Medical Futility
Law and Ethics:
Where Are We Now?

Thaddeus Mason Pope, J.D., Ph.D.
HealthPartners & Regions Hospital
Quarterly Ethics Grand Rounds
December 10, 2013

ACCMIE Core Competencies

- **Patient Care:** Practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and at the end of life.
- **Medical Knowledge:** Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and the education of others.
- **Practice Based Learning and Improvement:** Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care.
- **Interpersonal and Communication Skills:** Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, and understanding and sensitivity to diversity, and a responsible attitude towards their patients, their profession, and society.
- **Systems Based Practice:** Practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize healthcare.

Objectives:

1. Understand current legal developments related to medical futility policies.
2. Learn how law and ethics interact around the topic of medical futility.
3. Appreciate how discussions of medical futility relate to clinical practices.

There will be time for questions at the end of the presentation.
1136 patients
11% "futile"
8% "probably futile"

Clinician driven over-treatment

69 ICUs with correct patient codes completed ICU questionnaire

1447 Clinicians returned clinician questionnaire

29 Clinicians excluded (answers missing for perceived appropriateness of care rate)

1418 Clinicians completed questionnaire

320 Reported 21 patient was receiving inappropriate care

Lancet 2011; 378: 1408-13

Overlap Percentage of 2005 elderly Medicare decedents who underwent at least one surgical procedure during their last year of life by age
1. Causes
2. Prevention
3. Consensus
4. Intractable
5. ATS policy
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>
</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>92.8</td>
</tr>
<tr>
<td>All efforts should continue indefinitely</td>
<td>20.6</td>
<td>2.5</td>
</tr>
</tbody>
</table>

1. Surrogate demand
2. Provider resist

Surrogate demand

Cognitive

Iatrogenic

Inadequate communication
Uncoordinated, conflicting
Undue pressure
Mistrust

More 'empowered' patients question doctors' orders

By Mary Berkey Marcus, USA TODAY

In the past, most patients placed their entire trust in the hands of their physician. Your doc 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 Charlotte emergency room, near where he lives.

"I'm not going to pull the plug on granny."
Emotional Barriers

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

"I was really hoping, 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.
Religion
“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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<th>Professionals, % (n=774)</th>
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</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>
</tr>
<tr>
<td>Yes</td>
<td>57.4</td>
<td>19.5</td>
</tr>
<tr>
<td>No</td>
<td>33.5</td>
<td>61.1</td>
</tr>
</tbody>
</table>

Views About End-of-Life Treatment Over Time

% of U.S. adults

<table>
<thead>
<tr>
<th>1990</th>
<th>2005</th>
<th>2013</th>
<th>Diff. 90-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Which comes closer to your view?</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>
</tr>
<tr>
<td>Doctors and nurses should do everything possible to save the life of a patient in all circumstances</td>
<td>15</td>
<td>22</td>
<td>31</td>
</tr>
<tr>
<td>Don't know</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>
Medical staff should do everything possible to save patient's life in all circumstances.

Clinicians resist.

Avoid patient suffering.

20%: “More important to prolong life.”

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

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

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

Irish views on deaths and dying: a national survey
J McCanny, J Walker and M Loughney
doi: 10.1136/jme.2009.028516
“I do not see much difference between what we are doing . . . and . . . atrocities . . . in Bosnia.”

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

Moral distress

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

National Journal (Mar. 2011)
113TH CONGRESS
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
March 14, 2013

Mr. Blumenauer (for himself, Mr. Himes, Mr. Bentham, Mr. Costa of California, Mr. DeGette, Mr. Del Bene of Pennsylvania, Ms. Del Corato of Nevada, Mr. Doggett, Mr. Brasch, Mr. Waxman, Mr. Green, Mr. Scott of Virginia, Ms. Schakowsky, and Mr. Delgado) introduced the following bill, which was referred to the Committee on Ways and Means, and Committee on Education and the Workforce, for a period to be subsequently determined by the Speaker, in each case for a period of three months: if not reprinted in the Register within said period, such committee may further consider the same, in its discretion, and the House shall then be at leisure to consider the same:

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 Representa-
2. tives of the United States of America in Congress assembled,
3. SECTION 1. SHORT TITLE; FINDINGS; TABLE OF CONTENTS.
4. (a) Short Title—This Act may be cited as the
5. “Personalize Your Care Act of 2013.”

