Bridon Preston v. Meriter Hospital

Roadmap (part 1)

- Definition & orientation
- Causes
- Typical resolution pathway

Today

Past few weeks

The Wisconsin Surgical Society
A Chapter of the American College of Surgeons
What is a medical futility dispute?
Never give in, never give in, never, never, never, never, . . .

Causes of non-beneficial medicine

- Defensive medicine
- Surrogate demand
- Vague standards
- Physician religion
- Physician anti-death

- Patient
- Advance directive
- Proxy
- Agent
- Surrogate
- Conservator

“Continue to treat”

“Treatment is inappropriate”
Table 4. Responses Regarding Demanding Care and Goals of Care for Those in a Persistent Vegetative State

<table>
<thead>
<tr>
<th>Question and Responses</th>
<th>Public, % (n=1006)</th>
<th>Professionals, % (n=774)</th>
<th>P Value</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>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>72.4</td>
<td>44.3</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>No</td>
<td>20.2</td>
<td>44.8</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>
Why do surrogates demand non-beneficial treatment?

Table 3. Preferences for Goals of Care and Limited Resources

<table>
<thead>
<tr>
<th>Question and Responses</th>
<th>Public, % (n=1808)</th>
<th>Professionals, % (n=774)</th>
</tr>
</thead>
<tbody>
<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</td>
<td>2.5</td>
</tr>
</tbody>
</table>

Biggest reason YOU HAVE seen for surrogate insistence

- 14% 1. Prognostic distrust
- 14% 2. Racial/Ethnic
- 14% 3. Religion/Miracles
- 14% 4. Guilt/Loyalty
- 14% 5. Family Dynamics
- 14% 6. Financial
- 14% 7. Other
Externalization

- Costs
- Guilt
Religion 1

Table 5. Responses Regarding Race, Culture, Ethnicity, and Religion

<table>
<thead>
<tr>
<th>Question and Response</th>
<th>Public, % (n=1000)</th>
<th>Professionals, % (n=774)</th>
<th>P Value</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>Yes 57.4</td>
<td>19.5</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>No 35.5</td>
<td>61.1</td>
<td>&lt;.001</td>
<td></td>
</tr>
</tbody>
</table>

Religion 2

“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

Religion 3
Why do providers resist surrogate requests?

Why do YOU resist surrogate demand for non-beneficial treatment

1. Professional integrity
2. Patient suffering
3. Stewardship/resources
4. Distrust surrogate
5. Avoid staff moral distress

Avoid patient suffering

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

“abomination,” “immoral,” “tantamount to torture”
Moral distress

Category: futile care

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. 43 (98) 32 (73)
4. Initiate extensive life-saving action when I think it only prolongs death 44 (100) 38 (86)
5. Carry out the physician’s orders for necessary tests and treatments for terminally ill patients 45 (97) 30 (68)
6. Prepare an elderly man for surgery to have a gastrostomy tube put in, who is severely demented and a “No Code” 42 (95) 18 (41)

Integrity of the profession

正直
Table 2. Predictive Accuracy of Surrogates Versus a Preliminary Population-Based Treatment Indicator

<table>
<thead>
<tr>
<th></th>
<th>Accuracy</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surrogates</td>
<td>78.4%</td>
<td>(73.64)</td>
</tr>
<tr>
<td>Treatment indicator</td>
<td>78.5%</td>
<td>(72.18)</td>
</tr>
</tbody>
</table>

Stewardship
Growth in rate of conflict

<table>
<thead>
<tr>
<th>Population or percent, sex, and age</th>
<th>2000</th>
<th>2010</th>
<th>2020</th>
<th>2030</th>
<th>2040</th>
<th>2050</th>
</tr>
</thead>
<tbody>
<tr>
<td>PERCENT OF TOTAL TOTAL</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>0-4</td>
<td>6.8</td>
<td>6.9</td>
<td>6.8</td>
<td>6.7</td>
<td>6.7</td>
<td>6.7</td>
</tr>
<tr>
<td>5-19</td>
<td>21.7</td>
<td>20.0</td>
<td>19.6</td>
<td>19.3</td>
<td>18.2</td>
<td>18.3</td>
</tr>
<tr>
<td>20-44</td>
<td>36.9</td>
<td>33.8</td>
<td>32.3</td>
<td>31.6</td>
<td>31.0</td>
<td>31.2</td>
</tr>
<tr>
<td>45-64</td>
<td>22.1</td>
<td>26.2</td>
<td>24.9</td>
<td>22.3</td>
<td>22.3</td>
<td>22.3</td>
</tr>
<tr>
<td>65-84</td>
<td>10.9</td>
<td>14.1</td>
<td>14.1</td>
<td>13.9</td>
<td>15.4</td>
<td>15.8</td>
</tr>
<tr>
<td>85+</td>
<td>1.5</td>
<td>2.0</td>
<td>2.2</td>
<td>2.3</td>
<td>3.8</td>
<td>4.8</td>
</tr>
</tbody>
</table>


