Do Clinicians Always Need Consent to Stop Life-Sustaining Treatment?

Arizona Bioethics Network
June 19, 2014

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Hamline University Health Law Institute

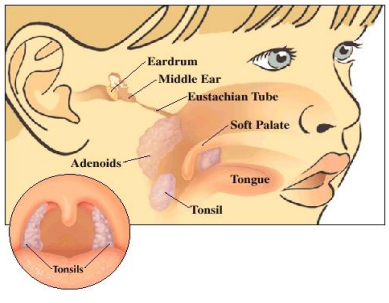
Brain death

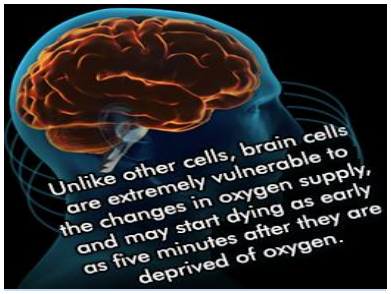
PVS

Jahi McMath

Jahi McMath

Case History



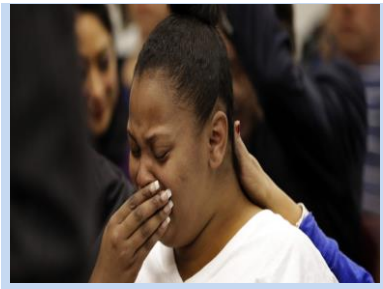


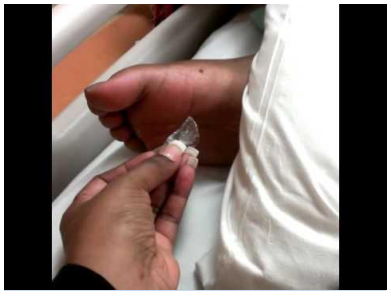
"An individual . . . . . **is dead** . . . who has sustained ***either***

(1) irreversible cessation of circulatory and respiratory functions, ***or***

(2) irreversible cessation of all functions of the entire brain."

Cal. H&S Code 7180(a)





Argument 1

Not dead under CA law

CHILDREN'S HOSPITAL & RESEARCH CENTER OAKLAND

Diagnosis confirmed by 3 CHO clinicians

"When an individual is pronounced [brain] dead . . ., there shall be **independent confirmation** by another physician."

Cal. H&S Code 7181

"independent . . . physician"

Paul Fisher

Stanford Child Neurology

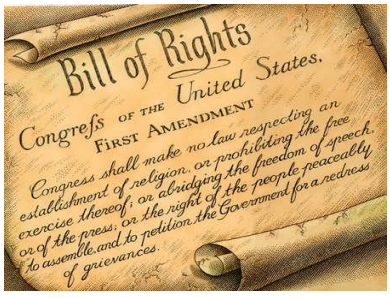
Jahi is dead under California law

Argument 2

CA law preempted

Argument 3

CA law unconstitutional

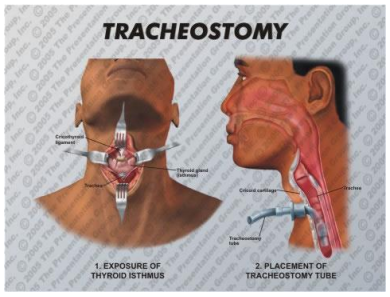


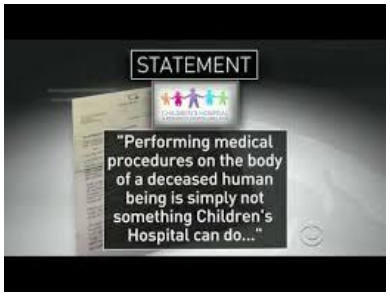
No

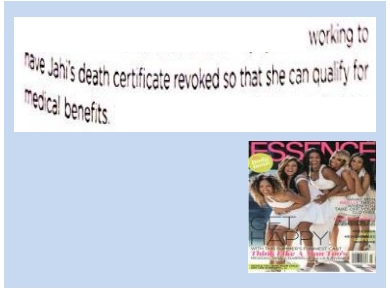
adjudication on the merits

TRO only

stopgap to preserve status quo pending hearing







Jahi McMath

Lawsuits

Claim:

CA should be like NJ

"Death . . . **shall not be declared** upon the basis of neurological criteria . . . when the licensed physician . . ., has reason to believe, . . . would violate the personal **religious beliefs** of the individual."

