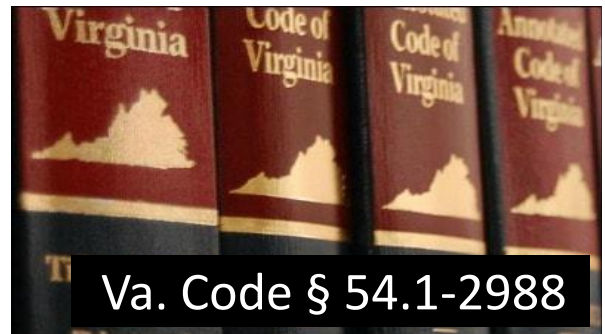
397

plus

398

legal
immunity

399



400

“**not** be subject to
criminal prosecution **or**
civil liability **or** ...
unprofessional conduct”

401



402



403



404

may stop LSMT
without consent

405

with legal
immunity

406

medically or
ethically
inappropriate

407

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

408

2 questions

409

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

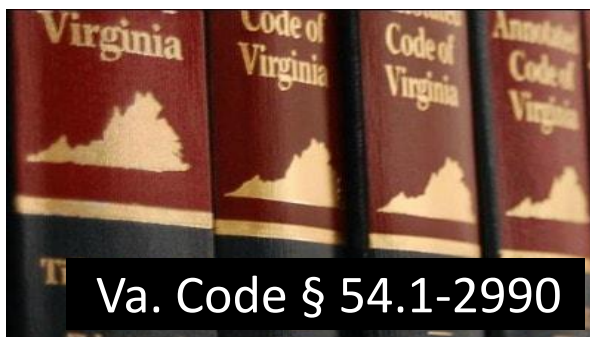
410

when may you
decline to comply
with those decisions

411

what
decisions

412



413

withhold
or
withdraw

414

parent asks to
start dialysis

415

you **may**
decline to
start

416

parent asks to
continue
dialysis

417

you **may**
decline to
continue

418

IN
OTHER
WORDS

419

VA HCDA
permits
clinicians to

420

withhold
or
withdraw

421

omit
or
cease

422

any
treatment

423



424

Physician Certification of Medically Ineffective Treatment

425

(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 _____ | |

426



427

may decline to
follow request
for LSMT

428

any **type** of LSMT
or healthcare
(except ANH)

429

but

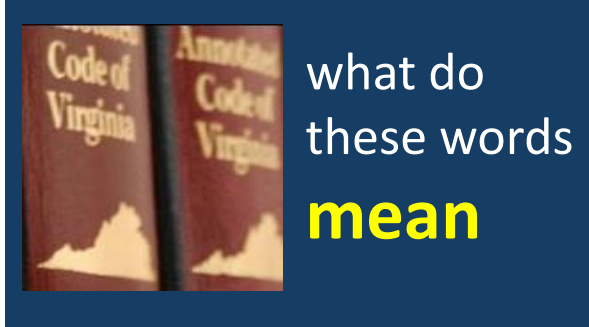
430

only if that
request is

431

medically
or ethically
inappropriate

432



433



434

AMERICAN THORACIC SOCIETY DOCUMENTS

An Official ATS/AACN/ACCP/ESICM/SCCM Policy Statement:
Responding to Requests for Potentially Inappropriate Treatments in
Intensive Care Units

435

potentially
inappropriate
treatment

436

cannot be
determined
by **definitions**

437

must be
determined
by **process**

438

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.

