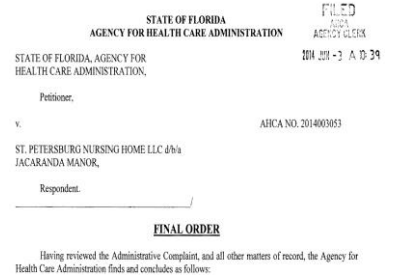


Futility Redux: When May / Should / Must a Clinician Write a DNR Order without Patient or Surrogate Consent?

University of Miami & Florida Bioethics Network • April 8, 2016

Thaddeus Mason Pope, J.D., Ph.D.
Mitchell Hamline School of Law



Lesson

DNR
↓
no CPR

Right to refuse

Sept. 1990
Browning



BUT . . .

Right to demand ?

Negative liberty ✓

Positive liberty ?

Our question

No DNAR
↓
CPR ?

No consent
↓
DNAR ?



Roadmap

Background

1. Consent
2. CPR is different
3. Medical futility
4. Prevalence

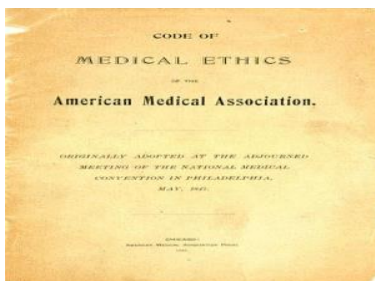
DNAR
without
consent

5. "Futile"
6. "Proscribed"
7. "PIT"
8. PIT traffic lights

Consent

1 of 8

1847



Do **NOT** consider
patient's "own
crude opinions"



1905

Clinicians
need
consent

Treat w/o
consent
is **battery**



Mohr v. Williams (Minn. 1905)

1914



Mary Schloendorff

Consent
But not
“informed”



1972



Clinicians normally need **consent**

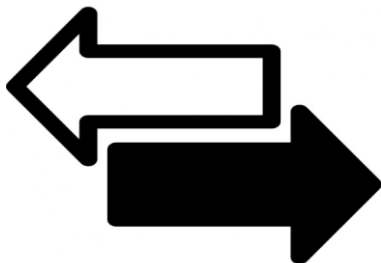
CPR is different

2 of 8

Normally need consent

But . . . consent to **what**

Consent to treatment



CPR is presumed

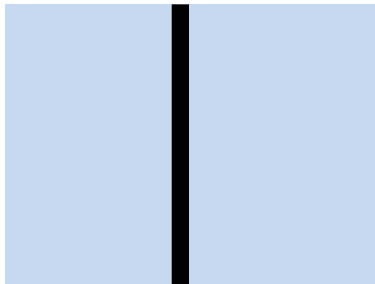
Consent **not** required for CPR

Consent
required for
no CPR (DNR)

**What is
a medical
futility dispute**

3 of 8

Surrogate will
not consent
when you think
they should



Appropriate | Inappropriate

Proportionate | Disproportionate

Beneficial | Non-beneficial



Surrogate
driven
overtreatment


Clinician	Surrogate
CMO	LSMT

Clinician	Surrogate
DNAR	CPR

Prevalence

4 of 8

“Conflict . . . in ICUs . . . epidemic proportions”



13%
ethics consults



MEMORIAL SLOAN-KETTERING
CANCER CENTER

J. Oncology Practice (June 2013)

> 16%
ethics consults

HEC Forum
DOI: 10.1007/s10730-015-9293-5

What Ethical Issues Really Arise in Practice at an Academic Medical Center? A Quantitative and Qualitative Analysis of Clinical Ethics Consultations from 2008 to 2013

Katherine Wasson^{1,2} · Emily Anderson¹

Original Investigation

The Frequency and Cost of Treatment Perceived to Be Futile in Critical Care **20%**


Thanh N. Hoynh, MD, MSHS; Eric C. Klemp, MD; Joshua F. Willey, MA; Terrance D. Savitsky, MBA, MA, PhD; Diana Guse, MD; Bryan J. Garber, MD; Neil S. Wenger, MD, MPH

JAMA Intern Med. 2013;173(20):1887-1894. doi:10.1001/jamainternmed.2013.10261
Published online September 9, 2013.



