

## The Law and Ethics of Non-beneficial Treatment Policies

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### ABSTRACT

A non-beneficial treatment is defined as when a physician decides that the patient's prognosis of a medical illness or injury, cannot be altered by a certain form of treatment.<sup>1</sup> No medical therapy can improve the patient's prognosis or condition. The ethics regarding non-beneficial treatment policies are of great debate due to their lack of consistency between healthcare systems. This paper compares the non-beneficial treatment policies between a hospital that operates under religious values and one that bases their values on community and population health with no religious ties. These policies will be compared to the guidelines put forth by the American Medical Association (AMA) Code of Medical Ethics, American Thoracic Society (ATS), American Association for Critical Care Nurses (ACCN), American College of Chest Physicians (ACCP), European Society for Intensive Care Medicine (ESICM), and Society of Critical Care (SCCM). The purpose of this paper is to highlight how subjective these policies can be and how their inconsistencies between hospital systems can lead to harmful patient outcomes.

**Keywords:** medical ethics, non-beneficial treatment, health care systems, health care law

### INTRODUCTION

Medical futility is when a physician decides that the patient's prognosis of a certain medical illness or injury cannot be altered by a certain form of treatment.<sup>1</sup> No medical therapy can improve the patient's prognosis or condition. When a physician analyzes the effect and benefit a treatment has on a patient, these outcomes should be observed independently of each other. The effect of a treatment is the localized outcome that a patient experiences at a certain part of the body.<sup>2</sup> The benefit of a treatment is the systemic response it provides the patient by improving their health.<sup>2</sup> If the medical treatment has no benefit, regardless of if there were effects that elicited a response from the patient, the treatment is futile.<sup>2</sup> The word futile should only be used for treatments that truly elicit no benefit to the patient. In all other clinical situations, the term non-beneficial treatment should be utilized.<sup>2</sup>

There is no consistency of non-beneficial treatment policies in the health care system. This causes several lawful and ethical dilemmas within the field. What is deemed a non-beneficial medical treatment can vary from physician to physician.<sup>1</sup> This can diminish the consistency and guiding principles of what a non-beneficial treatment is, set forth by the American Medical Association (AMA), American Thoracic

Society (ATS), American Association for Critical Care Nurses (ACCN), American College of Chest Physicians (ACCP), European Society for Intensive Care Medicine (ESICM), and Society of Critical Care (SCCM). Non-beneficial treatment guidelines were developed by diverse panels of experts from these organizations through collaboration and consensus on the core ethical values centering on patient welfare.

The outcomes of cases such as, *Cruzan v. Director, Missouri Department of Health*, 111 L.Ed.2d 224 (S. Ct. 1990) and *Betancourt v. Trinitas Hospital*, 1 A.3d 823 (N.J. Super. 2010) are what created the importance of non-beneficial treatment policies and guidelines to be put in place at healthcare institutions. Due to their significance in healthcare law and non-beneficial treatment, these cases were chosen to be analyzed. The outcome of *Cruzan v. Director, Missouri Department of Health* was the Patient Self-Determining Act (PSDA).<sup>3</sup> The *Betancourt v. Trinitas Hospital* case was one of the first cases that centered around the topic of non-beneficial treatment. It also highlighted the need of non-beneficial treatment policies in healthcare institutions.

This essay compares the non-beneficial treatment policies of a hospital that bases their values on community and population health under religious values, and one that bases their values on community and population health with no religious ties. These policies will be compared to the guidelines put forth by

the AMA Code of Medical Ethics, ATS, ACCN, ACCP, ESICM, and SCCM. The AMA was the first organization to publish a Code of Medical Ethics and is the code that all physicians in the United States are guided by when practicing medicine.<sup>4</sup> The guidelines put forth by the ATS, ACCN, ACCP, ESICM, and SCCM are included in this paper because they were developed through a collaborative approach that included expert input and representation from each committee listed.<sup>5</sup> The purpose of this paper is to highlight how subjective these policies can be and how their inconsistencies between hospital systems can lead to harmful outcomes patients.