N.J. Stat. 26:6A-5

CA rejected NJ rule

Brain death

1982

Accommodation

2008

"hospital shall [provide] next of kin with a **reasonably brief period of accommodation** . . . ."

Cal. H&S Code 1254.4

"**Reasonably brief period** . . . amount of time afforded to gather family or next of kin at the patient's bedside."

"continue only previously ordered **cardiopulmonary support**. No other medical intervention is required."

No

adjudication on the merits

Jahi McMath

Not unique

Children's National Medical Center
WASHINGTON DC

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

FILED
NOV 04 2008
Clerk, U.S. District and Bankruptcy Courts

IN RE:
M.B.

Case: 1:08-cv-01898
Assigned To : Kennedy, Henry H
Assign. Date : 11/4/2008
Description: Civil Rights - Non. Employ.

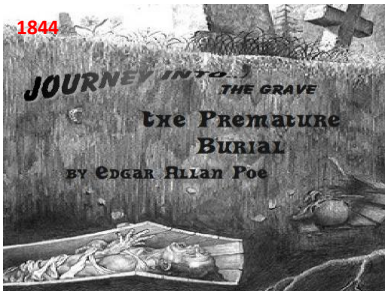
More disputes

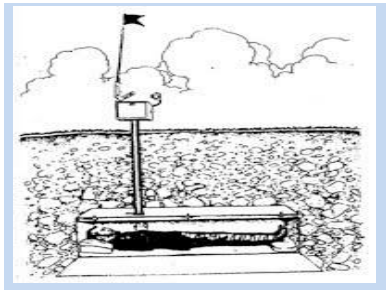
http://thaddeuspope.com/braindeath.html

Why conflicts over brain death?

Taphophobia
Linguistic confusion
Variability
Prognostic mistrust
Conceptual confusion

Taphophobia





HT: Seema Shah

Filed 4/2/14

CERTIFIED FOR PUBLICATION

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION FOUR

GUADALUPE ARROYO et al.,

Plaintiffs and Appellants,

v.

JOHN J. PLOSAY III et al.,

Defendants and Respondents.

B245659

(Los Angeles County Super. Ct. No. BC484024)

Linguistic Confusion

"Brain dead" implies not **really** "dead"

The New York Times

Friday, February 23, 2007

Health

WORLD | U.S. | N.Y. / REGION | BUSINESS | TECHNOLOGY | SCIENCE | HEALTH | SPORTS

FITNESS & NUTRITION | HEALTH CARE POLICY | MEN

Brain-Dead Florida Girl Will Be Sent Home on Life Support

Published: February 19, 1994

"she is **'brain dead' and** . . . being **kept alive** by life support to enable the family to say their goodbyes."

Daily Mail, 03-18-09

Brain-Dead Canadian Woman Dies After Giving Birth to Boy

Variability

Heterogeneity

Brain death **concept** accepted across USA & world

Irreversible cessation of all brain function including the brain stem

How is irreversible cessation **measured**?

Legal variation

physicians

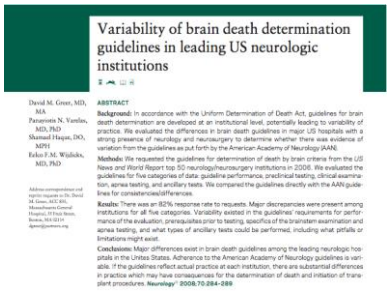
Qualifications

How tests performed

"acceptable medical standards"

"ordinary standards"

"usual & customary standards"



Variability of brain death determination guidelines in leading US neurologic institutions

David M. Greer, MD, MA
Panayiotis N. Varelas, MD, PhD
Shamael Haque, DO, MPH
Eelco F.M. Wijdicks, MD, PhD

ABSTRACT

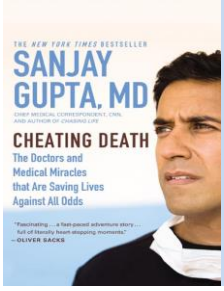
Background: In accordance with the Uniform Determination of Death Act, guidelines for brain death determination are developed at an institutional level, potentially leading to variability of practice. We evaluated the differences in brain death guidelines in major US hospitals with a strong presence of neurology and neurosurgery to determine whether there was evidence of variation from the guidelines as put forth by the American Academy of Neurology (AAN).