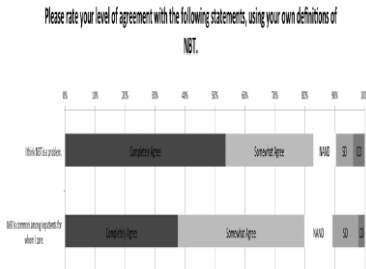
2 CPR futility cases per month

Courtwright. 2015 *J Crit Care* 30(1):173-77



Feb. 2015

700 acute care clinicians



UNIVERSITY OF TORONTO

“top healthcare challenge”

6 BMC Med. Ethics (2005)

Big problem – moral distress, etc

Surrogate will **not** consent to DNAR recommendation

When may / should / must a clinician write a DNAR order without patient or surrogate consent?

It depends

3 types of CPR

Futile
Proscribed
Potentially inappropriate

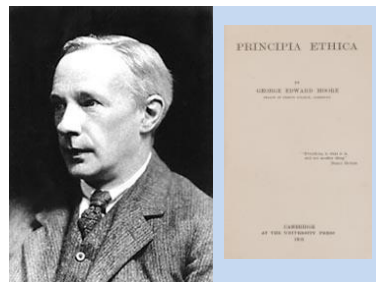
AMERICAN THORACIC SOCIETY DOCUMENTS

An Official ATS/AACN/ACCP/ESICM/SCCM Policy Statement:
Responding to Requests for Potentially Inappropriate Treatments in Intensive Care Units

Gabriel T. Bosslet, Theodorus M. Pope, Gordon D. Rubenfeld, Bernard Lo, Robert D. Truog, Cynda H. Rushton,

AMERICAN THORACIC SOCIETY
1905
ATS

We help the world breathe
PULMONARY • CRITICAL CARE • SLEEP



“In Ethics . . .
difficulties and
disagreements. . .
are mainly due to a
very simple cause . . .”

“the attempt to
answer questions,
without first
discovering precisely
what question it is
you desire to answer.”

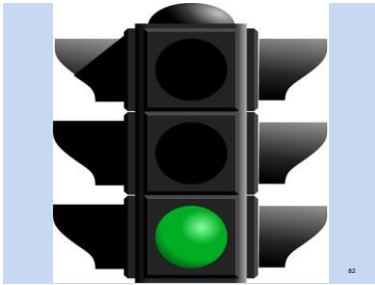
Futile

Proscribed

Potentially
inappropriate

Futile

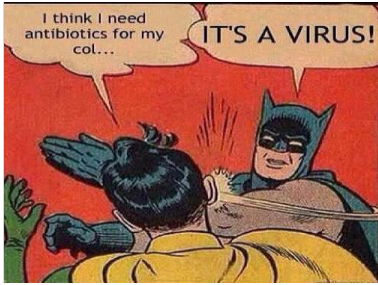
5 of 8



Interventions
cannot accomplish
physiological goals

Scientific
impossibility

Example 1



Example 2



Example 3



Example 4

total
brain = death
failure

Dead → No
duty to
treat

Annals of Internal Medicine

American College of Physicians Ethics Manual
Sixth Edition

Lois Snyder, JD, for the American College of Physicians Ethics, Professionalism, and Human Rights Committee*

“After a patient . . . brain
dead . . . medical support
should be **discontinued.**”

Aden
Hailu



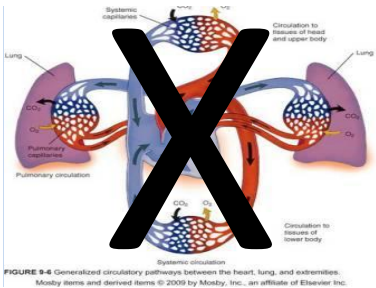
Jahi McMath



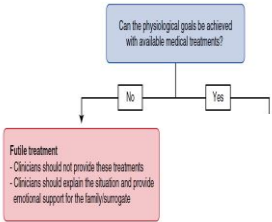
“Futile”

