Resolving Medical Futility Disputes

Thaddeus Mason Pope, J.D., Ph.D.
Fletcher Allen Health Care
May 10, 2013

73yo male
PVS
COPD
End-stage renal disease
Hypertensive cardiovascular disease

Stage 4 decubitus ulcers
Osteomyelitis
Diabetes
Parchment-like skin

Non-beneficial

“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.”
Surrogate driven over-treatment

Clinician
CMO

Surrogate
LSMT

2 features
1. Causes
2. Prevention
3. Consensus

4. Intractable
5. ATS policy

### Causes

1. **Surrogate demand**
2. **Provider resist**

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

Cognitive

Iatrogenic
- Inadequate communication
- Uncoordinated, conflicting
- Undue pressure

Mistrust
More ‘empowered’ patients question doctors’ orders

By Mary Dophy Marcus, USA TODAY

In the past, most patients placed their entire trust in the hands of their physicians. Your doctor said you needed a certain medical test, you got it. Not so much anymore.

Jeff Chappell of Montgomery, Ala., recalls a visit a couple of years ago to a Charleston emergency room, near where the family...
Psychological Barriers
Never give in, never give in, never, never, never, never, . . .

Sanjay Gupta, MD
Chief Medical Correspondent, CNN, and New York Times
Bestselling Author of Chasing Life

Leci n’est pas une pipe.
"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

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<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>
</tr>
<tr>
<td>Yes</td>
<td>57.4</td>
<td>19.5</td>
</tr>
<tr>
<td>No</td>
<td>42.6</td>
<td>80.5</td>
</tr>
</tbody>
</table>
Clinicians resist

Avoid patient suffering

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

“I do not see much difference between what we are doing ... and ... atrocities ... in Bosnia.”

Moral distress
Distrust surrogate

66% accurate
50% = pure chance

Prevention

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

National Journal (Mar. 2011)
### Question and Responses

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### National POLST Paradigm Programs

- **Endorsed Programs**
- **Developing Programs**
- **No Program (Contacts)**

*As of September 2013*

### Rep. Blumenauer

### Dying at Home: Wishes vs. Reality

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

### USA CARE

**Seniors Check In... But They Don't Check Out!**

### H.R. 1173

**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**

Mr. BLUMENTAAL of the District of Columbia, Mr. PARKER of Oklahoma, Mr. JOHN CONEY of Minnesota, Mr. S. KENNY of California, Ms. MACCAGNONI of Tennessee, Ms. FLENSBURG of Florida, Mr. GEORGE JOHNSON of Georgia, Mr. TAYLOR of Texas, Mr. CONNOLLY of Virginia, Mr. RICHARDSON of New Jersey, Mr. BEGALA of Ohio, Mr. LEE of Virginia, and Mr. CORNELIUS of South Carolina, introduced the following bill, which was referred to the Committee on Education and the Workforce.

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,
2. That the Social Security Act is amended by striking the first paragraph of section 1830(a) and inserting after the first paragraph thereof as follows:
3. **SECTION 1. SHORT TITLE; FINDINGS.**
   a. (a) Short Title.——This Act may be cited as the "Personalized Your Care Act of 2013".
Assent

Consent

EOL disclosures (NY, CA, MI, VT)

Limited effectiveness
Side effects
Options
Informal Resolution

Consensus

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

Garros et al. (2003)

1. Earnest attempts . . . deliberate . . . negotiate . . .

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

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

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

95%
Transfer

Rare, but possible

Intractable Conflict

1. Covert
2. Cave-in
3. New surrogate
4. Unilateral stop

Covert
**Cave-in**

“Remove the __, and I will sue you.”

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

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

Robert Sibbald MSc, James Downar MD, Laura Koryshuk MD MSc

“Why they follow the . . . SDMs instead of doing what they feel is appropriate, almost all cited a lack of legal support.”
“It is **not** settled law that, in the event of disagreement . . . **the physician** has the final say.”