## BACKGROUND

In Western medicine, before the principle of autonomy was established, the patient-physician relationship was characterized as more of a one-sided, paternalistic relationship. Physicians, in the earlier and mid decades of the 1900s, would determine the best plan of care for a patient by themselves or with other healthcare provider colleagues.<sup>2</sup> Patient autonomy and participation in health care was not required until the PSDA was established in 1991.<sup>6</sup> The PSDA states that if a health-care institution wants to receive government funding through Medicare or Medicaid, they must inform their patients of the state laws governing self-determination issues.<sup>6</sup> This law required physicians to tell their patients that they have the right to refuse medical treatment. It also established the requirement that care plan discussions be facilitated among patients, their physicians, and family members who are involved in the well-being of the patient. According to the PSDA, if the patient does not have an appointed surrogate to make healthcare decisions on their behalf, the hospital does not have the right to determine the type of treatment the patient will receive.<sup>6</sup> If a situation like this is encountered, the hospital and physicians providing the care should reach out to family members of the patient to consult them about the next steps of care.<sup>6</sup>

The landmark case that provoked the establishment of the PSDA and prompted a critical ethical examination of the withdrawing of treatment, was *Cruzan v. Director, Missouri Department of Health*, 111 L.Ed.2d. 224 (S. Ct. 1990). Nancy Cruzan was a 25-year-old woman who, in 1983, got in a car accident that caused her to be ejected out of her vehicle.<sup>3</sup> Cruzan remained in a rehabilitation hospital for three years after the accident. It was later concluded by her physician and family members that she would never regain full consciousness.<sup>3</sup> The family wanted to remove the life support treatment from Cruzan, but since it was keeping her alive, the hospital would not withdraw treatment from the patient.<sup>3</sup> The *Cruzan v. Director, Missouri Department of Health*, 111 L.Ed.2d. 224 (S. Ct. 1990), case lasted for eight years, before the Cruzan family finally won, and the feeding tube could be removed from the patient.<sup>3</sup> The outcomes of this case ruled that any adult patient who is competent to make decisions

about their health, have the right to:

- (1) Decide if they want medical or surgical intervention, including artificial nutrition and hydration.
- (2) Make advance directives.
- (3) Decide on a surrogate to make decisions on their behalf.<sup>3</sup>

To assess competency the individual must be able to understand their current condition, communicate their decision on how they want to proceed, and understand the consequences, risks, and benefits of this decision.<sup>7</sup>

The next case that is remarkable on the topic of non-beneficial treatment, is that of *Betancourt v. Trinitas Hospital*, 1 A.3d 823 (N.J. Super. 2010). This case highlights the importance of a standardized non-beneficial treatment policy within healthcare systems. Reuben Betancourt underwent a surgical procedure to remove a malignancy from his thymus at the Trinitas Hospital in New Jersey.<sup>8</sup> Betancourt's surgery was a success; but while in the post-operative intensive care unit, the tube providing oxygen to the patient became dislodged.<sup>8</sup> This caused Betancourt to be without oxygen for some time, causing him to develop anoxic encephalopathy, eventually leading to permanent unconsciousness.<sup>8</sup> In addition to this, the patient needed to undergo dialysis weekly. He also developed decubitus ulcers that later developed into osteomyelitis. It was deemed by the hospital and the health care providers on Betancourt's case that any further treatment of the patient would be non-beneficial and not better than his current prognosis,<sup>8</sup> thus upholding the ethical principles of beneficence and non-maleficence. The physicians placed a Do Not Resuscitate (DNR) order in the patient's chart. The plaintiff Jacqueline Betancourt, the patient's daughter, filed an action that the hospital and physicians must continue to treat the patient.<sup>8</sup> The judge ruled in favor of the plaintiff and required the hospital to reinstate treatment of Betancourt.<sup>8</sup> However, within three months of the judge's order requiring reinstatement of treatment, Betancourt passed away.<sup>8</sup> The case ultimately ended on a basis of mootness. This hallmark case established the need for non-beneficial treatment policies in healthcare institutions.

## GUIDELINES FOR NON-BENEFICIAL TREATMENT POLICIES

The AMA, ATS, ACCN, ACCP, ESICM, and SCCM established guidelines that help facilitate the implementation of a non-beneficial treatment policy in a hospital system. All sources should be utilized when deciding if a medical treatment is beneficial for a patient or not. When a patient is incapacitated and can no longer make decisions about their treatment plan, it is unethical to give complete authority to one

individual, whether it be the patient's surrogate or the treating physician.<sup>5</sup> To ethically create a care plan for a patient, it should be a collaborative team effort between the care team and the patient's family. If disagreements arise about the appropriate action of care, a negotiation must be conducted that brings in more expert consultants.<sup>5</sup>