Methods: We requested the guidelines for determination of death by brain criteria from the *US News and World Report* top 50 neurology/neurosurgery institutions in 2006. We evaluated the guidelines for five categories of data: guideline performance, preclinical testing, clinical examination, apnea testing, and ancillary tests. We compared the guidelines directly with the AAN guidelines for consistencies/differences.

Results: There was an 82% response rate to requests. Major discrepancies were present among institutions for all five categories. Variability existed in the guidelines' requirements for performance of the evaluation, prerequisites prior to testing, specifics of the brainstem examination and apnea testing, and what types of ancillary tests could be performed, including what pitfalls or limitations might exist.

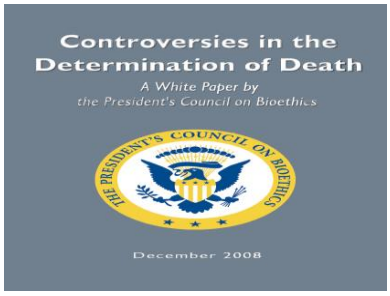
Conclusions: Major differences exist in brain death guidelines among the leading neurologic hospitals in the United States. Adherence to the American Academy of Neurology guidelines is variable. If the guidelines reflect actual practice at each institution, there are substantial differences in practice which may have consequences for the determination of death and initiation of transplant procedures. *Neurology*® 2008;70:284–289

Prognostic mistrust



They were declared **brain dead**. It was written in their chart as such. And here they are, sitting up talking to me.

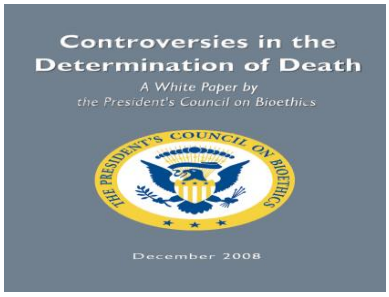
Conceptual confusion



"brain death" = death?

"total brain failure" = death?

Heal wounds
Fight infections
Gestate fetus
Stress response



Legal status

"total brain failure" = death

Legally settled since 1980s

Remains settled (legally)

"durable worldwide consensus"

Bernat 2013

Consent **not** required to stop LSMT

cites

Dead → Not a patient

Not a patient → No duty to treat

Custody of dead body → Other duties

Notification

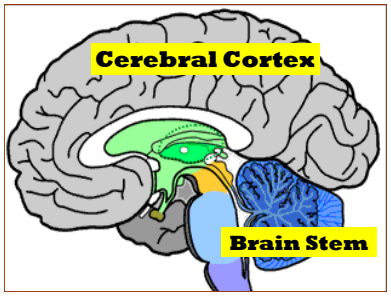
Accommodation

Religious opt out

"Hospitals must establish written procedures for the **reasonable accommodation** of the individual's religious or moral objections . . . limits to the duration of the accommodation."

10 N.Y.C.R.R. § 400.16

PVS



No consciousness

No thoughts, feelings, sensations, desires, emotions

No purposeful action, social interaction, memory

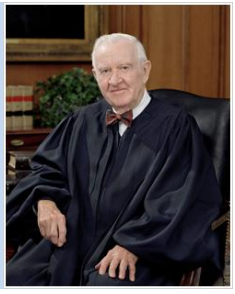
Functioning brainstem tissue

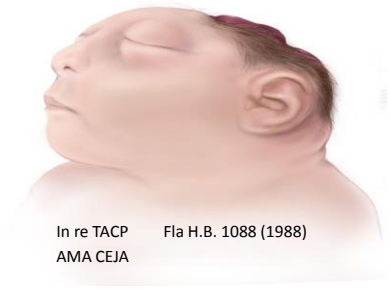
Maintain some autonomic functions: heart, lungs, kidneys and intestinal tract, certain reflex actions

Breathe, suck, spontaneous movements of eyes, arms, legs, respond to noxious stimuli with crying, exhibit facial expressions

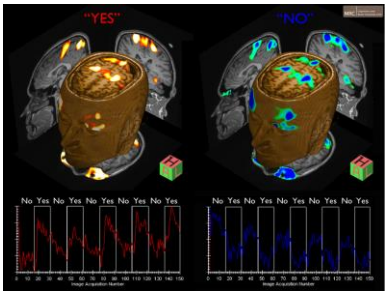
PVS = Death ?

