Medical Futility: Top Two Formal Mechanisms for Resolving Intractable Disputes
Department of Population Health, NYU Langone Medical Center • Feb. 26, 2015
Thaddeus Mason Pope, J.D., Ph.D.
Hamline University Health Law Institute

Must a Death Panel be a Star Chamber?
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Should we delegate the resolution of treatment disputes to a tribunal other than a court?

Quinlan yes
Saikewicz no

“questions of life and death . . . require . . . detached but passionate investigation and decision that forms the ideal on which the judicial branch . . . was created . . . not to be entrusted to any other group”

What do we want that alternative tribunal to look like?

Prefatory Remarks

No relevant conflicts to declare
Roadmap

Background & Context
Definition
Prevalence
Typical dispute resolution (informal)

Intractable conflicts

TADA
CCB

What is a medical futility dispute

Surrogate driven over-treatment

"I'm afraid there's really very little I can do."
3 key attributes

Clinician
CMO

Surrogate
LSMT

Disputed treatment might keep patient alive.

Value laden

E.g. dialysis for permanently unconscious patient

But . . . is that chance or that outcome worthwhile

Prevalence
“Conflict . . . in ICUs . . . epidemic proportions”

13% ethics consults

MEMORIAL SLOAN-KETTERING CANCER CENTER

J. Oncology Practice (June 2013)

> 33% ethics consults

University of Michigan Health System

Physician Executive Journal (37 no. 6)

> 50% ethics consults

Lucile Packard Children’s Hospital AT STANFORD

Am. J. Bioethics (Apr. 2009)

Views About End-of-Life Treatment Over Time

<table>
<thead>
<tr>
<th>% of U.S. adults</th>
<th>1999</th>
<th>2005</th>
<th>2013</th>
<th>Diff. 90-13</th>
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</thead>
<tbody>
<tr>
<td>Doctors and nurses should do everything possible to save the life of a patient in all circumstances</td>
<td>75</td>
<td>70</td>
<td>66</td>
<td>-7</td>
</tr>
<tr>
<td>Don’t lose</td>
<td>12</td>
<td>8</td>
<td>3</td>
<td>-9</td>
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Probably Futile

Futile

904

Population of 65+ in United States

 Millions

2030  2040  2050  2060  2070  2080

60  50  40  30  20  10  0
Prevent Disputes

Most patients do NOT want futile treatment

Views on End-of-Life Medical Treatments
Growing Minority of Americans Say Doctors Should Do Everything Possible to Keep Patients Alive

PCIA

18-29 15%
30-49 33%
50-64 38%
65-74 61%
75+ 58%
Disputes will arise

Typical dispute resolution

Consensus Intractable

Negotiation Mediation 95%

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

Garros et al. (2003)

Northbeneficial Treatment and Conflict Resolution: Building Consensus

- Immediate
- Three Days
- Eventual

Hooser (2006)

- Resolved
- Unresolved

5%
Transfer

Cave-in

“follow the . . . SDMs instead of doing what they feel is appropriate . . .”
Medscape Ethics Report 2014

Red light states

UCLA Ronald Reagan Medical Center

Would you give life-sustaining therapy if you considered it futile?

46% YES
19% NO
35% IT DEPENDS

Patient will die soon
Provider will round off
Nurses bear brunt

83% physicians practice "defensive" medicine

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

“not . . . much difference . . . atrocities in Bosnia”

ED patients boarded & denied / delayed ICU

Community hospital patients denied / delayed ICU

Feb 2015
700 acute care clinicians
Clinicians want Adjudicators

Cumbersome
Time consuming
Expensive

Custom designed mechanism

Faster
Cheaper
Better
2/26/2015

Resolution 355/98

Title: Legal Support for Nonbeneficial Treatment Decisions

Author: C. Hugh Vezeau, MD
Wollum, Wisconsin, MD

Introduced by: District 9 Delegation

Endorsed by: District 9 Delegation

Reference Committee: October 4, 2011

WASHINGTON STATE MEDICAL ASSOCIATION
HOUSE OF DELEGATES

WA

Resolution C-5 (4/9)

Subject: Legal Protection for Physicians When Treatment is Considered futile

Introduced by: King County Medical Society Delegation

Referred to: Reference Committee C

RESOLUTION 1 - 2004

(Read about the action taken on this resolution)

Subject: Futility of Care

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

RESOLUTION 1, That the Wisconsin Medical Society, concerned with a recommendation of the American Medical Association, Medical Futility in End-of-Life Care policy E-2007, 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.