Value free
objective

But . . .
futile for **what**
outcome

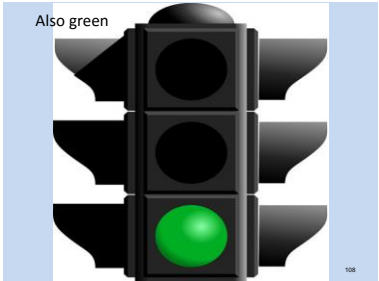


May &
should
refuse



Futile
Proscribed
Potentially
inappropriate

Proscribed
6 of 8

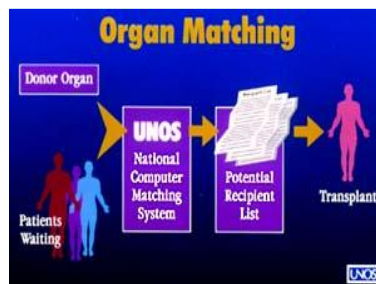


Treatments that **may accomplish** effect desired by the patient

Laws or public policies
Prohibit
or
Permit limiting

Prohibited
provision

Example 1

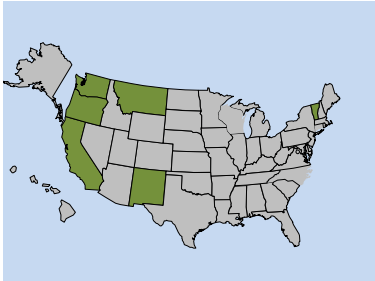


Example 2



Example 3

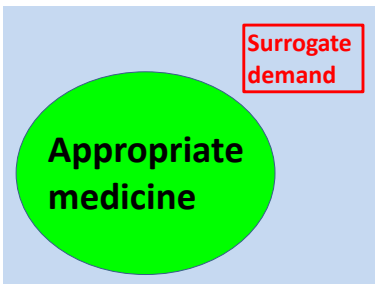




Proscribed



Permitted
limiting



Example 1

Trisomy 18
22-week gestation
ECMO



Example 2



Example 3



WHA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

Physician Orders for Life-Sustaining Treatment (POLST)-Florida

A CARDIOPULMONARY RESUSCITATION (CPR): Patient is unresponsive, pulseless, and not breathing.

Check One

Attempt Resuscitation/CPR

Do Not Attempt Resuscitation/DNR

When not in cardiopulmonary arrest, follow orders in B and C.

Print Patient/Resident or Surrogate/Proxy Name	Relationship (write self if patient)
Patent or Surrogate Signature (mandatory)	Date



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

Patent Last Name: _____
 Patient First/Middle/Initial: _____
 Date of Birth: _____

FIRST follow these orders. THESE control if patient/resident has no pulse and/or no respirations.

A	DO NOT RESUSCITATE (DNR) <input type="checkbox"/> DNR Do Not Attempt Resuscitation (Allow Natural Death)	CARDIOPULMONARY RESUSCITATION (CPR) <input type="checkbox"/> CPR Attempt Resuscitation
----------	--	--

For patient who is breathing and/or has a pulse, GO TO SECTION B - (i.e. 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.

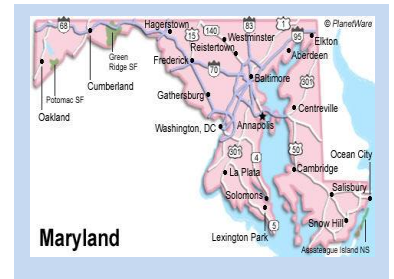
Not ATS "futility"

Might restore CP function

"imminent death"

3 days

http://healthvermont.gov/regs/ad/dnr_colst_instructions.pdf



Maryland Medical Orders for Life-Sustaining Treatment (MOLST)

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

The 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. The 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 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 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 Health Care Decisions Act; or
- if the patient is a minor, the patient's legal guardian or another legally authorized adult.

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.

