Betancourt v. Trinitas Hospital

Oral Argument of Amicus Thaddeus Mason Pope
New Jersey Superior Court Appellate Division, A-003849-08 T2
New Brunswick, New Jersey (April 27, 2010)

This morning in New Brunswick, New Jersey, a totally packed appellate courtroom was treated to a lively 90 minutes of oral argument on the law and ethics of medical futility. The hearing in Room 103 of the Middlesex County Courthouse Room was attended by local hospital physicians and ethicists, by representatives of several Jewish groups, by interested attorneys, by the press, and, most visibly, by members of Not Dead Yet and other disability groups. Their specialized wheelchairs and mechanical ventilators sent a very strong message to the judges (and everyone else) about the dangers of judging the value of someone else's diminished physical condition.

There were six separate attorneys who argued before an informed, smart, and active bench:

(1) Gary Riveles for Trinitas Hospital;
(2) John Jackson for NJHA, MSNJ, and CHPNJ;
(3) Todd Drayton for Betancourt;
(4) Anne Studholme for Not Dead Yet, ADAPT, and other disability groups;
(5) Larry Loigman for Agudath Israel and the Rabbinical Council of America; and
(6) Law professor Thaddeus Pope

This is a summary of the argument that I presented on April 27, 2010. Obviously, I was busy answering questions from the bench and did not present the entire argument below. Still, the arguments below capture the heart of what I conveyed. In addition, I made other points both in response to questions from the bench and in response to points that came up earlier in the hearing. I recall only two of those other points.

First, I wanted to remind the Court that New Jersey healthcare providers have been ordered to provide care contrary to their judgment. This is exactly what happened in

Jobes and *Requena.* But there are many other examples. In 2007, the pharmacist statute required pharmacists to dispense morning-after pills even if they had a conscience objection.

Second, the Court wanted to know whether I thought there were limits to self-determination. Of course, I said that there are. Between the bench and me, we articulated four. The healthcare provider can refuse desired treatment where:

(a) The treatment would be physiologically futility,

(b) In a true triage situation,

(c) Where the provider can transfer the patient, and

(d) Where the provider can replace the surrogate asking for the disputed treatment.

Had I not been on the hot seat, I might have also articulated others like the protection of third parties.

Still, as my argument below illustrates, getting to the point that there ***are limits*** to patient autonomy does not get one very far. The real problem is defining where those limits are? I continue to think that, given fundamental value conflicts, a pure process approach is the best we can hope for. But any such process must be fairer than the Texas-style process offered by Trinitas and NJHA-MSNJ-CHPNJ.

INTRODUCTION

Brevity may be the soul of wit. But seismic change is no laughing matter. The thin trial record and the thin appellate briefing in this case is not an adequate presentation for the revolutionary result that Appellants seek.

Appellants seek a fundamental change to health law jurisprudence. Since the 1960s, the clear and unmistakable trend in New Jersey has been on the patient -- on patient autonomy and self-determination. This is evidenced: (a) in the Supreme Court's right-

to-die cases, (b) in the Advance Directives Act, and (c) in the doctrine of informed consent.

In 1988, New Jersey joined the majority of states, in moving from a professional standard to a patient-centered material risk standard for informed consent. *Matthies* confirms that a physician's duty is not limited to what "he" thinks is the best course of treatment. It is measured by the "patient's" own preferences and values.

Appellant wants this court to adopt a rule that "healthcare providers need not provide medical treatment outside the standard of care." Appellant wants this court to draw a line, to place a limit on patient autonomy. But Appellant's proposed rule is both flawed and incomplete. Appellant admits that this is a case of first impression, unsupported by statute or judicial precedent. But a bigger problem is that the rule is tautological. If the standard of care is the level of care that a healthcare provider has a duty to provide, then the rule is circular. It is necessarily true.

To have any real meaning we need to answer three questions:

(1) Is the requested treatment outside the standard of care?

