Medical Futility: Recent Legal Developments

Thaddeus Mason Pope, J.D., Ph.D.
Widener University Health Law Institute
HCA webinar • November 7, 2011

Define “medical futility dispute”
Identify causal factors
Intramural resolution

Intractable cases
Typical pathway
Recent court cases
Surrogate replacement

Limits of surrogate replacement

What is a medical futility dispute?
January 2008
Ruben Betancourt
73yo male
Surgery - thymus gland tumor

January - July 2008
Other facilities

July 2008
Readmitted to Trinitas
COPD
ESRD
Hypertensive cardiovascular disease

Stage 4 decubitus ulcers
Osteo- myelitis
Diabetes
Parchment- like skin
“It all seems to be ineffective. It’s not getting us anywhere.”

“We’re allowing the man to lay in bed and really deteriorate.”

Proposed Tx plan

DNAR
Stop dialysis

Surrogate
Daughter
Jacqueline
Late 2008

Multiple family conferences

Surrogate will **not** consent

<table>
<thead>
<tr>
<th>D: Palliative</th>
<th>D: Curative</th>
</tr>
</thead>
<tbody>
<tr>
<td>P/S: Palliative</td>
<td>1</td>
</tr>
<tr>
<td>P/S: Curative</td>
<td><strong>3</strong></td>
</tr>
</tbody>
</table>

**Question and Responses**

<table>
<thead>
<tr>
<th>Question and Responses</th>
<th>Public, % (n=1006)</th>
<th>Professionals, % (n=774)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do patients have the right to demand care that doctors think will not help?</td>
<td>Yes: 72.4</td>
<td>44.3</td>
</tr>
<tr>
<td></td>
<td>No: 20.2</td>
<td>44.8</td>
</tr>
</tbody>
</table>
### Question and Responses

<table>
<thead>
<tr>
<th>Question and Responses</th>
<th>Public, % (n=1006)</th>
<th>Professionals, % (n=774)</th>
</tr>
</thead>
<tbody>
<tr>
<td>If doctors believe there is no hope of recovery, which would you prefer?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life-sustaining treatments should be stopped and should focus on comfort</td>
<td>72.8</td>
<td>92.6</td>
</tr>
<tr>
<td>All efforts should continue indefinitely</td>
<td>20.6 ←— 2.5</td>
<td></td>
</tr>
</tbody>
</table>

### Question and Responses

<table>
<thead>
<tr>
<th>Question and Responses</th>
<th>Public, % (n=1006)</th>
<th>Professionals, % (n=774)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do patients have the right to demand care that doctors think will not help?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>72.4</td>
<td>44.3</td>
</tr>
<tr>
<td>No</td>
<td>20.2</td>
<td>44.8</td>
</tr>
</tbody>
</table>
Causal Factors

1. Surrogate demand
2. Provider resist

Why surrogates demand non-beneficial treatment?
Misunderstand Prognosis

Iatrogenic

Inadequate communication
Uncoordinated, conflicting
Undue pressure
Mistrust

More 'empowered' patients question doctors' orders

By Mary Dwispel Marcus, USA TODAY

In the past, most patients placed their entire trust in the hands of their physician. Your doc said you needed a certain medical test, you got it.

Not so much anymore.

Jeff Chappell of Montgomery, Ala., recalls a visit a couple of years ago to a Charlotte emergency room near where he lives.
Emotional Barriers
Psychological Barriers
Religion
“religious grounds were more likely to request continued life support in the face of a very poor prognosis”

Zier et al., 2009 Chest 136(1):110-117

<table>
<thead>
<tr>
<th>Question and Responses</th>
<th>Public, % (n=1006)</th>
<th>Professionals, % (n=774)</th>
</tr>
</thead>
<tbody>
<tr>
<td>If the doctors treating your family member said futility had been reached, would you believe that divine intervention by God could save your family member?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>57.4</td>
<td>19.5</td>
</tr>
<tr>
<td>No</td>
<td>35.5</td>
<td>61.1</td>
</tr>
</tbody>
</table>
Why providers resist

Avoid patient suffering
“This is the Massachusetts General Hospital, not Auschwitz.”