EOL disclosures (NY, CA, MI, VT)

Limited effectiveness
Side effects
Options
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%
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

Intractable Conflict

Rare, but possible

1. Covert
2. Cave-in
3. New surrogate
4. Unilateral stop
Without legal support to w/d or w/h openly and transparently, some do it covertly.


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

Robert Stibald MSc, James Donwar MD, Laura Karrasch MD MSc  
CMAJ 2007;177(10):1201-8

“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.”

“It is not settled law that, in the event of disagreement . . . the physician has the final say.”


Legal Risk

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

Secretive

Insensitive

Outrageous

$250,000
Risk > 0

Process = punishment

Even prevailing parties pay transaction costs

Time

Emotional energy

Liability averse

Litigation averse

A thorough and accurate medical record is evidence that the doctor provided appropriate care and can be strong evidence that the physician complied with the standard of care.

Source: Murray SA et al.

- Cancer (n=5)
- Organ failure (n=6)
- Physical and cognitive frailty (n=7)
- Other (n=2)

Risk > 0

Liability averse

Litigation averse
Easier to cave-in
Patient will die soon
Provider will round off
Nurses bear brunt

Defensive Medicine


Get a new Surrogate

New surrogate
Substituted judgment
Best interests

Minn. Stat. 145C.07(3)
Duty to act in good faith

~ 60% accuracy

More aggressive treatment

Improve Surrogate Accuracy
Surrogate Advance directive

Albert Barnes

Dorothy Livadas

State of Minnesota
District Court
County of Hennepin
Probate Division
Judicial District: Fourth

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
<table>
<thead>
<tr>
<th>Surrogate</th>
<th>Best interests</th>
</tr>
</thead>
<tbody>
<tr>
<td>GO</td>
<td>STOP</td>
</tr>
</tbody>
</table>

“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 . . .

**Evidence**

<table>
<thead>
<tr>
<th>Burden / benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
<tr>
<td>0</td>
</tr>
</tbody>
</table>

**BUT**

Providers cannot show deviation
Surrogates get benefit of doubt

In re Helga Wanglie (May 1991)

Surrogates are faithful
Consent and Capacity Board

Stop without consent

Unilateral w/d
“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)

SB 172, HB 309 (2012)
“A health care provider who is unwilling to provide directed health care . . . that, in reasonable medical judgment, has a significant possibility of sustaining the life of the [patient] . . . shall take all reasonable steps to ensure provision of the directed health care until the [patient] is transferred.”
Expressio unius est exclusio alterius

“administers health care necessary to keep the principal alive, despite . . . agent . . ., is not subject to criminal prosecution, civil liability, or professional disciplinary action . . .”

<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>
Not green either

Yellow

“generally accepted health care standards”
0% $\rightarrow$ 13%

Lantos, Am J Med 1989
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)
“general, if unofficial, **consensus** among most intensivists that surrogate requests . . . be granted even when patients are irreversibly ill and will not survive”
You may stop LSMT for any reason so long as 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
WASHINGTON STATE MEDICAL ASSOCIATION
HOUSE OF DElegates

WA

S.B. 1114
(Mar. 2009)

Subject: Legal Protection for Physicians When Treatment is Considered Futile

Introduced by: King County Medical Society Delegation

Referred to: Reference Committee C

Resolution: C-5 (A-09)

Title: LEGAL SUPPORT FOR NONBENEFICIAL TREATMENT DECISIONS

Author: H Hugh Vincent, MD
William Anocek, MD

Introduced by: District 8 Delegation

Endorsed by: District 8 Delegation

Reference Committee

October 4-6, 2008

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 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.
MEDICAL FUTILITY & MARYLAND LAW
Tuesday, November 30, 2010

Treat ‘til transfer
## New ATS Policy

<table>
<thead>
<tr>
<th>Society of Critical Care Medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Global Leader in Critical Chest Medicine</td>
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</tbody>
</table>

### Maryland Medical Orders for Life-Sustaining Treatment (MOLST)

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Name</td>
<td></td>
</tr>
<tr>
<td>Date of Birth</td>
<td></td>
</tr>
<tr>
<td>Male/Female</td>
<td></td>
</tr>
</tbody>
</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 select only one choice in Section 1 and only one choice in any of the other sections that apply to the patient. If any of Sections 2-6 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 soonest if the patient is discharged or transferred.