439

2nd opinion

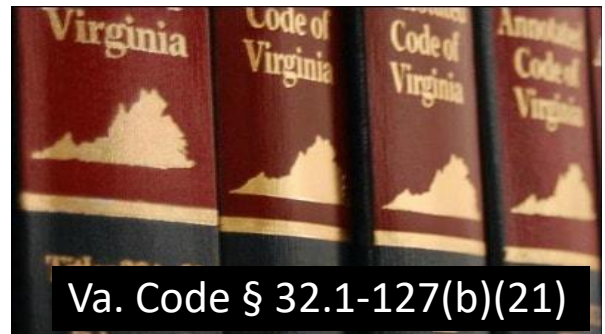
interdisciplinary

institutional committee

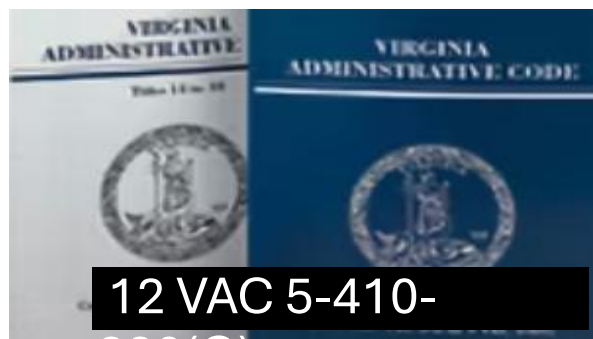
440

helps consensus
assures carefully
considered

441



442



443



444

3 paradigm situations

445

Sept. 2016

Society of
Critical Care Medicine

The Intensive Care Professionals



446



447



Model Policy on "Non-beneficial Treatment"

Lynette Cederquist, MD, [July 2009 "San Diego Physician" • Ethics in Medicine](#)

448

	Department: Medical Staff	DRAFT
	Policy/Procedure: MEDICALLY INEFFECTIVE TREATMENT	

WITHDRAWING OR WITHHOLDING MEDICALLY INAPPROPRIATE LIFE-SUSTAINING TREATMENT WITHDRAWING OR WITHHOLDING MEDICALLY INAPPROPRIATE LIFE-SUSTAINING TREATMENT	HS 1319 UCLA Health
--	-------------------------------

449

imminent death
irreversible coma
Rs outweigh Bs

450

imminent
death

451

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

452

advanced
metastatic
disease

453

advanced multi-
system organ
failure from sepsis

454

active clinical
deterioration

455



456

not futile

might be able to
restart circulation

457

but

458



459

actively dying
death impending
imminent - hours

460

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

461

irreversible
coma

462

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

463

**burdens
outweigh
benefits**

464



465



466

“no way to cure or alleviate T.L.’s severe
chronic lung disease, ventilator
dependence, pulmonary hypertension, and
bronchiectasis. She cannot recover ... and
has no chance of long-term survival”

but “her medical problems and **daily
suffering** ... have only increased”

467



468

may unilaterally
withdraw LSMT

469

potentially
inappropriate
treatment

470

determined
by **process**
not definition

471

potentially
inappropriate
treatment

permanent
coma

imminent
death

$R > B$

472



473

medically
& ethically
appropriate

never
leave ICU

474

common basis
for judging LSMT
inappropriate

475

no reasonable
expectation Pt will
improve ... to survive
outside the **acute**
care setting

476



477

but

478

federal
constraints

479



480

FEDERAL REGISTER

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



481

“discrimination is
particularly salient
in the context of
medical futility”

482

discriminatory

“deny ... treatment ...
cannot end dependence
on intensive ... care”

483

SO...

484

may not withdraw LSMT
based on judgment

“life ICU is not
worth living”

485

more on how disability
discrimination laws
constrain PIT
determinations

486



487

Supreme Court of the United States

ST. DAVID'S HEALTHCARE PARTNERSHIP, L.P., L.L.P.,
Applicant,

v.

MELISSA HICKSON, *Individually and as the Independent Administrator of THE ESTATE OF MICHAEL HICKSON, deceased and as next friend of M.H., M.H., and M.H. (all minors);*
MARQUES HICKSON,

Respondents.

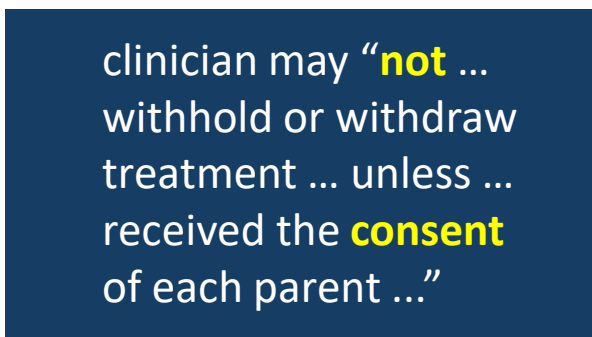
488



489



490



491



492



493

conclusion

494

clinician

CMO

surrogate

LSMT

495

options



496

try to prevent

w/ better communication
w/ documentation Pt wishes

497

try to reach consensus

with more family meetings
with EC, palliative, chaplaincy ...

498

no consensus?

499

try **transfer**
to another
facility

500

try to **replace**
surrogate

501

if **none** of
that works ...

502

use your fair
multidisciplinary
review process

503

withdraw LSMT
without consent

504

*Thank
you!*

505



506

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C 310-270-3618

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B medicalfutility.blogspot.com

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