

Nonbeneficial Treatment and Conflict Resolution: Building Consensus

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Abstract

Introduction: We established a fair and explicit nonbeneficial treatment and conflict resolution policy at our medical center. The policy was designed to help us acknowledge and respect both patients and clinicians involved in treatment planning and decision making.

Objective: To qualitatively describe how our hospitalwide nonbeneficial treatment and conflict resolution policy was used.

Design: Retrospective evaluation of all bioethics consultations from November 6, 2009, when the policy was adopted, through August 6, 2012. Case-specific data were obtained when nonconsensus occurred involving withholding or withdrawing of nonbeneficial treatment.

Main Outcome Measures: Rates of resolution of conflicts and treatment plan consensus when nonbeneficial treatment was withheld or withdrawn.

Results: We identified 146 (39.4%) cases where there was a treatment-level conflict between patients/surrogates and the treatment teams responsible for their care. In 54 (37.0%) of the cases, resolution occurred. In 92 (63.0%) of the cases, nonbeneficial treatment was eventually withheld or withdrawn. In 87 (94.6%) of the cases where treatment was withheld or withdrawn, the treatment teams and patients/surrogates reached consensus by the conclusion of the bioethics consultation process using the fair and explicit nonbeneficial treatment and conflict resolution policy.

Conclusion: A fair and explicit nonbeneficial treatment and conflict resolution policy can result in a high level of consensus between patients/surrogates and the treatment teams responsible for their care when treatment is withheld or withdrawn.

Introduction

In 2009, our hospital approved a nonbeneficial treatment policy to establish a fair and explicit process to acknowledge and respect the views of all parties involved in conflict situations involving treatment plan decision making, to honor patient autonomy, and to respect the rights and professional obligations of physicians and other members of the medical team. In an acute care medical setting, conflicts often arise when parties disagree on what constitutes the best treatment course for patients. When disagreements arose at our medical center about a particular treatment or treatment plan, such as cardiopulmonary resuscitation, dialysis, tracheostomy, or artificial nutrition, all parties involved were best served by a process that helped them to navigate through the layers of complex decision making, to

better understand what constituted beneficial treatment, and to choose the optimum treatment plan to provide it.

Physicians are not obligated to provide medical treatment that is outside the standard of care, including treatment that, in the physician's exercise of professional judgment, will cause suffering and intrusiveness that greatly outweighs any potential clinical benefit. "First do no harm" is always an important directive when discussing what constitutes beneficial treatment in addition to defining quality of life from the patient's perspective. According to the California Medical Association,¹ nonbeneficial treatment is any medical treatment a physician determines, in the exercise of his/her professional judgment, that:

1. Will be ineffective for producing the physiologic effect that the patient/surrogate desires or expects of the medical treatment;
2. Will produce no effects that can reasonably be expected to be experienced by the patient as beneficial for accomplishing the patient's expressed and medically obtainable goals;
3. Will more likely cause harm than benefit for the patient;
4. Has no realistic chance of returning the patient to a level of health that permits survival outside of a general acute care hospital as defined in the California State Health and Safety Code section 1250(a); or
5. Would serve only to maintain the patient's life in a permanently unconscious state.¹

The Ethics Consultation Service helped create "moral space" for patients, families, and the treatment team by nurturing shared decision making that included both clinician and patient and had as its goal of excellence the creation of an atmosphere of trust. This atmosphere of trust included making sure that patients and their families understood treatment choices, making sure patients and families understood the possible outcomes of the treatment choices presented, and ensuring that patients and their surrogates used their right to an informed acceptance or refusal of these treatment choices presented by the health care team.

Moral space is a place reserved for ethical reflection. Patients and families need space to reflect on their lived values and to discover whatever is good for the patient from the perspective of the patient.¹ The medical team also enters moral space when they elicit the patient's story and lived values. The medical team hears the patient's preferences with a clear lens allowing all parties to forge a treatment plan that honors the patient's good.^{2,3} The moral space needed to build consensus for treatment goals relies heavily on the bilateral nature of the physician-patient encounter and a discussion workflow that directs the process for resolution of disagreements (Figure 1).