"life expired when her biological existence ceased serving any of her own interests"





In re TACP Fla H.B. 1088 (1988)
AMA CEJA



Stop LSMT without consent

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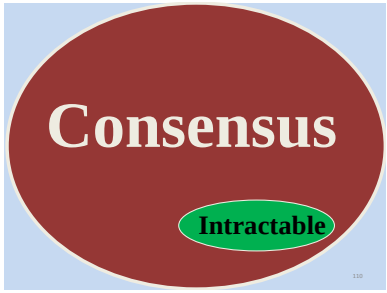

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Green

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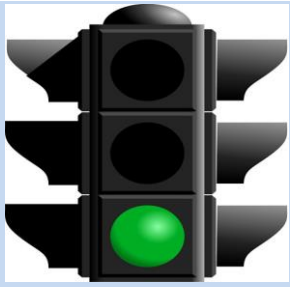

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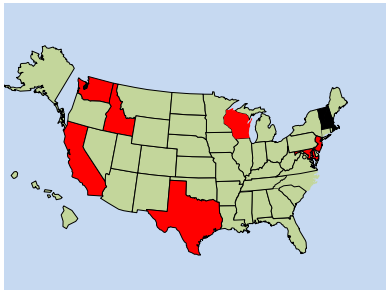
You may stop LSMT for

any reason

- with immunity
- if your HEC agrees

Tex. H&S 166.046

1. 48hr notice HEC
2. Written decision
3. 10 day transfer



Resolution 505-08 **TITLE:** LEGAL SUPPORT FOR NONBENEFICIAL TREATMENT DECISIONS

Author: H Hugh Vincent, MD;
William Andereck, MD

Introduced by: District 8 Delegation

Endorsed by: District 8 Delegation

CA

Reference Committee E

October 4-6, 2008

WASHINGTON STATE MEDICAL ASSOCIATION
HOUSE OF DELEGATES

WA

Resolution: C-5
(A-09)

Subject: Legal Protection for Physicians When Treatment is Considered Futile

Introduced by: King County Medical Society Delegation

Referred to: Reference Committee C

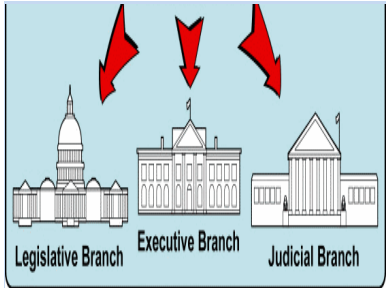
RESOLUTION 1 - 2004
(read about the action taken on this resolution)

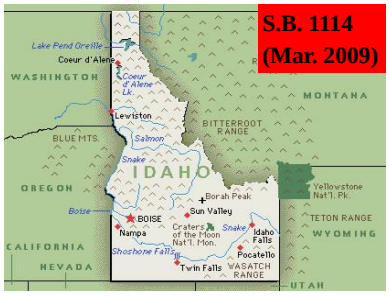
WI

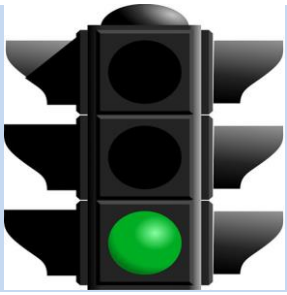
Subject: Futility of Care

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.







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ARS 36-3205

"A health care provider is not subject to . . . liability or professional discipline for . . . failing to comply with a decision or a direction that violates the provider's **conscience** . . . ."

129

Treat 'til transfer

130

Miss. Code § 41-107-3

131

L.B. 564 (2013)

41

Mich. S.B. 136 (2013)

42

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

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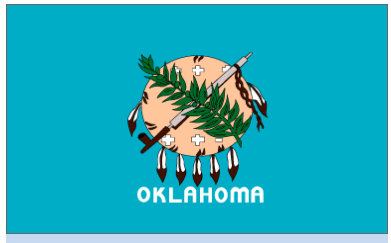

Okla. H.B. 2460 (2012)

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HIPAA PERMITS DISCLOSURE OF COLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

DNR/ COLST
CLINICIAN ORDERS
for DNR/CPR and OTHER LIFE SUSTAINING TREATMENT

Patient Last Name
Patient First/Middle Initial
Date of Birth

FIRST follow these orders, **THEN** contact **Clinician.**

(If patient/resident has no pulse and/or no respirations)