The AMA Code of Medical Ethics provides guidelines to physicians when facing decisions about withholding or withdrawing life-sustaining treatments.<sup>4</sup> According to this code, the physician should first review with the patient and their surrogate, the individual's advance directive or their values, goals for care, and treatment preferences.<sup>4</sup> Next, the physician should be sure to document these preferences and confirm the patient's surrogate is identified and recorded in the medical record.<sup>4</sup> It is the physician's duty to provide all relevant health information and treatment options to the patient, or surrogate, during the decision-making process.<sup>4</sup> For example, the physician should discuss with the patient and/or surrogate the option of initiating a treatment to determine its clinical effectiveness for the patient.<sup>4</sup> If the treatment does not prove to be effective for the patient, it should be withdrawn from the patient.<sup>4</sup> It is important to reassure the patient and surrogate that the patient will receive appropriate medical care. Withdrawing medical treatment does not mean stopping patient care. Lastly, it is important that the physician consults with the ethics committee of the health care facility throughout the patient care process.<sup>4</sup> This is especially important when the patient or surrogate and the physician cannot reach agreement about whether to withdraw life-sustaining treatment.<sup>4</sup> The ethics committee should also be consulted when there is no surrogate available to make decisions on the behalf of the patient or the physician believes that the surrogate is not making the appropriate decision based on the values, goals of care, or treatment preferences expressed by the patient.<sup>4</sup>

The ATS, ACCN, ACCP, ESICM, and SCCM have developed four recommendations physicians should use to resolve any conflict during the decision-making process.<sup>5</sup> The first recommendation is that health care institutions should be proactive in preventing intractable treatment conflicts.<sup>5</sup> This includes early communication and intervention between the physician, patient, surrogate, and relevant expert consultants.<sup>5</sup> Communication is the most important part of any decision-making process. Evidence suggests that most disagreements between the provider and surrogate can be resolved through further communication about what exactly the treatment goals are for each party. Outside help from expert consults, such as ethics or palliative care consultants, can also help the resolution process.<sup>5</sup>

The second recommendation is the term "futile" should not be used to describe treatment options that have the potential to achieve the therapeutic goals the patient is seeking.<sup>5</sup> The term that should be used to describe such a treatment is "non-beneficial." If the

family or surrogate of the patient does not agree with the decision of a non-beneficial treatment, the next steps then for the care management of the patient would be to:

- (1) Seek expert consultation to help the physician and surrogate negotiate a solution to the disagreement.
- (2) The surrogate can obtain a second opinion from an outside provider.
- (3) The surrogate can have the patient's case reviewed by the designated hospital committee that handles non-beneficial treatment cases.
- (4) The surrogate should be offered the choice to transition the care of the patient to a different medical hospital or team.
- (5) If the treatment plan is negotiated, the decision between the surrogate and the physician should then be implemented.<sup>5</sup>

The third recommendation is that physicians should refuse to give care to patients whose surrogates request futile interventions.<sup>5</sup> As stated above, the word futile should never be used in the clinical setting. However, if a medical treatment is truly futile, based off the definition provided above, it is unethical for a physician to provide this form of care upon a surrogate's request.<sup>2</sup>

The last recommendation provided by the ATS, ACCN, ACCP, ESICM, and SCCM is, health care providers should advocate for policies and laws that address the issues pertaining to non-beneficial treatment and when life-prolonging care should not be used.<sup>5</sup> The most important part about non-beneficial treatment policies is to ensure that they are consistent. This consistency should not only be maintained from hospital to hospital, but from patient to patient. Having a clear, consistent non-beneficial treatment policy in place would limit the conflict between the provider and the surrogate, therefore allowing more time to be spent on treating the patient.

## COMPARISON OF POLICIES

From this point, this paper will analyze and compare the non-beneficial treatment policies between two different healthcare systems. A comparison between the policy of a secular hospital system and a religious hospital system will be made to highlight the differences between them. One such hospital system that focuses on community-based health with no religious ties, is a hospital system in Akron, OH. In their policy, the steps that are laid out should only be considered if there is a disagreement between the surrogate and the physician regarding the care plan.

The first step that must be followed when a physician becomes aware of disagreement about the care plan is to schedule a meeting with all parties to address the discrepancies between them. In a conversation with Julie Aultman, PhD (Oct 16th, 2021), she stated that the goal of this meeting would be to

discuss what exactly the goals of care are for the patient regarding their medical condition and prognosis. The physician should explain all treatment options to the patient or surrogate and why some options could be deemed non-beneficial.

The next part of the policy outlines how different consulting parties should be utilized while developing a specific care plan for the patient. If the physician feels that it is necessary, they can request a palliative care consult to review the care plan. This consult will review the patient's case and decide if the care plan is appropriate for a particular patient (Julie Aultman, PhD, conversation, Oct 16th, 2021). If there is disagreement between the consult and the physician, an ethics committee consult should be brought into the discussion. A second opinion from another physician can also be utilized to resolve any conflict between parties. This physician should not know about the case and should have no significant relationship with the physician in charge of implementing the non-beneficial treatment process on the patient. In addition to this, the patient/surrogate should be made aware that they are given a minimum of 48 hours to pursue a second opinion/transfer if they do not agree with the physician that is a part of the care team for the patient. If consultation and second opinions from other physicians does not resolve the discrepancies between parties and the care plan, this is when the ethics committee will step in. The ethics committee will do their own investigation and determine the next best steps for the patient. If there is still no resolution after three business days, the physician has an obligation to go through with their treatment plan (Julie Aultman, PhD, conversation, Oct 16th, 2021).