**Civil liability**
- Battery
- Medical malpractice
- Informed consent
- State HCDA
- EMTALA

**Licensure** discipline

**Criminal** liability
- e.g. homicide

Providers have **won** almost every single damages case for unilateral w/h, w/d
Providers typically lose only IIED claims

Risk $> 0$

Liability averse

Process = punishment

Even prevailing parties pay transaction costs

Easier to cave-in

Nurses bear brunt
Defensive Medicine

<table>
<thead>
<tr>
<th>Factor</th>
<th>Extremely or Very Important</th>
<th>Most Important of All Factors Listed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient's proposal</td>
<td>98.5</td>
<td>12.0</td>
</tr>
<tr>
<td>What was best for the patient overall</td>
<td>98.1</td>
<td>33.2</td>
</tr>
<tr>
<td>Respecting the patient as a person</td>
<td>96.6</td>
<td>5.4</td>
</tr>
<tr>
<td>Patient's pain and suffering</td>
<td>94.6</td>
<td>12.5</td>
</tr>
<tr>
<td>What the patient would have wanted you to do</td>
<td>81.8</td>
<td>29.4</td>
</tr>
<tr>
<td>Providing the standard of care</td>
<td>81.5</td>
<td>2.2</td>
</tr>
<tr>
<td>Respecting the wishes of the family or surrogate(s)</td>
<td>80.9</td>
<td>3.3</td>
</tr>
<tr>
<td>Following the law</td>
<td>68.6</td>
<td>1.1</td>
</tr>
<tr>
<td>The burden on the family</td>
<td>44.8</td>
<td>0</td>
</tr>
<tr>
<td>Religious beliefs of the patient</td>
<td>35.5</td>
<td>0</td>
</tr>
<tr>
<td>Religious beliefs of the family or surrogate(s)</td>
<td>20.6</td>
<td>0</td>
</tr>
<tr>
<td>Cost to society of caring for the patient</td>
<td>14.2</td>
<td>0</td>
</tr>
<tr>
<td>Physician's religious beliefs</td>
<td>9.3</td>
<td>0</td>
</tr>
<tr>
<td>Concerns about paying for</td>
<td>8.4</td>
<td>1.1</td>
</tr>
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</table>

Get a new Surrogate

Substituted judgment
Best interests
18 Vt. Stat. § 9711(d)

~ 60% accuracy

Improve Surrogate Accuracy

More aggressive treatment
18 Vt. Stat. §§ 9707(b)(1) 9711(d)(4)

Baby M
“failed to follow medical advice”

“failed to use good judgment”

Your own personal issues are “impacting your decisions”

“Refocus your assessment”

AMA Code Ethics 2.20

Though the surrogate’s decision . . . should almost always be accepted . . . situations . . . may require . . . institutional or judicial review . . .
18 Vt. Stat. § 9714(a)

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

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Evidence

Burden / benefit

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**BUT**
1. Providers cannot show deviation

2. Surrogates get benefit of doubt

3. Surrogates are faithful
20%: “More important to prolong life.”

National Journal (Mar. 2011)
Archives Surgery (Aug. 2008)

### Table 3. Preferences for Goals of Care and Limited Resources

<table>
<thead>
<tr>
<th>Question and Responses</th>
<th>Public, % (n = 1006)</th>
<th>Professionals, % (n = 774)</th>
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<tr>
<td>If doctors believe there is no hope of recovery, which would you prefer?</td>
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**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/Sometimes let it depend</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>to save life</td>
<td>15</td>
<td>73</td>
</tr>
<tr>
<td>a patient die</td>
<td>12</td>
<td>100</td>
</tr>
<tr>
<td>DK/Ref</td>
<td>22</td>
<td>70</td>
</tr>
</tbody>
</table>

4. If severely ill with no hope of recovery, the quality of my life would be more important than how long it lasted

6. If severely ill with no hope of recovery I would want to be kept alive at all costs

Irish views on death and dying: a national survey
J McCarthy, J Weir and M Loughney
doi: 10.1136/jme.2005.025915
Stop without consent
“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

H.B. 1403 (2013)
“generally accepted health care standards”

Extrapolate: populations to individuals

0% $\rightarrow$ 13%

Lantos, Am J Med 1989
“The essence of futility is overwhelming improbability in the face of possibility”
Bernat 2008

Safe harbor attributes
Clear
Precise
Concrete
Certain
Not just ambiguity
Providers continue to create the “wrong” standard of care

Dan Merenstein
291 JAMA 15 (1994)
M.D. 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
**WA**

WASHINGON STATE MEDICAL ASSOCIATION
HOUSE OF DELEGATES

**Subject:** Legal Protection for Physicians When Treatment is Considered Futile

**Introduced by:** King County Medical Society Delegation

**Referred to:** Reference Committee C

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**WI**

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 E2.007, 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.