S.B. 1114 (Mar. 2009)

New York State Bar Association
Health Law Section
Summary Report on Healthcare Costs:
Legal Issues, Barriers and Solutions
September, 2009

TADA

Comprehensive legislation on healthcare decisions
M.D. may stop LSMT for **any reason** with immunity if HEC agrees

Tex. H&S 166.046

<table>
<thead>
<tr>
<th>Step 1</th>
<th>Step 2</th>
<th>Step 3</th>
<th>Step 4</th>
<th>Step 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attending refers to “review committee”</td>
<td>HEC MARC</td>
<td>Open meeting</td>
<td>Review committee decides &amp; serves “written explanation”</td>
<td>Attempt to transfer (10 days)</td>
</tr>
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</table>
Step 6
Treating hospital may stop LSMT

Safe harbor legal immunity

Fairness problems

There are few substantive criteria for identifying inappropriate EOL treatment:
- Brain death
- Anencephaly
- Physiological futility

No substantive criteria
Pure procedural justice

If process is all you have, it must have integrity & fairness

TADA’s 6 steps are not adequate
TADA decisions too vulnerable to 4 risks

Corruption
self-interest

Carelessness
ill-considered
ill-supported

Bias
disparaging to certain class

Arbitrariness
Abuse of process norms like notice

Procedural Due Process

Life
Liberty
Property

Notice
Opportunity to present
Opportunity to confront
Statement of decision
Independent decision-maker
Judicial review
Fundamental fairness

Neutral & independent decision maker

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

1-5 members  48%
5-10 members  34%
Mostly physicians, administrators, nurses

No community member requirement, like IRB
< 10% TX HECs have community member

COI
More documented
More targeted

Ruben Betancourt (NJ)
Brianna Rideout (PA)
James Bland (TX)
Kalilah Roberson-Reese (TX)
Statement of Decision

Provide rationale
Factual basis
Considered, supported

TADA specifies no minimum form or content

Other due process problems

Only 48 hours to prepare for the review committee meeting – notice often on FRI

Surrogate may attend.
But unclear right to participate

Issues that were identified and considered:

- The treatment team is in agreement that this terminal and irreversible condition 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 physicians, 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.
TADA is *silent* not only on substantive criteria but also on procedures and methodology

*E.g.* quorum
*E.g.* voting

No judicial review

HEC is forum of last resort

**CCB**

Consent and Capacity Board

1995

Health Care Consent Act
Mental Health Act
Substitute Decisions Act
Long-Term Care Act

Surrogate replacement
Substituted judgment
Best interests

~ 60% accuracy

More aggressive treatment

Consent and Capacity Board

Surrogate directive
GO STOP

Surrogate known wishes
GO STOP

Surrogate best interests
GO STOP
Responsive

APPLICATION TO DETERMINE SDM COMPLIANCE
WITH REGARD TO TREATMENT
(FORM G)

The Applicant believes that the SDM is not complying with the principles for giving or refusing substitute consent, (s. 27 (1), (2), HCCA).

How is the SDM not complying with the principles for giving or refusing substitute consent?

Hearing
within
7 days

Decision
within 1 day
of hearing

Independent
Neutral

Psychiatrist
Lawyer
Public member

Board
members
are trained

Rules of
procedure

CONSENT AND CAPACITY BOARD
RULES OF PRACTICE

7. (1) The respondent is entitled at any time during the hearing, to make a written request for the attendance of an advocate to represent the respondent. The Board may authorize an advocate to represent the respondent.
High quality written decisions

Judicial review

Limits

Surrogates loyal & faithful

CCB can only replace “bad” surrogates
Under TADA can determine a “good” surrogate has made a “bad” decision

CCB evaluates only the decision maker not the decision itself

Most benefits TADA without the affront to principles

Conclusion

2 objectives for DR mechanisms
- Fair
- Efficient

Fairness  Efficiency
As states look for models to follow, CCB beats TADA.


Pope TM, Legal Briefing: Medically Futile and Non-Beneficial Treatment, 22(3) J. CLINICAL ETHICS 277-96 (Fall 2011).


Pope TM, The Case of Samuel Golubchuk: The Dangers of Judicial Deference and Medical Self-Regulation, 10(3) AM. J. BIOETHICS 59-61 (Mar. 2010).

Pope TM, Restricting CPR to Patients Who Provide Informed Consent Will Not Permit Physicians to Unilaterally Refuse Requested CPR, 10(1) AM. J. BIOETHICS 82-83 (Jan. 2010).


Pope TM, Institutional and Legislative Approaches to Medical Futility Disputes in the United States, Invited Testimony, President’s Council on Bioethics (Sept. 12, 2008).


Pope TM, Philosopher’s Corner: Medical Futility, 15 MID-ATLANTIC ETHICS COMM. NEWSL, Fall 2007, at 6-7.