“I do not see much difference between what we are doing . . . and . . . atrocities . . . in Bosnia.”
The relationship between moral distress and perception of futile care in the critical care unit

1. Follow the family's wishes for the patient's care when I do not agree with them but do so because hospital administration fears a lawsuit
   - 41 (93)
   - 29 (66)

2. Follow the family's wishes to continue life support even though it is not in the best interest of the patient
   - 42 (95)
   - 39 (89)

3. Carry out a physician's order for unnecessary tests and treatment
   - 49 (98)
   - 32 (71)

4. Initiate extensive life-saving actions when I think it only prolongs death
   - 44 (100)
   - 38 (86)

→ Adverse impact on patient care
Integrity of profession

Stewardship
Limited ICU beds
ER boarding
Antibiotic resistance

Distrust
surrogate

?
66% accurate

50% = pure chance

Moorman & Carr 62%
2010

Barrio-Catelejo et al. 63%
2009

Shalowitz et al. 58%
2006

Even lower
when most needed
intermediate zones
Typical dispute resolution pathway

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

Garros et al. (2003)

Hooser (2006)

Code of Medical Ethics
of the American Medical Association

section 2.037
1. Earnest attempts . . .
   deliberate . . .
   negotiate . . .

2. Joint decision-making
   . . . maximum extent . . .

3. Attempts . . .
   negotiate . . .
   reach resolution . . .

4. Involvement . . .
   ethics committee . . .

Consensus

Intractable
Intractable cases
Typical resolution

“Remove the __, and I will sue you.”
"Why they follow the . . . SDMs instead of doing what they feel is appropriate, almost all cited a lack of legal support."

Bad law
Legal Risk

Civil liability
- Battery
- Medical malpractice
- Informed consent
- State HCDA
- EMTALA
Licensure discipline

Criminal liability
e.g. homicide

Providers have won almost every single damages case for unilateral w/h, w/d

Providers typically lose only IIED claims
  Secretive
  Insensitive
  Outrageous
Risk > 0

Process = punishment

Even prevailing parties pay transaction costs
  Time
  Emotional energy

Liability averse

Litigation averse
Easier to cave-in

Patient will die soon
Provider will round off
Nurses bear brunt

Defensive Medicine

HEALTH AFFAIRS 29, NO. 9 (2010): 1585-1592

I order some tests or consultations simply to avoid the appearance of malpractice

Feel pressured in my day-to-day practice by the threat of malpractice litigation

**DOCTOR SURVEY**

<table>
<thead>
<tr>
<th>Action</th>
<th>% ordered for defensive reasons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital admissions</td>
<td>13.0%</td>
</tr>
<tr>
<td>Lab tests</td>
<td>17.9%</td>
</tr>
<tr>
<td>X-rays</td>
<td>21.9%</td>
</tr>
<tr>
<td>Ultrasound studies</td>
<td>24.0%</td>
</tr>
<tr>
<td>MRI studies</td>
<td>27.4%</td>
</tr>
<tr>
<td>CT scans</td>
<td>27.6%</td>
</tr>
<tr>
<td>Specialty referrals</td>
<td>28.4%</td>
</tr>
</tbody>
</table>

**Factor**

<table>
<thead>
<tr>
<th>Factor</th>
<th>Extremely or Very Important</th>
<th>Most Important of All Factors Listed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient's prognosis</td>
<td>98.5</td>
<td>12.0</td>
</tr>
<tr>
<td>What was best for the patient overall</td>
<td>98.1</td>
<td>23.2</td>
</tr>
<tr>
<td>Respecting the patient as a person</td>
<td>96.6</td>
<td>5.4</td>
</tr>
<tr>
<td>Patient’s pain and suffering</td>
<td>94.6</td>
<td>12.5</td>
</tr>
<tr>
<td>What the patient would have wanted you to do</td>
<td>81.8</td>
<td>29.4</td>
</tr>
<tr>
<td>Providing the standard of care</td>
<td>81.5</td>
<td>22.2</td>
</tr>
<tr>
<td>Respecting the wishes of the family or surrogates</td>
<td>80.9</td>
<td>3.3</td>
</tr>
<tr>
<td>Following the law</td>
<td>68.6</td>
<td>1.1</td>
</tr>
<tr>
<td>The burden on the family</td>
<td>44.8</td>
<td>0</td>
</tr>
<tr>
<td>Religious beliefs of the patient</td>
<td>35.3</td>
<td>0</td>
</tr>
<tr>
<td>Religious beliefs of the family or surrogates</td>
<td>28.6</td>
<td>0</td>
</tr>
<tr>
<td>Cost to society of caring for the patient</td>
<td>14.2</td>
<td>0</td>
</tr>
<tr>
<td>Physician’s religious beliefs</td>
<td>10.7</td>
<td>0</td>
</tr>
<tr>
<td>Concerns about paying for</td>
<td>9.3</td>
<td>0</td>
</tr>
<tr>
<td><strong>Notable</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concern that the surrogates might sue</td>
<td>8.4</td>
<td>1.1</td>
</tr>
</tbody>
</table>