A

DO NOT RESUSCITATE (DNR)
☐ **DNR/Do Not Attempt Resuscitation (Allow Natural Death)**

CARDIOPULMONARY RESUSCITATION (CPR)
☐ **CPR/Attempt Resuscitation**

For patient who is breathing and/or has a pulse, GO TO SECTION B – G, PAGE 2 FOR OTHER INSTRUCTIONS. CLINICIANS MUST COMPLETE SECTIONS A-1 THROUGH A-5

A-1 Basis for DNR Order
Informed Consent – Complete Section A-2
Futility - Complete Section A-3

A-2 Informed Consent
Informed Consent for this DO NOT RESUSCITATE (DNR) Order has been obtained from:

Name of Person Giving Informed Consent (Can be Patient) Relationship to Patient (Write "self" if Patient)

A-3 Futility (required if no consent)
☐ I have determined that resuscitation would not prevent the imminent death of this patient should the patient experience cardiopulmonary arrest. Another clinician has also so determined.

Page 1 of 2

Maryland Medical Orders for Life-Sustaining Treatment (MOLST)

Patient's Last Name, First, Middle Initial | Date of Birth | ☐ Male ☐ Female

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 1 choice in Section 1 and only 1 choice in any of the other Sections that apply to this patient. If any of Sections 2-9 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: 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 Heath 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.

Red

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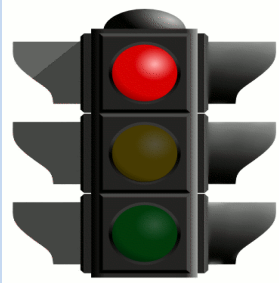

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Consent and Capacity Board

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Consent **always**

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

146

Discrimination in Denial of Life Preserving Treatment Act

147

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

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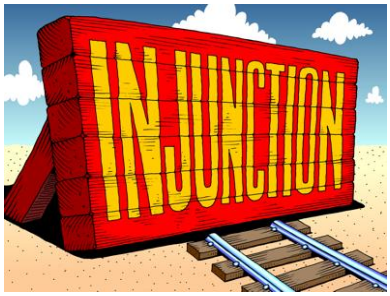
SB 172, HB 309 (2012)

150

SDM	Red Light
Agent / POA	Yes
Default surrogate	No; Maybe
Guardian	No; Maybe



"I . . . come in . . . and use the law to say stop"

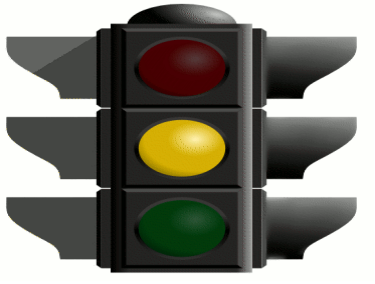
Life & death stakes

Unclear facts

Unclear law

TRO

Yellow



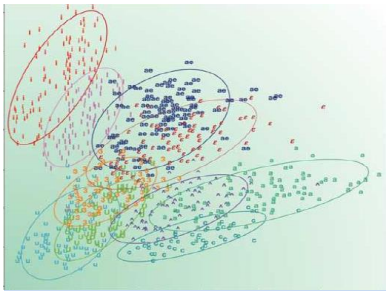
"provider . . . **may decline** to comply . . . contrary to generally accepted health care standards . . ."

Cal. Prob. Code 4735

"provider . . . acting in good faith and in accordance with generally accepted health care standards . . . **not subject to civil or criminal liability** or to discipline. . . "

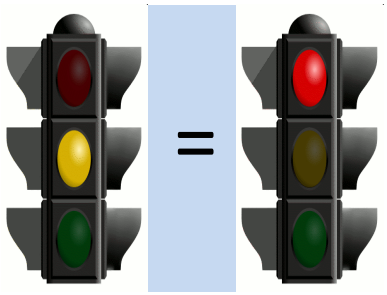
Cal. Prob. Code 4740

"generally accepted health care standards"



Safe harbor attributes

- Clear
- Precise
- Concrete
- Certain



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References

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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 600,000 direct visits. Plus, it is distributed through RSS, email, Twitter, and re-publishers like Westlaw, Bioethics.net, Wellsphere, and Medpedia.

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