(2) How is that determined?

(3) If a healthcare provider is allowed to stop, how can it stop? In other words, how is the right implemented?

This is where Appellant's argument falls apart. They want this Court to draw a line. But they cannot tell the court where to draw the line, because there is too much variability in medicine. So, Appellant ends up paraphrasing Justice Stewart's definition of obscenity: "I know it when I see it." Appellant cannot offer a substantive rule. So, it offers a procedural rule: "We must comply with decisions made by the patient or on the patient's behalf unless we (not "we" the medical profession, but "we" a single facility) determine that such requested treatment is inappropriate. But this is completely *ad hoc*. And it is subject to error and abuse – whether for reasons of race, ethnicity, or money.

RUBEN BETANCOURT'S DIALYSIS TREATMENT WAS WITHIN THE STANDARD OF CARE.

The trial court made this finding. Examining the transcript in conjunction with the written opinion, it is clear that the court addressed the standard of care issue -- to determine the appropriateness of the guardian. To such a factual finding, this court must defer.

Moreover, the trial court's finding was supported by substantial evidence. The issue was about dialysis. Plaintiff's nephrology expert, Dr. Goldstein, was far more credible. He was far more experienced, and unlike Appellant's experts was independent, neutral. Appellant's experts were all economically dependent on the hospital. Indeed, they were not even clearly opposed. Dr. Millman testified that while he would not "recommend" dialysis, he was unsure whether he would refuse it, if the family requested it. Dr. McCugh testified that dialysis is "usually," but not always withdrawn from PVS patients. Dr. Veirana, the president of the medical staff, testified that the issue was not so much professional as one involving "personal decisions" and "personal beliefs"

Dialysis for Ruben Betancourt was effective. It worked for long time (from July 2008 to May 2009). Appellant concedes that the treatment was successful. If it weren't, that would be physiological futility and would a legitimate ground for unilateral refusal. But here, Appellant's concern is not about medicine. It is about values. Appellant thinks that Mr. Betancourt's life was worthwhile or meaningful. Just as in *Causey*, the treatment at issue here was not counter-therapeutic. It was effective. The conflict is one over values, not over science.

Was dialysis "contraindicated"? Some contraindications are "absolute," meaning that there are no reasonable circumstances for undertaking a course of action. For example, a person with an anaphylactic food allergy should never eat the food to which they are allergic. That is not the case here. Dialysis was successful. Other contraindications are

"relative," meaning that the patient is at higher risk of complications, but that these risks may be outweighed by other considerations or mitigated by other measures. Under *Matthies*, the patient is the one to balance the benefits and burdens.

APPELLANTS WANT TO DETERMINE THEIR OWN STANDARD OF CARE

Dialysis, here, was treatment that successfully achieved exactly what it was intended to do for the patient. Nevertheless, Appellant argues that dialysis was outside the standard of care. Why? Appellant responds: "because we say so."

Appellant admits that the medical profession has been unable to define "medical futility" or medical inappropriateness. So it can offer no substantive rule. Instead, it offers a procedural rule: "If OUR doctors, in consultation with OUR ethics or prognosis committee, determine treatment is inappropriate, then we can refuse it."

This rule contradicts a mountain of jurisprudence. In 1935, New Jersey rejected the locality rule. The standard of care for a physician in Elizabeth is not different from that in New Brunswick. But the rule Appellants propose would define the standard of care not just by locality, but by individual facilities.

This court has already *sua sponte* raised the issue of the "baggage" in this case. The Trinitas prognosis committee is entitled to no deference from this court, or from any court. It suffered from a serious conflict of interest. The hospital review was driven by money, not by medicine. This was not a bottom-up process, where the bedside physician sees bad care and seeks the support of the administration. This was top-down. The CEO was involved. The Medical Director testified that the administration was fully aware of Ruben Betancourt: "Would they like him transferred? I'm sure they would." Why? There are at least three glaring reasons. First, Betancourt had a huge unpaid bill. Second, as Appellant itself notes, there was a pending malpractice action, the value of which would be far less if Mr. Betancourt were dead. Third, the hospital

wanted the ICU bed. Moreover, this is all highlighted by the furtiveness of the hospital's action in removing the port.

