Crisis Standards of Care Considerations: Non-Beneficial Care

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In crisis situations, healthcare providers should ideally allocate resources based on the needs of *all* patients and not based on our usual approach to meeting the needs of the individual. Though much of the focus of crisis standards of care planning has concentrated on forecasting prognosis between patients (i.e., who benefits the most), it is crucial that providers know when and how to de-escalate care to free up scarce resources.

Determining Type of Care

Hospitals should understand the following care definitions:

- Futile: Care that *cannot* benefit the patient – a difficult threshold to meet in many cases.
- Non-beneficial: Care that has *no reasonable expectation* of benefit to the patient.
- Inappropriate: Care that would usually be provided under conventional conditions but – during a crisis – *should not be continued* relative to patient prognosis or expectation of benefit.

While often difficult to demonstrate with certainty, some hospitals still use futility as their threshold for withdrawal of life-sustaining care. However, many have moved to a non-beneficial standard.

Hospital processes for determining non-beneficial care during conventional conditions often involve protracted processes that are not compatible with crisis conditions when multiple patients require a scarce resource. While the threshold for determining when care is non-beneficial should remain the same in all situations, the process for this determination may be expedited or a more streamlined process used during contingency or crisis situations.

When ongoing care is determined to be inappropriate based on a resource shortage, this pivot to a *situationally dependent* assessment of the care being provided should be acknowledged by caregivers and communicated to patients, other hospitals in the region, and the state. In some cases, this may involve relatively low risk (e.g., restricting continued use of chemotherapies for palliation) and in other cases, this may involve life-sustaining interventions such as mechanical ventilation. Decisions about discontinuing care that will likely result in death require additional provider protections and systems support when they fall outside of usual provider scope and are made during care that is ongoing (i.e., care that occurs beyond the initial triage, resuscitation, and emergency intervention phase). When providers believe care being provided is inappropriate, they should confirm this with additional consultation and make the decision to de-escalate or discontinue care in concert with existing guidance and prognostic information.

Because these determinations are difficult even during routine operations, it is suboptimal to enact changes to non-beneficial care processes during a crisis. Healthcare coalitions and other regional efforts can be helpful in developing consistent thresholds and language among hospitals in an area. The effort among San Diego hospitals to adopt common language around non-beneficial care is a good example.[1] Further, this is an

[1] San Diego Physician. 2009 July pp.22-27. https://issuu.com/mamsden/docs/200907sdp

opportunity to include consistent, agreed-upon guidance on how de-escalation processes will be expedited under crisis conditions across multiple hospitals.

De-Escalation of Care

Managing expectations with patients and their loved ones is a key first step in helping them understand the demand for resources and consequences of the shortages. It can also help set the stage for proactive discussions of the patient's wishes and desired outcomes and ease later discussions about the benefits of continued care.

During daily rounds, or when a patient's clinical condition changes significantly, the care providers should identify potential non-beneficial or inappropriate care. There should be a process to escalate these determinations to a larger consultative group for review unless clinical guidelines already exist that specify the care received will meet the definition.

After providers determine it is appropriate to de-escalate care, they should meet with the patient's loved ones to agree on next steps. The early involvement of palliative care teams/providers can help accelerate goals of care discussions with families as well as provide reassurance and consultation about supporting comfort during care de-escalation. In the absence of family support for de-escalation, stopping inappropriate care may only be an option if there are adequate legal protections for the provider and facility and this is consistent with regional strategies. Most hospital plans include mechanisms to proceed with discontinuing futile or non-beneficial care against the wishes of family and these should be closely reviewed and the process socialized across the facility in non-emergency times as the decisions will be accelerated during a crisis.

In some cases, family members have sought and obtained restraining orders preventing discontinuation of treatment while courts review futility decisions.[2] Though in most cases the hospital will prevail, this introduces hostility and delays that must be carefully weighed when determining whether to continue discontinuation of care efforts. In some of these adversarial situations, families have conducted social media campaigns against facilities and providers resulting in threats against both. It is critical for the state and health systems to disseminate pre-scripted, coordinated, and proactive messages about the current conditions, the scarcity of resources, and the challenging choices facing providers. This can help boost understanding and community support for providers and facilities.

Conclusion

Identifying non-beneficial and inappropriate care during crisis can contribute to improved use of resources and access to care, but identifying this care and applying an effective process to de-escalate or discontinue care requires commitment by both providers and their institutions and, in many cases, protection and support from the state.

Access the other documents in this collection:

- CSC Considerations: De-Escalation of Care
- CSC Considerations: Legal/Regulatory
- CSC Considerations: Pharmaceutical and Supply Shortages
- CSC Considerations: Recognizing and Mitigating Crisis Care
- CSC Considerations: Reducing Provider Distress

[2] https://www.startribune.com/judge-mercy-hospital-must-keep-patient-suffering-from-covid-on-ventilator/600136066/