Providers resist

Conflict rate

Surrogates demand
Table 4. Responses Regarding Demanding Care and Goals of Care for Those in a Persistent Vegetative State

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<td>44.8</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

- More palliative care
- More EOL training
- Provider rights
- Financial incentives

Typical dispute resolution pathway
How are futility disputes usually resolved?

1. Surrogate eventually agrees with HCP
2. HCP accedes to surrogate demands
3. Patient dies
4. Patient transferred

Prendergast (1998)

- 57% surrogates immediately agree
- 90% agree within 5 days
- 4% continue to insist on LSMT

Garros et al. (2003)

Hooser (2006)
1. Earnest attempts . . . deliberate over and negotiate prior understandings . . .

2. Joint decision-making should occur . . . maximum extent possible.

3. Attempts . . . negotiate . . . reach resolution . . . with the assistance of consultants as appropriate.

4. Involvement of . . . ethics committee . . . if . . . irresolvable.

5. 

6. If the process supports the physician's position and the patient/proxy remains unpersuaded, transfer. . .

7. If transfer is not possible, the intervention need not be offered.
Consensus

Intractable

Roadmap (part 2)
Intractable conflict
Court cases
4 legislative approaches

Intractable conflict
Mediation occurs in the “shadow” of the law

Bad law


<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>
Physicians' Level Of Agreement With Items In The Malpractice Concerns Scale, 2003

<table>
<thead>
<tr>
<th>Item</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>In order some tests or consultations simply to avoid the appearance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>of malpractice</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel pressured in my day-to-day practice by the threat of</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>malpractice litigation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

HEALTH AFFAIRS 29, NO. 8 (2010): 1585-1592

“Please…”

“...Let Me Pass.”

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

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
Damages

Exposure to civil liability
- State HCDA (incl. fees)
- Battery
- Medical malpractice
- IIED / NIED
- Informed consent
- EMTALA

Criminal liability
- e.g. homicide

Licensure discipline
What is the legal risk from unilateral w/h or w/d

<table>
<thead>
<tr>
<th>%</th>
<th>1. High</th>
<th>2. Medium</th>
<th>3. Low, yet material</th>
<th>4. Low and immaterial</th>
</tr>
</thead>
<tbody>
<tr>
<td>25%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Providers typically only lose on claims for IIED

- Secretive
- Insensitive
- Outrageous

Luce is confirming the trend of unsuccessful lawsuits against providers

Risk > 0
Grossly overstated risks

But **some** real exposure
“It is not settled law that, in the event of disagreement . . . the physician has the final say.”


“The only fear a doctor need have in denying heroic measures to a patient is the fear of liability for negligence . . . where qualified practitioners would have thought intervention warranted.”


But the process itself can be punishment

Even prevailing parties pay transaction costs
Liability averse

Litigation averse too

Providing good, clinically appropriate medicine

Acceding to surrogate demands
Easier to accede to surrogate demands

- Patient will die
- Provider will round off
- Nurses bear brunt

But not happy about it

Injunctions

Courts frequently grant temporary injunctions to preserve status quo

But patients often die before adjudication of merits
Ruben Betancourt vs. Trinitas Hospital

- 73yo male
- PVS
- COPD
- End-stage renal disease
- Hypertensive cardiovascular disease
- Stage 4 decubitus ulcers
- Osteomyelitis
- Diabetes
- Parchment-like skin

"The only organ that's functioning really is his heart."

"It all seems to be ineffective. It's not getting us anywhere."

"We're allowing the man to lay in bed and really deteriorate."
Intramural process
  No consensus

Unilateral withdrawal
  • DNR order written
  • Dialysis port removed

January 21, 2009
  Jacqueline files complaint

January 23, 2009
  Court issues TRO

February 10, 2009
  Court extends TRO

January – February 2009
  Evidentiary hearings
    • Medical expert witnesses
    • Family witnesses
<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
<th>Parties</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 4, 2009</td>
<td>Permanent injunction on the merits</td>
<td></td>
</tr>
<tr>
<td>August 2009</td>
<td>Appeal: NJHA, MSNJ, NJP, GNYHA</td>
<td></td>
</tr>
<tr>
<td>August 13, 2010</td>
<td>Appellate court refuses to reverse</td>
<td></td>
</tr>
</tbody>
</table>
Easier to ask for forgiveness than to ask for permission.

