Futility Redux: When May / Should / Must a Clinician Write a DNAR Order without Patient or Surrogate Consent?

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Lesson

DNAR
no CPR

Right to refuse

Sept. 1990
Browning

BUT . . .
Right to demand?  
Negative liberty

Positive liberty?

Our question
No DNAR
CPR?

No consent
DNAR?

Roadmap
Background

1. Consent
2. CPR is different
3. Medical futility
4. Prevalence

DNAR without consent

5. “Futile”
6. “Proscribed”
7. “PIT”
8. PIT traffic lights

Consent

Do NOT consider patient’s “own crude opinions”

1847
Clinicians need consent

Treat w/o consent is battery

Consent

But not “informed”

1905

1914

1972
Clinicians normally need consent.

CPR is different.

Normally need consent.

But . . . consent to what?

Consent to treatment.

CPR is presumed.

Consent not required for CPR.
Consent required for no CPR (DNR)

What is a medical futility dispute

Surrogate will not consent when you think they should

Appropriate

Inappropriate

Proportionate

Disproportionate

Beneficial

Non-beneficial

Surrogate driven overtreatment

"I'm afraid there's really very little I can do."
“Conflict . . . in ICUs . . . epidemic proportions”

13% ethics consults

> 16% ethics consults

Prevalence

4 of 8

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

20%

2 CPR futility cases per month

Feb. 2015

700 acute care clinicians
When may / should / must a clinician write a DNAR order without patient or surrogate consent?

It depends

3 types of CPR

Futile
Proscribed
Potentially inappropriate
“In Ethics . . . difficulties and disagreements . . . are mainly due to a very simple cause . . .”

“the attempt to answer questions, without first discovering precisely what question it is you desire to answer.”

Futile
Proscribed
Potentially inappropriate

Futile
5 of 8
Interventions cannot accomplish physiological goals

Example 1

Example 2

Example 3

Scientific impossibility
Example 4

total brain failure = death

Dead → No duty to treat

“After a patient . . . brain dead . . . medical support should be discontinued.”

Aden Hailu

Jahi McMath

“Futile”
Value free objective

But . . .
futile for what outcome

May & should refuse

Futile
Proscribed
Potentially inappropriate

Proscribed

6 of 8

Also green
Treatments that **may accomplish** effect desired by the patient

Laws or public policies
- Prohibit
- Permit limiting

Prohibited provision

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**Example 1**

**Example 2**

**Example 3**
Proscribed

- Prohibited
- Permitting limiting

Permitted limiting

Example 1

- Trisomy 18
- 22-week gestation
- ECMO

Example 2

Surrogate demand

Appropriate medicine
Example 3

Not ATS “futility”

Might restore CP function

“imminent death”

3 days

“medically ineffective”  

“[not] prevent the impending death”

imminent = impending

May & should refuse

Futile  
Proscribed  
Potentially inappropriate

Potentially Inappropriate  
7 of 8
Some chance of accomplishing the effect sought by the patient or surrogate

Not “futile” because might “work”

E.g. dialysis for permanently unconscious patient

E.g. vent for patient w/ widely metastatic cancer

We call them “futility disputes” . . . BUT . . .

Disputed treatment might keep patient alive.

But . . . is that chance or that outcome worthwhile

Not a medical judgment

Value judgment
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 seek expert consultation to aid in achieving a negotiated agreement.
2. Surrogacy should be given clear instruction in writing regarding the initiation of the procedure and the steps and timelines to be expected in this process.
3. Clinicians should obtain a second medical opinion to verify the diagnosis and the judgment that the requested treatment is inappropriate.
4. There should be clear evidence by an interdisciplinary institutional committee.
5. If a conflict of interest is identified, the patient should be informed and an independent provider should be consulted.
6. If the committee agrees with the clinicians and no other provider can be found, a legal focus should be informed of the right to seek case review by an independent appeals board.
7. If the conflict or disputes to occur, the patient or the patient’s request for mediation, treatment decisions should be consulted.
8. If the committee agrees with the clinician’s judgment, the request to the provider.
9. If the provider does not agree independently, the process for the clinician’s position, clinicians may or may or may not provide the requested treatment and should provide high-quality palliative care.

“potentially”

Legal focus

Try again for consent

PDA
Mediation
Transfer
New surrogate

1
PDA

Robust evidence shows PDAs are highly effective

Informed surrogates are less aggressive

2

Negotiation Mediation
Prendergast (1998)
57% agree immediately
90% agree within 5 days
96% agree after more meetings


Garros et al. (2003)

Hooser (2006)

Transfer
New provider

but
possible


Replace Surrogate
Substituted judgment
Best interests

~ 60% accuracy

More aggressive treatment

2.20: “surrogate’s decision . . . almost always be accepted”

Still no consent?
Not futile
Not proscribed

Fla. Stat. 765.105
“the health care facility, or the attending physician, . . . may seek expedited judicial intervention . . . surrogate . . . not in accord with the patient’s known desires . . . failed to discharge duties . . .”
No surrogate consent
No “new” surrogate
No transfer

May you write DNAR?

Traffic Lights

Consent always

Examples only
Nondiscrimination in Treatment Act  
November 2013

“health care provider shall not deny . . . life-preserving health care . . . directed by the patient or [surrogate]”

Medical Treatment Laws Information Act  
November 2014

Review & sign once per year  

SB 172, HB 309 (2012)
**Physician may stop LST without consent for any reason**, if review committee agrees.

- Give the surrogate
- 48hr notice RC
- Written decision RC
- 10 days to transfer
- Write DNAR without consent
"health care provider . . . that refuses to comply . . . make reasonable efforts to transfer"
Fla. Stat. 765.1105

Want to refuse
Try to transfer

“not been transferred, carry out the wishes of the patient or . . . surrogate”
Fla. Stat. 765.1105

No transfer
Must comply

But . . .
“unwilling to carry out . . . because of moral or ethical beliefs”

Confidential Party v. Confidential Party, No. 14MH165 (Lee County Circuit Court, Mar. 2014)

How to proceed

Overt & Open


IIED

NIED

Secretive
Insensitive
Outrageous
Consultation expected

Distress foreseeable

Wendland v. Sparks (Iowa 1998)

Seek assent

Not consent

Open ended question

More directive

Announce plan: “We are going to…”

Silence = assent

Transparent enough
Thank you

References

Medical Futility Blog

Since July 2007, I have been blogging, almost daily, to medicalfutility.blogspot.com.

This blog reports and discusses legislative, judicial, regulatory, medical, and other developments concerning end-of-life medical treatment conflicts. The blog has received over one million direct visits. Plus, it is distributed through RSS, email, Twitter, and re-publishers like Westlaw, Bioethics.net, Wellsphere, and Medpedia.
2015 – 2016


2012 – 2014


2007 – 2011


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