Cost to society

Quality & safety of patient
Medical push for right to object

WHEREAS, it is still common for physicians who feel non-beneficial or futile treatments are being provided or considered to feel threatened by legal action by the patient’s family or other surrogates, and thus continue to provide such care against their best medical judgment; and
RESOLUTION 1 - 2004
(read about the action taken on this resolution)

Subject: Futility of Care

Introduced by: Michael Kozloff, MD and the Medical Society of Milwaukee County

RESOLVED, That the Wisconsin Medical Society, concurrent with a recommendation of the American Medical Association, Medical Futility in End-of-Life Care policy E-2.037, supports the passage of state legislation which establishes a legally sanctioned extra-judicial process for resolving disputes regarding futile care, modeled after the Texas Advanced Directives Act of 1999.
Late 2008

Try to transfer
No facility willing

January 2009

Unilateral DNAR
Remove dialysis port

January 2009

Jacqueline files
Court issues TRO
Courts almost always grant temporary injunctions to preserve the status quo.

But litigation is slow. Patients often die before adjudication of the merits.

February 2009
Evidentiary hearings
Medical experts
Family members
March 2009
Permanent injunction

April 2010
NJHA   GNYHA
MSNJ   CHPNJ
NJP

August 2010
Appeal dismissed
Treat ‘til transfer
Surrogate Selection
85-year-old
Irreversible dementia
End-stage kidney failure
Chronic respiratory failure

Recurrent pneumonia and infections
Dependent on ventilator
Dependent on CANH

Nephrologist
Dialysis will not improve or lengthen life
Unethical and painful
1993 advance directive

Appoints Lana

Appears silent as to Al’s wishes
Try to transfer

But Al already at 10 other hospitals

80 ambulance transports

“substantial harm”
“inappropriate”
“unnecessary”
“harmful”
“painful”
1993 advance directive

“allowed to die and not be kept alive by artificial medical means or heroic measures”

1994 advance directive

Appointed son (by earlier marriage) to be agent

Feb. 2011

ALTERNATE DECISION MAKERS INC.
Surrogate

Advance directive

A

B

Surrogate

Best interests

A

B

Mass. General v. Carol Carvitt
Court to surrogate:

“Your own personal issues are impacting your decisions”

“Refocus your assessment”

Not just an option, an obligation
Pascentia McDonald
74yo
Aug. 14, 2002
Surgery
thoraco-abdominal aneurysm

Advance directive
1. Bobby Miles is agent
2. Cynthia Cardoza is alternate agent
3. “Do Not prolong life if incurable condition”

Aug. 14-30
Post-op infections
Aug. 30
Sepsis
Non-cognitive
Sept. 1-16
Bobby
Continue LSMT
3 more surgeries
Cynthia
Disagrees

Sept. 17
Cynthia
Threatens to sue
USC stops
Pascentia dies

Probate Code 4740
**immunizes** providers
who “in **good faith**
comply with . . . decision
made by one whom they
believe authorized . . .”
“Operation of the immunity here is not so certain.”

“Compliance with an agent’s decision that is at odds with the patient’s own expressed decision, in her AHCD, would probably not qualify as in good faith.”

The agent (Bobby) was not authorized to depart from AD. USC should have known that.
“This case does not provide the appropriate **platform** . . .”

**Limits of surrogate replacement**
Without evidence of patient wishes, providers cannot show deviation.

Surrogates are often **faithful** to patient wishes.
Consent and Capacity Board

Sunnybrook Health Sciences Centre
when it matters MOST

[Image of a person smiling]
October 2010
Surgery to remove benign tumour in head
Bacterial meningitis and ventriculitis

Severe brain damage
ICU – vent + CANH
PVS

“No realistic hope recovery”
“No medical benefit”
“May cause harm”
Many conferences

Wife

Physician from Iran

Does not consent

Tried to transfer
withdrawal of LST violates a tenet of the Shia Muslim faith

Plan unilateral withdraw
Wife moves to enjoin
Docs argue they do not need consent
Not “treatment”
No benefit
Outside standard care
Intractable conflicts

Intractable conflict where surrogate replacement can work