NO relevant personal financial relationships or intent to discuss an off-label / investigative use of a commercial product or device.
Orientation

Surrogate driven over-treatment

Clinician
CMO

Surrogate
LSMT
End orientation

1. Vocabulary
2. Prevalence
3. Causes
4. Prevention
5. Consensus
6. Intractable

Vocabulary
### Futile Treatment

<table>
<thead>
<tr>
<th>Interventions that cannot accomplish the intended physiological goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Clinicians should explain that the requested treatment is ineffective and explore the surrogates’ reasons for the request.</td>
</tr>
<tr>
<td>2. If conflict persists or if there is any doubt about the futility determination, clinicians should consult another qualified provider to evaluate the case.</td>
</tr>
<tr>
<td>3. Clinicians should consider expert consultation to mediate the conflict.</td>
</tr>
<tr>
<td>4. Institutions should retrospectively review the case to identify opportunities to prevent future similar occurrences.</td>
</tr>
</tbody>
</table>

### Inappropriate Treatment

<table>
<thead>
<tr>
<th>Treatments which may accomplish an effect desired by the patient, but for which there are widely accepted rules that prohibit their use</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. A surrogate requests antibiotics as treatment for an acute ill in a critically ill patient.</td>
</tr>
<tr>
<td>2. A clinician refuses to provide CPR in a patient with rigor mortis.</td>
</tr>
</tbody>
</table>

---

1. Futile
2. Inappropriate
3. Provisionally inappropriate
1. No meet patient goal
2. Imminent death
3. Permanent unconscious
4. No survive outside ICU
5. Burden > benefit

Value laden
Prevalence

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

Original Investigation

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

Thanh N. Huynh, MD, MS(H); Eric C. Illeperg, MD, Joshua F. Wiley, MA; Terrance D. Sivitsky, MBA, MA, PhD; Diana Gose, MD; Bryan J. Garber, MD; Neil S. Wenger, MD, MPH

Published online September 9, 2013.

Clinician driven over-treatment
Causes

1. Surrogate demand
2. Provider resist

Surrogate demand

Cognitive

<table>
<thead>
<tr>
<th>Question and Responses^a</th>
<th>Public, % (n=1006)</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>

^a Should the effort continue indefinitely?
Iatrogenic
Inadequate communication
Uncoordinated, conflicting
Undue pressure
Emotional Barriers

Psychological Barriers
Never give in, never give in, never, never, never, never, . . .

“I was really hoping, what with all those new radiology treatments, rescue helicopters, aerobics TV shows and what have you, that we might at least make a dent in it this year,” WHO Director General Dr.
Question and Responses

<table>
<thead>
<tr>
<th>Question</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</td>
<td></td>
<td></td>
</tr>
<tr>
<td>reached, would you believe that divine intervention by God could save</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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>

Zier et al., 2009
*Chest* 136(1):110-7

---

**Views on End-of-Life Medical Treatments**

Growing Minority of Americans Say Doctors Should Do Everything Possible to Keep Patients Alive

---

**Views About End-of-Life Treatment Over Time**

<table>
<thead>
<tr>
<th>% of U.S. adults</th>
<th>1990</th>
<th>2005</th>
<th>2013</th>
<th>Diff. 90-13</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Which comes closer to your view?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There are circumstances in which a patient should be allowed to die</td>
<td>73</td>
<td>70</td>
<td>66</td>
<td>-7</td>
</tr>
<tr>
<td>Doctors and nurses should do everything possible to save the life</td>
<td>15</td>
<td>22</td>
<td>31</td>
<td>+16</td>
</tr>
<tr>
<td>of a patient in all circumstances</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Don’t know</td>
<td>12</td>
<td>8</td>
<td>3</td>
<td>-9</td>
</tr>
<tr>
<td></td>
<td>100</td>
<td>100</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>
Clinicians resist

Avoid patient suffering

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

“This is not . . . much difference . . . atrocities in Bosnia”
Moral distress

Absenteeism
Retention
Quality

Integrity of profession
Stewardship

Distrust surrogate

66% accurate
50% = pure chance
71%: “More important to enhance the quality of life for seriously ill patients, even if it means a shorter life.”

*National Journal (Mar. 2011)*

<table>
<thead>
<tr>
<th>Question and Responsesa</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</td>
<td>2.5</td>
</tr>
</tbody>
</table>

Dying at Home: Wishes vs. Reality

- Wish To Die At Home: 67%
- Die At Home: 24%

Percent

0 10 20 30 40 50 60 70 80

Wish To Die At Home  Die At Home
H. R. 1173

110th CONGRESS
1st Session

To amend the Social Security Act to provide for coverage of voluntary advance-care planning consultation under Medicare and Medicaid, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

March 14, 2007

Mr. Burgess of New Mexico, Mr. Knowles of Texas, Mr. Bilirakis of Florida, Mr. Waxman of California, Mr. Heflin of Alabama, and Mr. Carney of Delaware introduced the following bill; which was referred to the Committee on Energy and Commerce, and to the Committee on Education and the Workforce, for a period to be designated by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

A BILL

To amend the Social Security Act to provide for coverage of voluntary advance-care planning consultation under Medicare and Medicaid, and for other purposes.

