1. What is a futility dispute
2. Causes of futility disputes
3. Resolving intractable disputes
4. Association & institution policies
5. U.S. “safe harbor” statutes
6. Texas pure process
What is a futility dispute?

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

- Health care provider

“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>
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<td>44.3</td>
<td>&lt;.001</td>
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<tr>
<td>No</td>
<td>20.2</td>
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Can = may
Can = should
Can = must

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Table 3. Preferences for Goals of Care and Limited Resources

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<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>
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Causes of Futility Disputes

Surrogate demand

<table>
<thead>
<tr>
<th>Question and Responses</th>
<th>Public, % (n = 1800)</th>
<th>Professionals, % (n = 274)</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></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>67.4</td>
<td>19.5</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>No</td>
<td>32.6</td>
<td>80.5</td>
<td></td>
</tr>
</tbody>
</table>
Surrogate demand

Provider resistance

Avoid patient suffering

Provider resistance
Provider resistance

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
2. Follow the family's wishes to continue life support even though it is not in the best interest of the patient
3. Carry out a physician's order for unnecessary tests and treatments
4. Initiate extensive life-saving actions when I think it only prolongs death
5. Carry out the physician's orders for necessary tests and treatments for terminally ill patients
6. Prepare an elderly man for surgery to have a gastrostomy tube put in, who is severely demented and has a "No Code".

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

<table>
<thead>
<tr>
<th></th>
<th>Accuracy (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td></td>
</tr>
<tr>
<td>Surrogates</td>
<td>78.4% (73.64)</td>
</tr>
<tr>
<td>Treatment Indicator</td>
<td>78.9% (72.85)</td>
</tr>
<tr>
<td>Videos</td>
<td></td>
</tr>
</tbody>
</table>
Resolution of Futility Disputes through Consensus

Prendergast (1998)
- 57% surrogates immediately agree
- 90% agree within 5 days
- 4% continue to insist on LSMT

Garros et al. (2003)
AMA Code 2.037

When further intervention . . . becomes futile, physicians have an obligation to shift . . . toward comfort and closure

1. Earnest attempts should be made in advance to deliberate over and negotiate prior understandings between patient, proxy, and physician on what constitutes futile care for the patient, and what falls within acceptable limits . . . .

2. Joint decision-making should occur between patient or proxy and physician to the maximum extent possible.

3. Attempts should be made to negotiate disagreements if they arise, and to reach resolution within all parties' acceptable limits, with the assistance of consultants as appropriate.

4. Involvement of an institutional committee such as the ethics committee should be requested if disagreements are irresolvable.

5. . . .

6. If the process supports the physician's position and the patient/proxy remains un-persuaded, transfer to another institution . . . .

7. If transfer is not possible, the intervention need not be offered.
Chill from Legal Fear

- Barber (Cal. 1983)
- Manning (Idaho 1992)
- Rideout (Pa. 1995)
- Bland (Tex. 1995)
- Wendland (Iowa 1998)
- Causey (La. 1998)
Liability Exposure

- Grossly overstated risks
- But *some* real exposure

- Never give in, never give in, never, never, never, never . . . except to convictions of honor and good sense
Statutory Safe Harbors

Safe harbor

[Map of the United States with states highlighted in red]
New Mexico (1995)
Maine (1995)
Delaware (1996)
Alabama (1997)
Mississippi (1998)
California (1999)
Hawaii (1999)
Tennessee (2004)
Wyoming (2005)

N.M.S.A. 24-7A-7(D)

Except as provided in Subsections E and F of this section, a health-care provider shall comply with an individual instruction of the patient.

N.M.S.A. 24-7A-7(F)

A health-care provider or health-care institution may decline to comply with an individual instruction or health-care decision that requires medically ineffective health care or health care contrary to generally accepted health-care standards applicable to the health-care provider or health-care institution.
N.M.S.A. § 24-7A-9

A health-care provider . . . is not subject to civil or criminal liability or to discipline for unprofessional conduct for:

(4) declining to comply . . . as permitted by Subsection E or F of Section 24-7A-7 NMSA . . .

Illusory Safe Harbors

Safe harbors NOT navigable
“Bad” safe harbor language

“generally accepted health care standards”

“significant benefit”

Effect of bad safe harbor

- Uncertainty
- Few futility policies
- Little “full” implementation of futility policies

Brain death
Anencephaly

Physiological futility


APACHE Scores and Mortality

Predicted Risk Range (%)

Observed Death Rate (%)
Qualitative Futility

- Benefit burden
- QOL
- Cost per QALY

Goals of Medicine

- Cure disease
- Alleviate pain & suffering
- Restore function
- Prevent disease
- Prolong corporeal existence
Growing Intractable Conflict

Consensus

Intractable

TREND: DO EVERYTHING TO SAVE LIFE, OR SOMETIMES LET PATIENT DIE?

<table>
<thead>
<tr>
<th></th>
<th>May 1990</th>
<th>November 2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do everything</td>
<td>to save life</td>
<td>Do everything</td>
</tr>
<tr>
<td>Sometimes let</td>
<td>a patient die</td>
<td>Sometimes let</td>
</tr>
<tr>
<td>It depends</td>
<td>DK/Rf</td>
<td>DK/Rf</td>
</tr>
<tr>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>15</td>
<td>73</td>
<td>12=100</td>
</tr>
<tr>
<td>22</td>
<td>70</td>
<td>8=100</td>
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<sup>a</sup> Responses are based on the number of respondents who answered the question.
- More palliative care
- More EOL training
- Provider rights
- Financial incentives

Providers resist
Surrogates demand
Rate of intractability

Exception 1: Replace the Surrogate
<table>
<thead>
<tr>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Howe (Mass. 2005)</td>
</tr>
</tbody>
</table>

Exception 2: Underground Refusals
TABLE 5

PROPORTION OF PHYSICIANS (n = 726) WHO WITHHELD LIFE-SUSTAINING TREATMENT ON THE BASIS OF MEDICAL FUTILITY

<table>
<thead>
<tr>
<th>Consent Status</th>
<th>n</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Without the written or oral consent of the patient or family</td>
<td>219</td>
<td>25%</td>
</tr>
<tr>
<td>Without the knowledge of the patient or family</td>
<td>120</td>
<td>14%</td>
</tr>
<tr>
<td>Despite the objections of the patient or family</td>
<td>28</td>
<td>3%</td>
</tr>
</tbody>
</table>


- Slow Code
- Show Code
- Hollywood code

Way Forward?

Texas pure process
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

TX safe harbor

- Measurable procedures
- Safe harbor protection certain

NM safe harbor

- Vague substantive standards
- Safe harbor protection uncertain
Dear Mr. 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 would 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 Pediatric Ethics Committee to consider Raulito Gonzalez’s case. This meeting will be held on February 16, 2007 at 09:00 a.m. in the 3rd floor boardroom at Brackenridge Hospital of 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. While that is not 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.

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 Emelia’s mother and family members.

In summary, the medical team, with the recommendation of the Attending Physician and patient care team, will 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 5: Unilateral Withdrawal

No transfer

Can withdraw on the 11th day after HEC written decision given to surrogate

Texas is a model
Due Process
- Notice
- Opportunity to present
- Opportunity to confront
- Assistance of counsel
- Independent, neutral decision maker
- Statement of decision with reasons
- Judicial review (after exhaustion)

Tex. SB 439 (2007)
- More notice
- Get to “participate” not just “attend”
- Access to medical records
- More time to prepare
- Get to bring 5 or more helpers

Thank you