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In the period from November 6, 2009, to August 6, 2012, a total of 371 formal bioethics case consultations were requested, and 39% (146 cases)⁴ involved addressing treatment-level conflict between the attending physician or treatment team and the patient or the patient's surrogate. In 54 cases, treatment plan agreement was reached between the patient/surrogate with the help of a clinical ethicist, and the process outlined in the nonbeneficial treatment and conflict resolution policy was not invoked. In 92 of the 146 cases, nonbeneficial treatment was withdrawn or withheld, and the nonbeneficial treatment and conflict resolution policy was invoked. Our data highlighted the importance of bilateral decision making in the process, outlined by the nonbeneficial treatment and conflict resolution policy, of withdrawing or withholding nonbeneficial treatment for these 92 cases.

The main objective of this study was to describe, by qualitative method, the common patterns observed in the process of consensus building and conflict resolution.

Methods

This project was reviewed and approved by the Kaiser Permanente Southern California institutional review board. The Ethics Consultation Service kept a running record of all cases and outcomes that formally used the "Nonbeneficial Treatment and Conflict Resolution Policy" and also used a clarity report

from an efficient retrieval server (SAP Crystal Reports Server 2008, SAP North America, Newtown, PA)⁵ to examine the medical center electronic database to capture all categories of recorded bioethics consultation. We were able to identify how many times the nonbeneficial treatment and conflict resolution policy was invoked and how many cases reached decision-making consensus as a result of using the steps in the process outlined in the policy.

In contrast to quantitative studies, the qualitative data collection for this study continued until reaching saturation, which means that distinct patterns of information emerged. Our data collection spanned approximately a 3-year period from November 2009 to August 2012. Our sampling method was both well designed and purposive because it relied on a comprehensive electronic medical record system linked to an efficient retrieval server. We were able to generate case outcomes data that indicated consensus building occurred in 92 (95%) cases (Figure 2) when nonbeneficial treatment was withheld or withdrawn.^{6,7}

Results

The process of consensus building relied on quality conversations that involved all of the appropriate stakeholders for the patient. Following the policy's process, the first interdisciplinary team meeting included the attending physician, a social worker, physician consultants, and all key medical professionals involved in the case (eg, nurses and respiratory therapists). If consensus was not reached, the patient/surrogate/family was offered a second in-house medical opinion and treatment team meeting. If consensus was still not reached, a third meeting was held with the family, attending physician, professional stakeholders, and the clinical ethicist.

If, despite previous attempts, resolution was not attained, an Ethics Committee case review was performed with an intradisciplinary team from the Ethics Committee. The entire treatment team and the patient's surrogate and interested family members were gathered to discuss the clinical rationale for the attending physician's treatment plan. After hearing all relevant discussion, the Ethics Committee members would convene separately and review the case. The committee members would then determine whether the physician's treatment plan without the treatment identified as nonbeneficial by the attending physician was within the acceptable ethical range of treatment alternatives for the patient's specific context. If the Ethics Committee agreed with the attending physician that the treatment fell within the acceptable range of ethical alternatives, the disputed nonbeneficial treatment was withdrawn or withheld at the medical center. The patient/surrogate/family were given the opportunity to transfer the patient to another physician's care at another medical center or to commence legal proceedings. If the Ethics Committee did not agree that the treatment plan offered by the attending physician fell within the acceptable ethical range of treatment alternatives, treatment and care were transferred to a physician in the hospital who was willing to take responsibility for the patient's treatment plan.

The treatment team reached consensus during a family meeting to limit nonbeneficial treatment with patients and

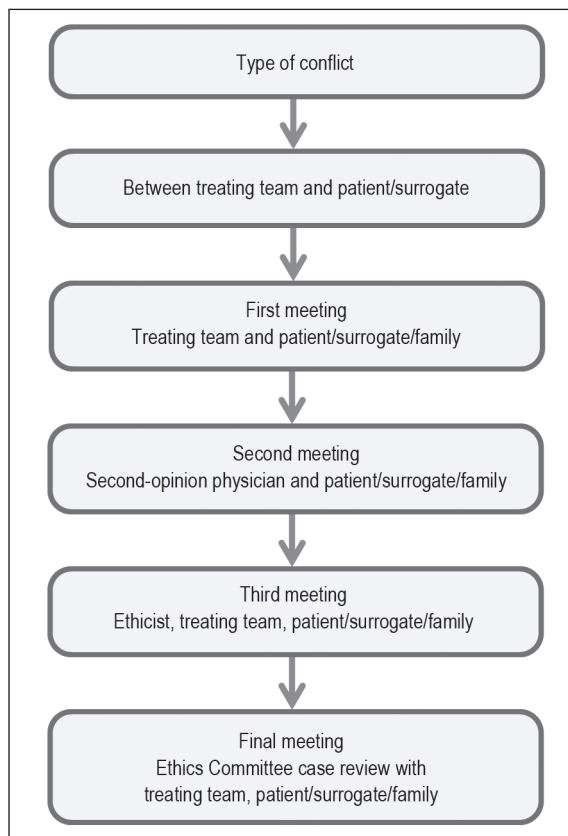


Figure 1. Process for resolution of disagreements about treatment plan.