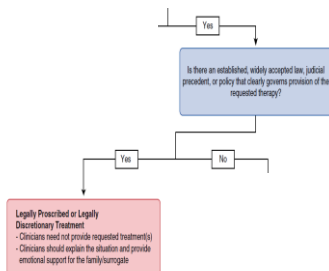
“medically ineffective”

“[not] prevent the **impending death**”

imminent = impending



May & should refuse



Futile
Proscribed
Potentially inappropriate

Potentially Inappropriate
7 of 8

Some chance of accomplishing the effect sought by the patient or surrogate

Not “futile” because might “work”

E.g. dialysis for permanently unconscious patient

E.g. vent for patient w/ widely metastatic cancer

We call them “futility disputes”
... BUT ...

Disputed treatment **might** keep patient alive.

But ... is that chance or that outcome **worthwhile**

Not a medical judgment

Value
judgment

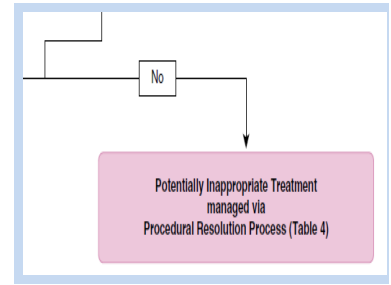
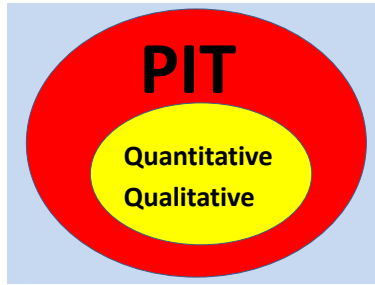


Table 4. Recommended Steps for Resolution of Conflict Regarding Potentially Inappropriate Treatments

1. Before initiation of and throughout the formal conflict-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 medical opinion to verify the prognosis and the judgment that the requested treatment is inappropriate.
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 case review by an independent appeals body.
- 7a. If the committee or appellate body 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.
- 7b. If the committee agrees with the clinicians' judgment, 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.

“potentially”

Legal focus

Try again for consent

PDA
Mediation
Transfer
New surrogate

1

PDA



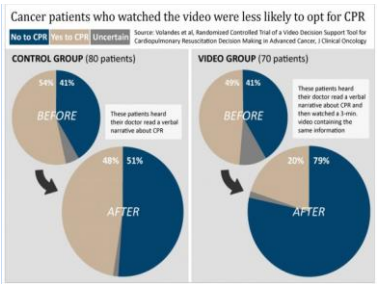
Robust evidence shows PDAs are highly effective



Shared Decision Making in ICUs: An American College of Critical Care Medicine and American Thoracic Society Policy Statement

Alexander A. Kon, MD, FCCM^{1,2}; Judy E. Davidson, DNP, RN, FCCM³; Wynne Morrison, MD, MBE, FCCM⁴; Marion Davis, MD, FCCM⁵; Douglas B. White, MD, MAS⁶

Copyright © 2015 by the Society of Critical Care Medicine. All Rights Reserved. DOI: 10.1187/ccm.0000000000001198 Critical Care Medicine



Informed surrogates are **less** aggressive

2

Negotiation Mediation

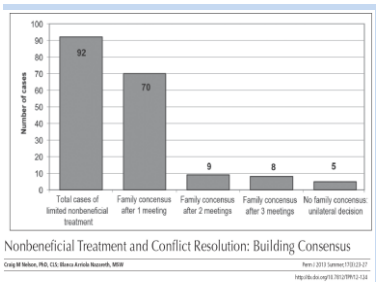
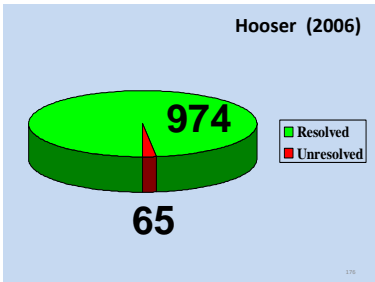
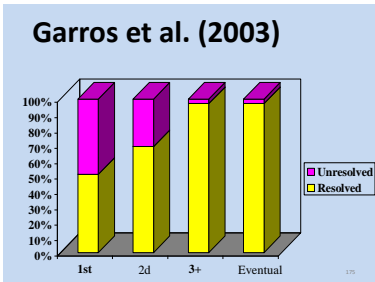
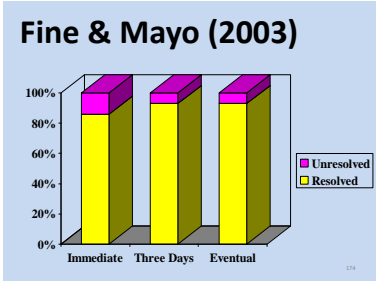
95%

