Resolution of Intractable Medical Futility Conflicts on Life-Sustaining Treatment: United States Law & Practice

International Conference on End of Life: Law, Ethics, Policy & Practice, Brisbane, QLD (14 Aug. 2014)

Thaddeus Mason Pope, J.D., Ph.D.
Hamline University Health Law Institute
Saint Paul, Minnesota USA

Introduction

Surrogate driven over-treatment

Prevent Disputes

Prevention Consensus
Switch parties
Intractable

Clinician
CMO

Surrogate
LSMT
Most patients do NOT want futile treatment

Advance care planning
More
Better
Earlier

Limits to Prevention

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Percentage</th>
</tr>
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<tbody>
<tr>
<td>18-29</td>
<td>15%</td>
</tr>
<tr>
<td>30-49</td>
<td>33%</td>
</tr>
<tr>
<td>50-64</td>
<td>38%</td>
</tr>
<tr>
<td>65-74</td>
<td>61%</td>
</tr>
<tr>
<td>75+</td>
<td>58%</td>
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</table>

30% want LSMT

Disputes will arise

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

Negotiation

Mediation

Consensus

Intractable

Hooser (2006)

95%

Resolved

Unresolved

5%

Switch parties
New clinician
New surrogate

Transfer

Rare, but possible

Replace Surrogate

Substituted judgment
Best interests

~ 60% accuracy
More aggressive treatment

Surrogate | Advance directive
GO | STOP

LIMITS of surrogate replacement

Surrogate Best interests
GO STOP

1. Providers cannot show deviation

2. Surrogates get benefit of doubt

Good ?? Bad
Surrogates
loyal & faithful

Truly Intractable

Covert
Act w/o consent
Cave-in

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

<table>
<thead>
<tr>
<th>IIED</th>
<th>NIED</th>
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</thead>
<tbody>
<tr>
<td>Secretive</td>
<td>Consultation expected</td>
</tr>
<tr>
<td>Insensitive</td>
<td>Distress foreseeable</td>
</tr>
<tr>
<td>Outrageous</td>
<td></td>
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Stop LSMT *without consent*

You may stop LSMT for *any reason* with immunity if your HEC agrees

*Tex. H&S 166.046*
48hr notice HEC
Written decision
10 days to transfer
“This is the Massachusetts General Hospital, not Auschwitz.”

Cal. Prob. Code 4734(a)

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

Treat ‘til transfer

Want to refuse

Try to transfer
No transfer
Must comply

Miss. Code § 41-107-3

L.B. 564 (2013)


H.B. 279 (2013) (over veto)


Red

Consent always
If surrogate directs [LST]... provider that does not wish to provide ... shall nonetheless comply ..."

"Health care . . . may not be . . . denied if . . . directed by . . . surrogate"

Discrimination in Denial of Life Preserving Treatment Act

OKLAHOMA

Rodgers and Hammerstein's Oklahoma!
SB 172, HB 309 (2012)

Life & death stakes
Unclear facts
Unclear law

TRO

Yellow

INJUNCTION

ADF

8 national RIGHT TO LIFE committee, inc.
“provider . . . may decline to comply . . . contrary to generally accepted health care standards . . .”
Cal. Prob. Code 4735

“provider . . . not subject to civil or criminal liability or to discipline. . .”
Cal. Prob. Code 4740

“generally accepted health care standards”

Standard of Care

Standard of Care

Pool
Safe harbor attributes

Clear
Precise
Concrete
Certain

TX
Measurable
Purely procedural

CA
Vague
Substantive

Cave-in

“follow the . . . SDMs instead of doing what they feel is appropriate . . .”

Very few judgments & settlements

Risk > 0

Liability averse
Litigation averse
Even prevailing parties pay transaction costs—time, emotional energy.

Patient will die soon
Provider will round off
Nurses bear brunt

"Conflict... in ICUs... epidemic proportions"

Conclusion

> 33% ethics consults

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

904

Futile

Probably Futile

96

123

98

904
Medical Futility Blog

Since July 2007, I have been blogging, almost daily, to medicalfutility.blogspot.com. This blog is focused on reporting and discussing legislative, judicial, regulatory, medical, and other developments concerning medical futility and end-of-life medical treatment conflict. The blog has received over 650,000 direct visits. Plus, it is distributed through RSS, email, Twitter, and re-publishers like Westlaw, Bioethics.net, Wellsphere, and Medpedia.

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