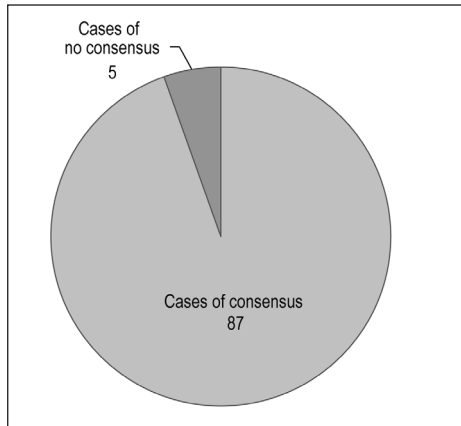


Figure 2. Outcome of cases of conflict regarding the provision of perceived nonbeneficial treatment (n = 92).

their surrogates for 70 of the 92 cases. For the remaining 22 cases, nonbeneficial treatment remained a request by patient or surrogate after the family meeting or meetings with the treatment team. Following the process outlined in the nonbeneficial treatment policy, 9 of the 22 cases concluded with the treatment team building consensus with the patient/surrogate/family for the issue of withholding or withdrawing the nonbeneficial treatment. The remaining 13 cases continued to follow the process outlined in the nonbeneficial treatment policy, with 8 cases reaching consensus after further family meetings. In those 8 cases the nonbeneficial treatment was withheld or withdrawn.

In 5 cases, the treatment team and patient/surrogate did not reach consensus, and the attending physician, after the final bioethics case review, withheld or withdrew the defined nonbeneficial treatment (Table 1). Families from 2 cases accepted the unilateral decision of treatment withdrawal after the bioethics consult. For Case 1, the family verbally expressed thanks to multiple staff members once the decision was made to

withdraw treatment and focus on comfort measures. For Case 2, the family never commented on the decision but indicated by their behavior that they were agreeable and at peace with the decision. Both patients died in the hospital with comfort measures initiated according to the treatment plan offered by the attending physician and which followed the process outlined in the nonbeneficial treatment policy.

Two families (Cases 3 and 4) continued to disagree with the unilateral decision of treatment withdrawal after the bioethics consult. One family decided to allow the patient to remain in the hospital, and the patient died with comfort measures initiated. One family requested transfer to a subacute care facility, and the patient died the day after discharge with comfort measures initiated at the subacute care facility.

The fifth family (Case 5) continued to disagree with the unilateral decision of treatment withdrawal and arranged for the patient to be transferred to another medical center. Once transfer was made, there was no further contact with the patient or family. In all five cases there was no postoutcome litigation to date (Table 1).

The 5 cases in which nonbeneficial treatment was unilaterally withheld or withdrawn are described as follows:

1. A 55-year-old woman with Stage 4 non-small cell lung cancer was previously treated with partial lobectomy, chemotherapy, and radiation. She experienced hepatic and nodal metastases and was admitted to the emergency room after complaining of shortness of breath with hemoptysis. She experienced a pulseless electrical activity arrest en route to the emergency room. She was resuscitated, intubated, and transferred to the intensive care unit. The patient remained unresponsive.
2. A 51-year-old man had a history of diabetes, hypertension, metastatic non-small cell lung cancer (squamous cell carcinoma) with multiple rounds of chemotherapy during the previous 2 years. He suffered a cardiac arrest, sustained anoxic brain injury, and continued to experience multiorgan failure. He remained unresponsive while in the hospital.
3. An 83-year-old woman had a history of end-stage renal disease and was receiving hemodialysis; she also had a