Above and beyond the hospital's conflict of interest, there is no evidence of the prognosis committee process here. Who is on it? Is it multidisciplinary? Does it include community members? What did they do here? Where are the bylaws? Where are the minutes? What exactly is this review mechanism to which Appellant wants the court to defer?

Ethics committees were never intended for conflict. In *Quinlan, Jobes,* and *Farrell* – the Supreme Court provided substantial guidance so that families and physicians could make decisions WITHOUT going to court. But these opinions are clear that the extrajudicial processes were for consensus decisions. Ethics committees were intended to be mediators, not adjudicators. These cases state the courts remain THE place to go when there is conflict and dispute. Notably, *Causey* did not defer to that hospital's ethics committee. The court sent the dispute to an independent board, the medical review panel.

If this Court is going to convert ethics committees into arbitrators, if you are going to give them that kind of authority, then you must also demand more in terms of due process.

EVEN IF PROVIDERS MAY STOP, THEY MAY NOT ABANDON THE PATIENT.

Providers can terminate the treatment relationship, but they cannot terminate treatment itself, where that would constitute abandonment. A provider can stop treatment for any reason (including disagreement regarding the standard of care). But there are mandatory preconditions. New Jersey precedent clearly demands that the refusing

provider must arrange for transfer. In life & death situations, the provider must continue to treat pending transfer.

In *Couch,* this Court reversed the trial court's order to continue treatment, but only because a transfer had actually already been found. The Court expressly conditioned the right to withdraw on the provision of reasonable assurances that basic treatment and care will continue. Contrary to some earlier suggestions, there would not be a different result had Mr. Betancourt had an advance directive and this case were controlled by the Advance Directives Act. That Act requires transfer -- just like the BME rule, just like *Couch,* and just like *Mathies.*

Here, no transfer was found. Appellants suggest that this is evidence not of their duty to treat confirmation of their standard of care determination. But this is quite a stretch. First, we have no evidence of how hard, how far, or how long the hospital sought a transfer. Who refused transfer? How many hospitals? Why? Moreover, to infer agreement on the standard of care based on a refusal to accept transfer is implausible on the facts of this case. This was expensive and unreimbursed care in a case with conflict. No hospital would take this case, no matter the standard of care.

JACQUELINE BETANCOURT WAS AN APPROPRIATE SURROGATE FOR HER FATHER.

Appellant cites *Causey*. Indeed, *Causey* is consistent with New Jersey law in that where a surrogate insists life-prolonging treatment that physician thinks inhumane, there are two options: (1) transfer the patient and (2) replace the surrogate if she is guilty of abuse. Appellants did not transfer the patient. And they had no grounds to replace the surrogate, much less to reverse the trial court's determination that Jackie was an appropriate surrogate.

The family is presumed to be the best guardian. The decision standard is substituted judgment. This family was very close. The testimony regarding the patient's preferences was consistent. It was based on considered and deliberated preferences. Mr. Betancourt's son testified about his father's opinions on the *Schiavo* case. His wife testified as to his values.

The patient was in no pain. Sure, he has reflexes to pain. But the only neurologist evidence clearly explains that reflect is not awareness. Moreover, the family held out hope. They (and even some of the treating physicians) had some evidence of awareness. People do emerge from states diagnosed as PVS. There are limits to prognostication. Sure, there was some money at stake. But *Jobes* and the statutes rightly provide that the family is the best surrogate. The family will almost always have monetary interests – from life insurance, from co-pays for the treatment. Therefore, merely having ANY financial stake cannot be sufficient. The conflict must be material. And Appellants have done nothing to show that.