When it comes to the non-beneficial treatment policy of a religious system in Midlothian, VA, they follow the Virginia Code Provisions and Regulations. Under Virginia Law, every hospital that has the facilities to provide life-sustaining treatments must have a non-beneficial treatment policy.<sup>9,10</sup> This policy must include the processes that the physician and the surrogate must go through for:

- (1) Obtaining a second opinion regarding the medical and ethical implications of a treatment plan and why they are deemed non-beneficial to the patient.
- (2) How to propose to an interdisciplinary ethical committee that a medical treatment is ethically inappropriate to implement on a patient.<sup>9</sup>

The only reason a physician might not have to follow the set forth law, is if they refuse to follow the advanced directive put forth by the patient or the decision made by the surrogate.<sup>9</sup> Any form of mercy killing or euthanasia is also prohibited. If a physician does deem that a patient's or surrogate's request for a treatment is ethically or medically inappropriate, they must explain to the individual why it is not ethical for them to allow treatment to occur. They then should help the surrogate or patient find a physician that is willing

to comply with their treatment requests within 14 days.<sup>9</sup>

It is the physician's responsibility to give full authority to the surrogate or patient when it comes to any decision-making regarding the care plan.<sup>9</sup> Therefore, within the 14-day window the physician must provide life-sustaining care that the patient or surrogate requested. After the 14-day period, if there is still conflict about the care plan and the physician has yet to identify another physician that will fulfill the patient or the surrogate's request, the physician does not have to provide the treatment that the physician has determined to be medically or ethically inappropriate.<sup>9</sup>

## DISCUSSION

Overall, when comparing the two non-beneficial treatment policies, there are major differences in how they relate to one another and the guidelines put forth by the AMA, ATS, ACCN, ACCP, ESICM, and SCCM. The secular hospital system in Akron's policy follows more closely with the guidelines put forth by the AMA, ATS, ACCN, ACCP, ESICM, and SCCM. The policy is structured to facilitate communication between all relevant parties, such as the patient, surrogate, physician, ethics committee, and palliative care team. When it comes to the non-beneficial treatment policy of the religious hospital system in Virginia, it ignores the autonomy of the patients and is a lot more authoritative in nature. Although their policy is based off state law, it has many religious values associated with the policy. These values include the banning of euthanasia, and the requirement to provide life-sustaining treatment for a two-week period.<sup>10</sup>

The non-beneficial treatment policy of the secular hospital system gives a step-by-step guide of how to resolve conflict between the surrogate/patient and the physician regarding the care plan. It also highlights the most important part of any non-beneficial utilization plan, which is communication. Communicating between interdisciplinary fields is the key to deciding what the best plan of action is for a particular patient. It also ensures that physicians tell the patient or surrogates exactly what their options are in terms of finding a second opinion and how they can maintain their own autonomy. The policy strives to ensure the treatment plan process is collaborative and no one individual has authority over another. It also ensures that all parties can maintain their autonomy.

The non-beneficial treatment policy of the hospital system in Virginia states that the physician must follow the care plan put forth by the patient or surrogate for 14 days even if the physician disagrees with it. There is little room for collaborative decision making for the treatment plan of a patient because of the law stating that the decision-making authority is given to the surrogate or patient. The physician can only state their opinions about why they feel a medical treatment would be non-beneficial. This policy does not really follow the collaborative nature that the guidelines put forth by the AMA and ATS suggest.

## CONCLUSION

Although there are guidelines that have been published by relevant societies, such as the AMA, ATS, ACCN, ACCP, ESICM, and SCCM, there is still no consistency between non-beneficial treatment plans. The importance of a consistent non-beneficial treatment policy is to ensure that both the physician and patient can maintain their autonomy in situations where critical decisions need to be made. Consistent guidelines will also allow for better collaborative decision making between parties, so no one party has complete authority over another. It could also stop some of the demands of transferring patients to hospitals to receive care from physicians that are willing to treat them. Ultimately, a non-beneficial treatment policy ensures decisions are being made in a timely matter, which limits any harm the patient may experience throughout the process. For guidelines of non-beneficial treatment to become universal in the United States health care system, there must be further development of shared policies for secular and religious hospital systems at the regional and national level.

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## CONFLICTS OF INTEREST

All authors declare no conflicts of interest.

## AUTHOR CONTRIBUTIONS

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