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**S.B. 1114**
(Mar. 2009)

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**MEDICAL FUTILITY & MARYLAND LAW**

Tuesday, November 30, 2010

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**NJHA**

NEW JERSEY HOSPITAL ASSOCIATION

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**MSNJ**

MEDICAL SOCIETY of NEW JERSEY
Est. 1766
If process is all you have, it must have **integrity and fairness**

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

No community member requirement, like IRB

< 10% TX HECs have community member
Notice
Opportunity to present
Opportunity to confront
Assistance of counsel
Independent decision-maker
Statement of decision
Judicial review

Neutral independent decision maker
Appellate review

Treat 'til transfer

Tex. S.B. 303
Want to refuse
Try to transfer

No transfer
Must comply

§ 9707(b)(3)

Miss. Code § 41-107-3

L.B. 564 (2013)

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


18 Vt. Stat. § 9708(d)(3)

Maryland Medical Orders for Life-Sustaining Treatment (MOLST)

Certification for the Basis of These Orders: Mark any and all that apply.

I hereby certify that these orders are entered as a result of a discussion with and the informed consent of:

☐ the patient; or
☐ the patient's health care agent as named in the patient's advance directive; or
☐ the patient's guardian of the person as per the authority granted by a court order; or
☐ the patient's surrogate as per the authority granted by the Health Care Decisions Act; or
☐ if 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:

☐ instructions in the patient's advance directive; or
☐ 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.
New Policy

ATS 1991
AMA 1999

We help the world breathe
PULMONARY • CRITICAL CARE • SLEEP

Society of Critical Care Medicine
The Intensive Care Professionals

AMERICAN COLLEGE OF CHEST PHYSICIANS'
The Global Leader in Clinical Chest Medicine

AA CN
1. Futile
2. Inappropriate
3. Provisionally inappropriate

<table>
<thead>
<tr>
<th>Futile treatment</th>
<th>Interventions that cannot accomplish the intended physiological goals</th>
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1. A surrogate requests antibiotics as treatment for an acute MI in a critically ill patient.
2. A clinician refuses to provide CPR in a patient with rigor mortis.

| Inappropriate Treatment | Treatments which may accomplish an effect desired by the patient, but for which there are widely accepted rules that prohibit their use |
2. A surrogate requests that clinicians circumvent the lung organ allocation policy to help a critically ill patient get faster access to an organ for transplantation.
3. A patient requests a prescription for a lethal dose of barbiturates (in states where PAS is illegal).

Provisionally Inappropriate Treatment

Treatments that have at least some chance of accomplishing the effect sought by the patient or surrogate and are not prohibited by an existing rule, but medical professionals believe that competing ethical considerations justify treatment refusal.

1. A surrogate requests ongoing mechanical ventilation for a patient with widely metastatic cancer and refractory multi-organ failure with progressive extremity necrosis from high-dose vasopressors.

2. A surrogate requests initiation of dialysis for a patient in a persistent vegetative state.

Figure 2: Recommended approach to the management of disputed requests in ICUs

Table 2: Model policy highlighting procedural steps for resolution of conflict regarding life-sustaining treatments

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
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<td>1</td>
<td>Prior to initiation of and throughout the formal dispute resolution procedure, clinicians should enlist expert consultation to aid in achieving a negotiated agreement.</td>
</tr>
<tr>
<td>2</td>
<td>Surrogate(s) should be given clear notification in writing regarding the initiation of the formal conflict resolution procedure and the steps and timeline to be expected in this process.</td>
</tr>
<tr>
<td>3</td>
<td>Clinicians should obtain a second and independent medical opinion to verify the diagnosis and prognosis.</td>
</tr>
<tr>
<td>4</td>
<td>There should be case review by an interdisciplinary institutional committee.</td>
</tr>
<tr>
<td>5</td>
<td>If the committee agrees with the clinicians, then clinicians should offer the option to seek a willing provider at another institution and should facilitate this process.</td>
</tr>
<tr>
<td>6</td>
<td>If the committee agrees with the clinicians and no willing provider can be found, surrogate(s) should be informed of their right to seek appeal to an independent body.</td>
</tr>
<tr>
<td>7a</td>
<td>If no willing provider can be found and the surrogate does not seek independent appeal or the appeal affirms the clinicians’ position, clinicians may withhold or withdraw the contested treatments, and should provide high quality palliative care.</td>
</tr>
<tr>
<td>7b</td>
<td>If the committee agrees with the patient or surrogate’s request for life prolonging treatment, clinicians should provide these treatments or transfer the patient to a willing provider.</td>
</tr>
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</table>
Time pressured decisions

Consensus among clinicians present

Case review to extent possible

References


Thaddeus Mason Pope
Director, Health Law Institute
Hamline University School of Law
1536 Hewitt Avenue
Saint Paul, Minnesota 55104
T 651-523-2519
F 901-202-7549
E tpope01@hamline.edu
W www.thaddeus pope.com
B medicalfutility.blogspot.com


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