1 Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, that:

2 SECTION 1. SHORT TITLE; FINDINGS; TABLE OF CONTENTS.

3 (a) SHORT TITLE.—This Act may be cited as the "Personalize Your Care Act of 2007".

EOL disclosures (NY, CA, MI, VT)

Limited effectiveness
Side effects
Options

Continuing Medical Education Credits
Learn More

CME

American Society of Clinical Oncology
Making a world of difference in cancer care

Choosing Wisely®
An initiative of the ABIM Foundation
Limits to Prevention

30%

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

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

Prevention

1. Negotiation & Mediation
2. Transfer
3. New Surrogate

Consensus

Negotiation

Mediation

<table>
<thead>
<tr>
<th></th>
<th>Stop</th>
<th>Go</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surrogate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stop</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Go</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Prendergast (1998)
57% agree immediately
90% agree within 5 days
96% agree after more meetings

Garros et al. (2003)


Hooser (2006)
1. Earnest attempts . . .
   deliberate . . .
   negotiate . .

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

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

4. Involvement . . .
   **ethics committee** . . .

Consensus

95%

Intractable
Transfer

<table>
<thead>
<tr>
<th>Surrogate</th>
<th>Clinician</th>
<th>Stop</th>
<th>Go</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Stop</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Go</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Rare, but possible
Replace Surrogate

Substituted judgment
Best interests

Cal. Prob. Code 4684, 4714
“... in accordance ... health care instructions ... and other wishes ... otherwise, ... in accordance with ... best interest.”
~ 60% accuracy

Improve Surrogate Accuracy

More aggressive treatment

2.20: “surrogate’s decision . . . almost always be accepted”

You’re Fired!
Cal. Prob. Code 4766(c)
“petition . . . whether . . . agent or surrogate . . . consistent . . . patient's desires . . . best interest.”

Cal. Prob. Code 4740(b)
“Declining to comply with a health care decision of a person based on a belief that the person then lacked authority.”

Reasons to Replace
In Re: Emergency Guardianship of
Albert N. Barnes, Respondent

Order Appointing Emergency Guardian

This matter came on for hearing on February 2, 2011 before the District Court on a petition seeking an emergency appointment of a guardian for the Respondent named above. The matter, having been considered by the Court and the Court being duly advised in the premises now makes the following:

FINDINGS OF FACT
“failed to follow medical advice”

“failed to use good judgment”
Your own personal issues are “impacting your decisions”

“Refocus your assessment”

Plascentia McDonald, 74yo

Advance directive:
1. Bobby is agent
2. Cynthia is alternate
3. “Do No prolong life if incurable condition”

Aug. 14

Surgery
thoracoabdominal aneurysm

Post-op infections
**Aug. 30**

Sepsis, non-cognitive

Continued LSMT

3 additional surgeries

Disagrees w/ brother

---

**USC:** Probate Code 4740 immunizes providers who “in good faith comply with a health care decision made by one whom they believe authorized.”

**Court:** “Compliance with agent’s decision . . . at odds with the patient’s own . . . AHCD . . . not qualify as in good faith.”

---

Agent **not** authorized to depart from AD

USC should have known that

---

**Limits of surrogate replacement**
1. Providers cannot show deviation

2. Surrogates get benefit of doubt

Cal. Prob. Code 4733

“provider . . . shall comply . . . instruction . . . decision”

3. Surrogates are faithful

Good ?? Bad
Consent and Capacity Board

Intractable Conflict
1. Covert
2. Cave-in
3. Unilateral stop

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

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

“provider . . . that declines to comply . . . shall . . . promptly so inform . . .”

Prob. Code § 4736

Perceptions of “futile care” among caregivers in intensive care units

“Why they follow the . . . SDMs instead of doing what they feel is appropriate, almost all cited a lack of legal support.”

“Remove the __, and I will sue you.”
**Easier** to cave-in

Patient will die soon
Provider will round off
Nurses bear brunt

**Civil liability**

Battery
Medical malpractice
Informed consent
State HCDA
EMTALA

**Licensure discipline**

**Criminal liability**
e.g. homicide
Legal Risk

Few cases

$250,000
Few successful

BUT
Risk > 0

Risk aversion

Process = punishment
Even prevailing parties pay transaction costs
Time
Emotional energy

Liability averse
Litigation averse

Manning (Idaho 1992)
Rideout (Pa. 1995)
Bland (Tex. 1995)
Wendland (Iowa 1998)
Causey (La. 1998)
Defensive Medicine


<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>

“in the medical environment . . . practically everything is regulated; regulation is the default, and only what is regulated is considered safe and acceptable.”