### Certification for the Basis of These Orders

I hereby certify that these orders are based on:

- Informed Consent.
- 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 record.
1. Futile
2. Inappropriate
3. Provisionally inappropriate

<table>
<thead>
<tr>
<th>Futile treatment</th>
<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>
<td></td>
</tr>
<tr>
<td>2) If conflict persists or if there is any doubt about the utility of the intervention, clinicians should consult another qualified provider to evaluate the case.</td>
<td></td>
</tr>
<tr>
<td>3) Clinicians should consider expert consultation to restate the conflict.</td>
<td></td>
</tr>
<tr>
<td>4) Institutions should retrospectively review the case to identify opportunities to prevent similar occurrences.</td>
<td></td>
</tr>
</tbody>
</table>

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.

| 1) | Clinicians should work to understand the reason for the request and clearly communicate the rule that governs the request. |
| 2) | Clinicians should involve individuals with expertise in interpreting existing regulations to ensure the rule is correctly interpreted and applied. |
| 3) | Clinicians should consider involving expert consultants to assist in clear communication and psychosocial support. |
| 4) | Institutions should retrospectively review these cases to identify opportunities to prevent future similar occurrences. |

### 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 surrogates requests long-term ventilator support to a patient who is brain dead in a state in which there is statutes permitting unilateral cessation of treatment in brain dead patients.
2. A surrogates 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).

### Dispute Resolution Process Overview

1. Time pressured decisions
2. Consensus among clinicians present
3. Case review to extent possible

#### Figure 1: Recommended approach to the management of disputed requests in ICUs

- **Inappropriate Treatment:**
  - Management outlined in Table 1.
  - Do the physiological goals align with requested medical treatments?
  - Yes: Proceed.
  - No: Proceed.

- **Provisionally Inappropriate Treatment:**
  - Management outlined in Table 2.
  - Do clinicians believe there are competing ethical considerations that justify treatment refusal?
  - Yes: Proceed.
  - No: Proceed.

#### Table 2: Model policy highlighting procedural steps for resolution of conflicts regarding life-sustaining treatment

1. Prior to initiation of and throughout the formal dispute resolution procedure, clinicians should enlist expert consultation to aid in achieving a negotiated agreement.
2. 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.
3. Clinicians should obtain a second and independent medical opinion to verify the diagnosis and prognosis.
4. There should be case review by an interdisciplinary institutional committee.
5. 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.
6. 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.
7a. If a 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.
7b. If the committee agrees with the patient or surrogate's request for life prolonging treatment, clinicians should provide those treatments or transfer the patient to a willing provider.

### Questions

- Time pressured decisions
- Consensus among clinicians present
- Case review to extent possible
References

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W www.thaddeuspope.com
B medicalfutility.blogspot.com


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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).


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

Problems with Texas

No substantive criteria

Pure procedural justice

If process is all you have, it must have integrity and fairness
Notice
Opportunity to present
Opportunity to confront
Assistance of counsel
Independent decision-maker
Statement of decision
Judicial review

Neutral independent decision maker
Appellate review

1-5 members 48%
5-10 members 34%

Mostly physicians, administrators, nurses

No community member requirement, like IRB

< 10% TX HECs have community member

Other
MN Law
FROEDTERT MEM LUTHERAN HSPTL 9200 W WISCONSIN AVE MILWAUKEE, WI 53226 Feb, 2, 2012

VIOLATION: PATIENT RIGHTS

Based on review of policies and procedures, patient’s medical records, and staff interviews the hospital failed to notify 1 of 1 patient of the hospital’s Medical Futility Policy prior to implementing the policy. This failure does not promote and protect patients’ rights, and potentially affects all patients admitted to the hospital.

Findings include:

The hospital changed patient #1’s Full Code status to Do Not Resuscitate without the consent of patient #1’s HCPOA (health care power of attorney). (A131)