“The Court cannot require a medical advisor to act... contradictory to... bona fide clinical judgment.”


4 Statutory Approaches
Typical response to “bad law” claims

Safe harbor immunity

1. UHCDA model
2. Ontario model
3. Texas model
4. Conscientious objection

UHCDA model
Statutory approach 1 of 4
New Mexico (1995)
Maine (1995)
Delaware (1996)
Alabama (1997)
Mississippi (1998)
California (1999)
Hawaii (1999)
Tennessee (2004)
Wyoming (2005)

Tenn. Code 68-11-1808(e)
“A health care provider . . . may decline to comply with . . . health care decision that requires medically inappropriate health care or health care contrary to generally accepted health care standards . . .”
Tenn. Code 68-11-1808(f)

(3) . . . make all reasonable efforts to assist in the transfer . . .

(4) If a transfer cannot be effected, the health care provider . . . shall not be compelled to comply.

16 Del. Code 2508(g)

A health-care provider . . . that declines to comply . . . shall . . . Provide continuing care, including continuing life sustaining care, . . . until a transfer can be effected

Are there “generally accepted healthcare standards”

1. Yes
2. No
“Bad” safe harbor language

“generally accepted health care standards”

“significant benefit”
Wide variation in what considered futile
  • Some: only when 0%
  • Others: as high as 13%

Lantos, Am J Med 1989
What threshold

Uncertainty in extrapolating from populations to individuals

“The essence of futility is overwhelming improbability in the face of possibility”

Bernat 2008

Qualitative Futility
- Benefit burden
- QOL
- Cost per QALY
Treatment for septic shock in vegetative patient

International Differences in End-of-Life Attitudes in the Intensive Care Unit

Goals of Medicine

- Cure disease
- Alleviate pain & suffering
- Restore function
- Prevent disease
- Prolong corporeal existence
Not just ambiguity

Providers continue to create the “wrong” standard of care

Dan Merenstein
291 JAMA 15 (1994)

Result of Ambiguity

- Few futility policies
- Rare “full” implementation
A proxy shall act in accordance

1. “directive . . . decisions”
2. “the maker’s . . . wishes”
3. “maker’s best interests”

Wis. Stat. 155.20(5)
The health care agent shall act in good faith consistently with the desires of the principal . . . with any valid declaration . . . in the best interests of the principal
Wis. Stat. 155.60(4)

The *court may . . .
"direct* the . . . agent
to act in accordance .
. . [or] rescind all
powers”

Have you ever replaced
a surrogate?
1. Yes
2. No
3. No, but
saw it
done

Helga Wanglie
(Minn. 1991)
Surrogate with material COI

Surrogate decision inconsistent with P preferences

Dorothy Livadas
Court to Barbara Howe:

Your own personal issues are “impacting your decisions”

“Refocus your assessment”
Limitations of surrogate replacement

Problem 1
Surrogates can often demonstrate congruity

Problem 2
Providers lack evidence to demonstrate deviation
If cannot replace the surrogate, then (in those rare cases) just provide the treatment.

We **still need** dispute resolution mechanisms for those intractable cases in which surrogates are “irreplaceable.”

**Texas model**

Statutory approach 3 of 4
You can stop LSMT for **any reason** if your **own** hospital’s ethics committee agrees

---

**Tex. H&S Code 166.046**
- 48hr notice
- Ethics committee meeting
- Written decision
- 10 days
- No judicial review

---

**Tex. H&S Code 166.045**
A physician . . . is not civilly or criminally liable or subject to review or disciplinary action . . . if the person has complied with the **procedures** outlined in Section 166.046
Dear Ms. Gonzalez,

We, the physicians and other members of the healthcare team, appreciate you taking your time to attend the patient care conference regarding your son.

At the last conference, your son’s physician discussed his brain condition and the poor prognosis for any further neurological improvement. As you know, the physicians involved in the care of your son believe that his condition is irreversible and that to continue certain treatments will serve to prolong his suffering without the possibility of cure. We understand that you do not agree with this position and want the hospital to continue to provide all current treatments for your son.