Cases of unilateral withdrawal	Patient preferences	After ethics committee case review	Treatment withheld or withdrawn	Outcome	Postoutcome litigation
1	Beneficial treatment per advance directive	Family thankful	CPR, increased dose of vasopressors, antiarrhythmics	Comfort measures initiated; patient died in hospital	No
2	Unknown; family never discussed treatment preferences with patient	Family accepting	CPR, stent, increased dose of vasopressors	Comfort measures initiated; patient died in hospital	No
3	No advance directive; patient ambivalent with treatment preferences, then lost capacity	Family unaccepting	CPR, dialysis, vasopressors, antiarrhythmics, tracheostomy, antibiotics	Comfort measures initiated; patient died in hospital	No
4	Family stated that patient requested conservative treatment; no advance directive	Family unaccepting	CPR, dialysis, feeding tube	Comfort measures initiated; patient died in subacute care facility posttransfer	No
5	Conservative treatment requested per advance directive	Family unaccepting	Nasogastric tube and percutaneous endoscopic gastrostomy tube	Transferred to another hospital by family; no further contact	No

CPR = cardiopulmonary resuscitation.

history of diabetes, hypertension, bilateral above-the-knee amputation, and worsening diastolic dysfunction. A computed tomographic scan showed extensive metastatic disease from underlying cancer. She experienced a cardiac arrest and was resuscitated but could not tolerate dialysis because of persistent hypotension and sepsis. She continued to decline and never regained consciousness.

4. A 67-year-old woman was in a vegetative state secondary to anoxic brain injury caused by cardiac arrest. Multiple electroencephalograms revealed no cortical function and no prognosis for recovery. The patient had glossitis due to chronic biting of her tongue, had a long-term tracheotomy, was ventilator dependent, had been living in a subacute care unit, and had recurrent hospital admissions because of worsening hypoxia, hypotension, pulmonary emboli, and pneumothorax. She has been comatose for the past 2 years.
5. An 81-year-old man lived at a skilled nursing facility and presented with recurrent abdominal distention. He had a recent history of atrial fibrillation and pulmonary embolism and was placed on a regimen of warfarin. He also had a history of a non-ST segment myocardial infarction, Ogilvie syndrome, hypertension, papillary renal cell carcinoma (status post left laparoscopic radical nephrectomy), and a gastrointestinal stromal tumor. He was deemed not a surgical candidate according to the consulting oncologist. He had not been able to tolerate nasogastric tube feedings and was not a candidate for a percutaneous endoscopic gastrostomy because of his ongoing Ogilvie syndrome. He had poor mental status, was only alert and oriented to self, and did not possess the capacity to make his own medical decisions.

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Discussion

Success with the process of decision making outlined in the nonbeneficial treatment and conflict resolution policy relies heavily on how well the process was embedded within the delivery of patient care. This required a great investment in teamwork and communication.⁸ This meant that the teamwork required for

consensus building needed to emphasize tools and behaviors easily incorporated into the treatment-planning workflow. We recognized that physicians were the de facto champions that must commit to embracing the nonbeneficial treatment and conflict resolution process and must be supported in its use by the health care team that works with them. This required thorough in-house education and in-servicing.

To ensure effective adoption and implementation of the Nonbeneficial Treatment and Conflict Resolution Policy, we developed a thorough process to educate the medical center. Education included a presentation to the Bioethics Committee for policy approval, a thorough discussion with the hospital Medical Executive Committee for approval, open medical center continuing education lectures for physician and staff with continuing medical education credits offered, separate department in-services for the intensivists and the hospitalists, and an in-service for the registered nurse care coordinators (discharge planners) working in utilization management.

Although the intensivists were the first group of physicians to embrace and exercise comfort in adopting the tools and steps in the process of our nonbeneficial treatment and conflict resolution policy, hospitalists were involved in most cases that used the process of deliberation outlined by the Nonbeneficial Treatment Policy when there were more than 2 family meetings in the process of building consensus. Nine of the 13 cases needing more than 2 family meetings involved hospitalists. Both the intensivists and the hospitalists experienced the outcome of consensus building between patient/surrogate/family and the treatment team as a result of using the policy (Figure 3). There was clearly great success with bilateral consensus building, compared with the results in Figure 2.

The final step in the nonbeneficial treatment and conflict resolution policy included a recommendation by the Ethics Committee as to whether the treatment plan—withholding or withdrawing the nonbeneficial treatment proposed by the attending hospitalist as conscientious refusal⁹—fell within the ethically acceptable range of alternatives for this patient in this context. In the five cases, the Ethics Committee recommendation concluded that all of the treatments proposed by the

