Pulling the Plug without Consent: the Unilateral Decision Statutes

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Patient

- 97 year-old woman
- Metastasized cancer liver, kidneys, lungs
- Will never again be conscious
- Dependent on mechanical ventilation
- Family wanted “everything done”

Health care providers

- Uncomfortable with other than comfort care
- Wanted to withdraw LSMT
- Law seems to authorize this
- But physicians and institution unwilling
Roadmap

1. Limiting LSMT without consent
2. Legislation to facilitate unilateral decisions
3. Legislation’s limited effectiveness
4. Sources of the limitations
5. Solutions
Limiting LST without Consent
Life-Prolonging Technology
**Classic Right to Die Situation**

- **Patient (or patient’s surrogate):**
  - Judges LSMT to be of no benefit
  - Wants to withdraw life-sustaining treatment

- **Health care providers:**
  - Must accede to patient preferences
Core Principle

If LSMT provides “no benefit”, it can be withheld or withdrawn.
Futility Dispute

- **Who** decides that life is not worth living

- The health care providers:
  - Judge LSMT to be of no benefit
  - Want to withdraw life-sustaining treatment.
Futility Dispute

- Health care providers have *no competence* to judge that LSMT provides no benefit.

- Except in cases of:
  - Brain death
  - Physiological futility
Futility Dispute

- Quantitative futility
  - Benefits very unlikely to be achievable

- Qualitative futility
  - Benefits not worth suffering
  - Benefits not worth resources
  - Achievable QOL not worthwhile
Motivations for Stopping LSMT

- Protect the integrity of the medical profession
- Providers are traumatized and demoralized.
Motivation for Stopping LSMT

- Providers do not want to prolong patient suffering.
- Providers do not want to offer false hope.
YOUR HUSBAND ISN'T GETTING ANY YOUNGER, MA'AM, AND THIS OPERATION IS QUITE EXPENSIVE... NO ONE WOULD BLAME YOU IF YOU JUST HAD HIM PUT DOWN...
Legal Constraints on Unilateral Decisions
FUTILITY

You'll Always Miss 100% of the Shots You Don't Take,
Legal Constraints  ■  pre-1995

- Sometimes conflict is intractable
- Health care providers may then *want* to take unilateral action
Legal Constraints ■ pre-1995

- Unilateral action exposes the provider -
  - Criminal sanctions
  - Civil liability
  - Disciplinary sanctions
- So, providers were “chilled” from taking unilateral action
“Sorry, Sylvia, but your mother’s long-term care has been going on just a little bit too long.”
Legislation Meant to Facilitate Unilateral Decision Making
UHCDA

Grounds to decline LSMT:

1. “Reasons of conscience”
2. “Medically ineffective care”
3. “Care contrary to generally accepted standards”
UHCDA

Type of treatment

Any HC decision

Decision maker status

Absence of consent

Triggering circumstances

Explicit opposition

Discretion
UHCDA

Provider complies with the exceptions

Provider is immune from legal liability
Other “Broad” Statutes Authorizing Unilateral Decisions
Unilateral Decision Statutes Are Not Working
Statutes Are Not Working

- Fewer institutions are adopting (desired) futile care policies.
- Even institutions with futile care policies are not implementing them.
Sources of Uncertainty

- Vague terms, unclear scope
- Preemption by federal statutes
Problem #1: Legal Uncertainty - Due to Vagueness
Vague Scope

- What is “ineffective”?
- What is “generally accepted HC standard”?

“I shall not today attempt further to define . . . . But I know it when I see it”

*Jacobellis v. Ohio, 378 U.S. 184, 197 (1964) (Stewart, J., concurring)*
Problem #2: Legal Uncertainty – Due to Preemption
Preemption

- EMTALA
- ADA
- Rehabilitation Act 1973
- CAPTA & BAIPA
- Antitrust
- 1st & 14th Amendments
Proposed Solutions
Proposed Solutions

- Recognize limited success
- Amend federal statutes or stick to non-preempted applications
- Amend state statutes to provide greater specificity
- Create consensus
Thank You
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