When disagreements of this nature arise, Texas law allows hospitals to call the hospital ethics committee meeting to review whether certain treatments are medically appropriate. A meeting has been called for the Seton Family of Hospitals Ethics Committee to consider Emilio Gonzalez’s care. This meeting will be held on February 16, 2007 at 9:00 a.m. in the 3rd floor conference rooms at Deaconess Hospital in Austin. The physicians providing care for your son, as well as the ethics committee members will attend the meeting. Under Texas law you have the right to attend and participate in this meeting. Whether you are legally required, we strongly encourage you to be present for this discussion. You will be given the opportunity to ask questions regarding your son’s care and to provide input into the committee’s decision-making process.

Emilio Gonzalez
Step 2: HEC Meeting

Step 3: HEC Decision

The Ethics Committee further recommends that:

- The treatment plan for the patient be modified to allow only comfort measures (such as hydration, pain control) and other interventions designed to decrease the patient’s suffering.
- New complications that develop should not be treated, except with additional palliative measures, as appropriate.
- The patient’s code status be changed to a DNR.
- Appropriate spiritual and pastoral care resources should be provided to Emilio’s mother and family members.

In summary, the consulted members of the Ethics Committee concur with the recommendation by the Attending Physician and patient care team to withdraw aggressive care measures, including use of the ventilator, and to allow palliative care only. The Attending Physician, with the help of the Children’s Hospital of Austin, will continue to assist the patient’s family in trying to find a physician and facility willing to provide the requested treatment. The family may wish to contact providers of their choice to get help in arranging a transfer.

Step 4: Attempt transfer
Step 5: Unilateral Withdrawal

No transfer — Withdraw 11th day

Texas: the good
<table>
<thead>
<tr>
<th>Ontario</th>
<th>Texas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fast</td>
<td>Fast</td>
</tr>
<tr>
<td>Judicial review</td>
<td>No judicial review</td>
</tr>
<tr>
<td>Independent</td>
<td>Not independent</td>
</tr>
<tr>
<td>Rules &amp; procedures</td>
<td>No rules</td>
</tr>
<tr>
<td>Only for bad proxies (not Golubchuk)</td>
<td>For all disputes</td>
</tr>
</tbody>
</table>

TADA as model
WASHINGTON STATE MEDICAL ASSOCIATION
HOUSE OF DELEGATES

Resolution C-5
(A-98)

Subject: Legal Protection for Physicians When
Termination is Considered futile

Introduced by: King County Medical Society Delegation

Referred to: Reference Committee C

WASHINGTON STATE MEDICAL ASSOCIATION
HOUSE OF DELEGATES

Resolution A-2
(A-10)

Subject: WSMA Opinion on Medical Futility in End-of-Life Care

Introduced by: Shani Macinlay, MD, Delegate
WSMA Board of Trustees

Referred to: Reference Committee A

---

MEDICAL FUTILITY & MARYLAND LAW
Tuesday, November 30, 2010

---

RESOLUTION 1 - 2004
(read about the action taken on this resolution)

Subject: Futility of Care

Introduced by: Michael Katzoff, 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 F-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.
Texas: the bad and the ugly

Few substantive criteria for identifying inappropriate EOL treatment

Without substantive criteria, we must resort to procedural criteria

Intractable value conflict

Pure process
If process is all you have, it must have **integrity** and **fairness**

Is the TADA process fair?

<table>
<thead>
<tr>
<th>20%</th>
<th>1. Very fair</th>
</tr>
</thead>
<tbody>
<tr>
<td>20%</td>
<td>2. Somewhat</td>
</tr>
<tr>
<td>20%</td>
<td>3. Neutral</td>
</tr>
<tr>
<td>20%</td>
<td>4. Somewhat unfair</td>
</tr>
<tr>
<td>20%</td>
<td>5. Very unfair</td>
</tr>
</tbody>
</table>

**Procedural defects recognized**

Tex. S.B. 439 (2007)

Due Process

- Notice (48hrs)
- Opportunity to present
- Opportunity to confront
- Assistance of counsel
- Independent, neutral decision-maker
- Statement of decision with reasons
- Judicial review

No time to evaluate all these aspects of due process

Basically, providers should give patients what they give themselves

E.g. Peer review
E.g. Licensure actions

Who Makes the Decision?