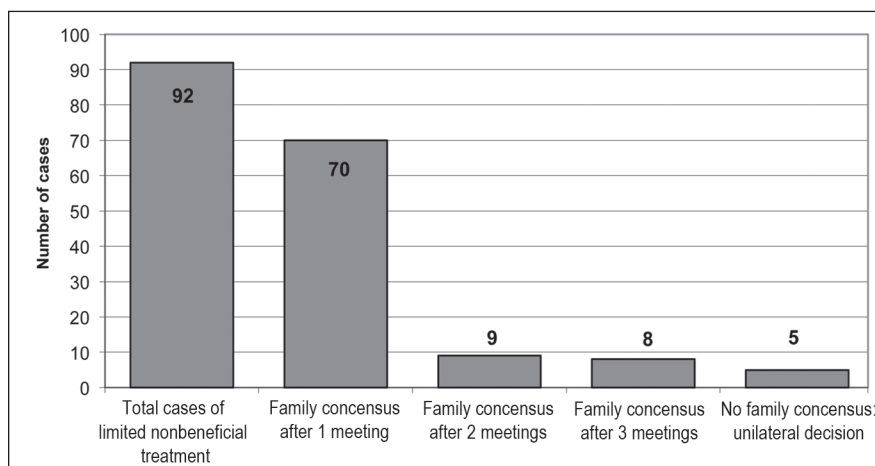


Figure 3. Steps in the policy process and number of cases resolved.

attending hospitalists, including the withholding or withdrawing of nonbeneficial treatment, were ethically defensible for these patients in their specific context. Restitution provided in the policy process allowed families to transfer their family member to another receiving physician outside the medical center or to begin legal proceedings.

Davis¹⁰ cogently states that although ethics recommendations similar to those for the five cases described earlier appear to include unilateral decision making, there is moral justification for unilateral decision making in intractable cases such as these. We agree that other clinicians outside our medical system, relying on community standard and professional conscience, would not provide a procedure, and not offering a patient said treatment would leave the patient no worse off than if s/he had gone to the other clinician in the first place. In addition, refusal to provide the treatments relies heavily on the patient's negative right of self-determination: providing treatment must be considered the right thing to do by the clinician to avoid patient coercion for the clinician when s/he provides treatment to the patient because of the fear of unpleasant consequences from the patient or family.¹¹

Our study described an explicit process that acknowledged and respected the views of both patient and clinician. By following the process outlined in the policy, the professional voice of the attending physician, conscientious refusal by the attending physician, and bilateral discussions of clinical treatment proposals prevailed. The right of therapeutic privilege and the professional obligation of clearly communicating a treatment rationale were both emphasized.

Patient autonomy was supported by honoring both precedent autonomy and current autonomy¹² because they were both important to the case contexts described earlier. The good of the patient,¹³ understood existentially, was addressed in a process of bilateral consensus building that was guided by following the steps outlined in the nonbeneficial treatment policy.

Consensus building occurred for most of the cases recorded. A consistent way to provide due process for treatment decision making was created, and our experience of using the nonbeneficial treatment policy appeared noteworthy.

There is future work to be done in evaluating the utility of a nonbeneficial treatment policy and process. The experience described in this article needs to be compared with the experiences of other medical centers. Sample studies within a variety of patient subgroups, including multiple medical center demographics, would strengthen the qualitative findings of this study by validating or by challenging the data presented here. In addition, the computerized tracking program used for codifying the data for this study may need refining so there would be a more simplified and direct way to connect cases counted in the clarity report to cases documented in the electronic medical record.

Data collection also did not include a clear understanding of the effectiveness of consensus building from the patient's perspective. Questions emerge: How does building consensus focus on and serve the "patient good"? Does the process help us honor the patient's story? Were we able to thoroughly employ the "fuller sense"² and more deeply understand the patient's perspective to the same degree for every case? Do the data cogently direct us to our hypothesis of consensus building? Have

our conversations avoided coercion and taken into account that we are often dealing with issues of power imbalance and patient vulnerability? Could our numerous family meetings have fatigued the family instead of having discovered their voice? Can our data become too easily co-opted by utilization management concerns for minimizing hospital readmission or hospital stay?

Future studies might also employ ethnographic techniques¹⁴ that examine the personal experience of families involved in the consensus-building process to help answer some of these questions, give deeper analysis, and offer a better grasp of effective consensus building.

We enthusiastically support a continued atmosphere of respect and understanding between clinician and patient. We hope that our experiences with the process in our nonbeneficial treatment policy continue to facilitate communication and recognize and respect both shared values and areas of disagreement in seeking the patient good. Those interested in reviewing our policy can request an electronic copy of it from the primary author (CN). ❖

Disclosure Statement

The author(s) have no conflicts of interest to disclose.

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