Bad law
Stop without consent

Prevention

Consensus

Unilateral w/d

Red

Yellow

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

*Tex. H&S 166.046*

1. 48hr notice
2. HEC meeting
3. Written decision
4. 10 days to transfer
5. Unilateral WH/WD
RESOLUTION 1 - 2004
(read about the action taken on this resolution)

Subject: Futility of Care

Introduced by: Michael Katzfiff, 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.
Treat ‘til transfer

Miss. Code § 41-107-3
### Maryland Medical Orders for Life-Sustaining Treatment (MOLST)

<table>
<thead>
<tr>
<th>Family Last Name, First, Middle Initial</th>
<th>Date of Birth</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
</table>

This form includes medical orders for Emergency Medical Services (EMS) and other medical personnel regarding cardiopulmonary resuscitation and other life-sustaining treatment options for a specific patient. It is valid in all health care facilities and programs throughout Maryland. This order form shall be kept with other active medical orders in the patient’s medical record. The physician or nurse practitioner must accurately and legibly complete the form and then sign and date it. The physician or nurse practitioner shall initial only 1 choice in Section 1 and only 1 choice in any of the other Sections that apply to the patient. If any of Sections 2-5 do not apply, leave them blank. A copy or the original of every completed MOLST form must be given to the patient or authorized decision maker within 48 hours of completion of the form or sooner if the patient is discharged or transferred.

**CERTIFICATION FOR THE BASIS OF THESE ORDERS:** I hereby certify that these orders are entered as a result of an oral discussion with and the informed consent of:
- [ ] the patient;
- [ ] the patient’s health care agent as named in the patient’s advance directive;
- [ ] the patient’s guardian of the person as per the authority granted by a court order;
- [ ] the patient’s surrogate as per the authority granted by the Health Care Decisions Act;
- [ ] the patient is a minor, the patient’s legal guardian or another legally authorized adult;

Or, I hereby certify that these orders are based on:
- [ ] other legal authority in accordance with all provisions of the Health Care Decisions Act. All supporting documentation must be contained in the patient’s medical records.

---

**Medical repatriation**
“If surrogate directs [LST] . . . provider that does not wish to provide . . . shall nonetheless comply . . . .”

“Health care . . . may not be . . . denied if . . . directed by . . . surrogate”
<table>
<thead>
<tr>
<th>SDM</th>
<th>Red Light</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agent / POA</td>
<td>Yes</td>
</tr>
<tr>
<td>Default surrogate</td>
<td>No; Maybe</td>
</tr>
<tr>
<td>Guardian</td>
<td>No; Maybe</td>
</tr>
</tbody>
</table>

**SB 172, HB 309 (2012)**

**Minnesota**

**INJUNCTION**

**FRCP 65**
“I . . . come in . . . and use the law to say stop”

Life & death stakes
Unclear facts
Unclear law

TRO

Yellow

CALIFORNIA REPUBLIC
“provider . . . **may decline** to comply . . . contrary to generally accepted health care standards . . .”

“provider . . . acting in good faith and in accordance with generally accepted health care standards . . . **not subject to civil or criminal liability** or to discipline. . .”
3. Does California law support physicians who decline to provide medically ineffective or nonbeneficial treatment?

Yes. California law contains broad immunities for physicians and health care institutions who decline

"Provide continuing care . . . until a transfer can be accomplished OR until it appears that a transfer cannot be accomplished."

Cal. Prob. Code 4736(c)

When

How

Want to refuse

Try to transfer

No transfer

Comply until transfer looks impossible
“[If] decline . . . provide continuing care . . . until a transfer can be effected

16 Del. Code 2508(g)(2)

Want to refuse
Try to transfer

No transfer
Must comply

When

“generally accepted health care standards”
Lantos, Am J Med 1989

Even if agree cutoff – how to extrapolate from populations to individuals

Standard of Care

Electrocerebral Silence

Normal Infant

Anencephalic Infant
Safe harbor attributes

- Clear
- Precise
- Concrete
- Certain

TX
- Measurable procedures

CA
- Vague substantive standards
Worse

Not just ambiguity
Providers continue to create the "wrong" standard of care
Dan Merenstein
291 JAMA 15 (1994)
Future

School of thought
Parris v. Sands (1993)
Barton v. Owen (1977)

Renal Physicians Association
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 550,000 direct visits. Plus, it is distributed through RSS, email, Twitter, and republishers like Westlaw, Bioethics.net, Wellsphere, and Medpedia.

References


Pope TM, Medical Futility, in GUIDANCE FOR HEALTHCARE ETHICS COMMITTEES ch.13 (MD Hester & T Schonfeld eds., Cambridge University Press 2012).


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

Community standards vs. locality rule
Model Policy on “Non-beneficial Treatment”

Lynette Cederquist, MD, July 2000 “San Diego Physician” • Ethics in Medicine

Penalties for over-treatment
Questions