Intramural institutional ethics committee

But the HEC is controlled by the hospital
TADA recognizes need for some "independent" check

- Requires HEC review
- Prohibits referring physician from serving on HEC

But the current mechanism is not sufficient

TADA is silent on HEC composition

No community member requirement, like IRB

Lack of transfer is not external review

COI

More documented

More targeted
Conflict of interest ($$$)

- Ruben Betancourt (NJ)
- Brianna Rideout (PA)
- James Bland (TX)
- Kalliah Roberson-Reese (TX)

Conflict of interest (other)

Statement of Decision

- Provide rationale
- Factual basis
- Considered, supported

But decisions are of variable quality
Issues that were identified and considered:

- The treatment team is in agreement that this is a terminal and irreversible condition which will result in his death.
- There is significant concern that this patient is suffering from pain related to his clinical condition.
- Dr. Wilson, Emilio's current attending physician, other physicians and other members of the patient care team believe Emilio is suffering and that the burdens associated with his current plan of care far outweigh any benefits that Emilio may be receiving.

Dear Mrs. Ellis Davis and Family,

This is to inform you of the decision of the Medically Inappropriate Treatment Review Committee that met on January 24, 2009 at 5:20 p.m. As a reminder, this Committee was comprised of independent clinicians who had not been involved in the treatment of Mr. Davis or his medical records that were presented.

The attending and consulting physicians of Mr. Davis presented the clinical case to this Committee, after which the Committee members were given the opportunity to ask questions. After reviewing the medical record and having had all questions asked and answered, the Committee is in agreement with the attending physicians that the current artificial life sustaining interventions are medically inappropriate. Please see the enclosed documentation.

We understand that the patient advocate has given you information from the Texas Advance Directive Act regarding the right to seek transfer of the patient to another facility and the limits from the Texas registry of hospice providers.

If we can be of further assistance please let us know.

Sincerely,

[Signature]

[Name]

Review Committee Chair

Memorial Hermann - SWH

Review Committee Facilitator

Memorial Hermann Memorial City Medical Center
Decision of the Medically Inappropriate Treatment Review Committee
Date: January 24, 2009 Time: 5:20 p.m.
Patient Name: Maurice Davis Medical Record #: 986839620

Background:
- Autistic Calf, Intestinal Malfunction, Gastrointestinal

Intervention under review:
- No

Committee's conclusion:
The Committee unanimously affirms the following intervention(s) is/are medically inappropriate treatment in this case:
- No
TADA is **silent** not only on substantive criteria but also on procedures and methodology

- *E.g.* quorum
- *E.g.* voting
Is TADA fair?

- 20% Very fair
- 20% Somewhat
- 20% Neutral
- 20% Somewhat unfair
- 20% Very unfair

Conscientious Objection

Statutory approach 4 of 4

No treatment relationship

May refuse to treat for any reason
Existing treatment relationship

Must continue to treat

Termination: normally
- Sufficient notice to find alternative
- Medical Board may require ~30 days

Termination: life-and-death
“free to refuse . . . upon providing reasonable assurances that basic treatment and care will continue”

Couch (N.J.A.D. 2000).
Del. Code 2508(e)

“. . . provider may decline to comply . . . for reasons of conscience.”

Del. Code 2510(a)(5)

. . . provider . . . not subject to civil or criminal liability or to discipline . . . for . . . declining to comply . . . because . . . conscience . . .

Del. Code 2508(g)

[If] decline to comply . . .

(2) Provide continuing care, including continuing life sustaining care, . . . until a transfer can be effected
Want to refuse

Try transfer

No transfer

Must comply

**Cal. Probate Code 4736**

(c) Provide continuing care . . until a transfer can be accomplished **OR** until it appears that a transfer cannot be accomplished.
Idaho Code 18-611
No health care professional . . . shall be civilly, criminally or administratively liable for . . . declining to provide health care services that violate his or her conscience

. . . in a life-threatening situation . . . professional shall provide treatment and care until an alternate health care professional capable of treating the emergency is found.

Miss. Code 41-107-5
A health care provider has the right not to participate, . . . violates his or her conscience.
. . .
No emergency exception
No duty to refer
Looking Forward

Without legal support to w/d or w/h openly and transparently, some do it covertly.
Avoid intractable conflict

Better ACP
- Most patients do not want overly aggressive treatment

More ethics resources
- Because they work

Better communication

Clinical Practice Guidelines

CPG linked to new safe harbors

CPGs make existing safe harbors effective
Multi-institutional ethics committee
Medical society
Specialized agency
  • Malpractice panel
  • Licensure board
Statement on futility and goal conflict in end-of-life care in ICUs revising the 1991 policy statement

Solution with most promise?
1. Better ACP
2. Better communication
3. CPGs
4. TADA
5. Surrogate selection
6. Reimbursement incentives

Thank you