172

Prendergast (1998)

57% agree immediately
 90% agree within 5 days
 96% agree after more meetings

173



5%

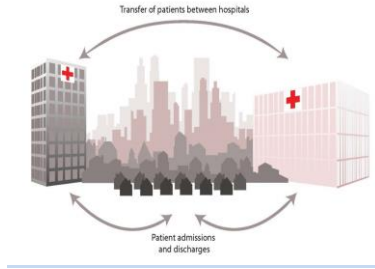
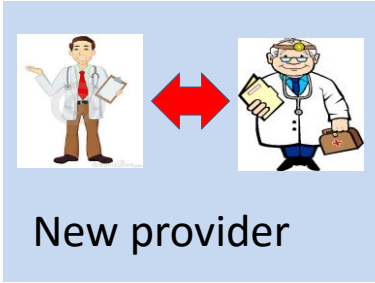
178

3

179

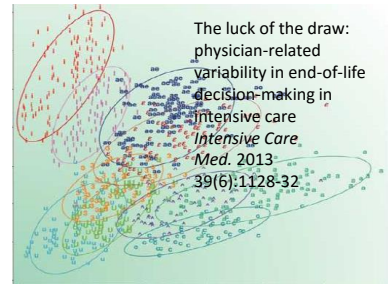
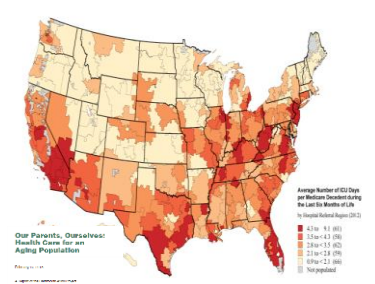
Transfer

180



Rare

but possible



4

Replace Surrogate



Substituted
judgment

Best interests

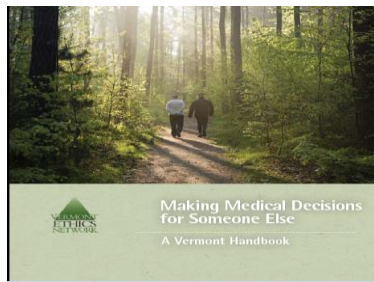
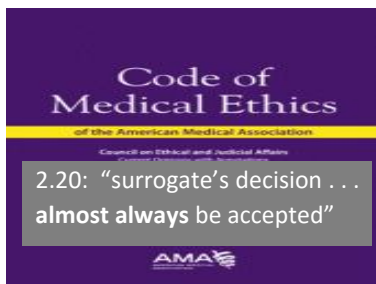
190

~ 60%
accuracy



More
aggressive
treatment

191



Fla. Stat. 765.105

“the health care facility, or the attending physician, . . . may seek expedited judicial intervention . . . surrogate . . . **not in accord** with the patient’s known desires . . . failed to discharge duties . . .”

**Still no
consent?**

197

Not futile
Not proscribed

198

No surrogate consent
No "new" surrogate
No transfer

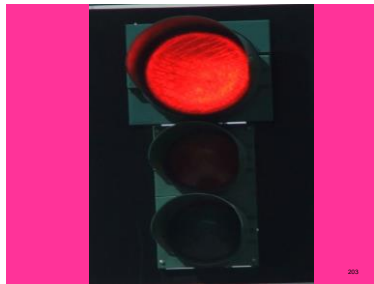
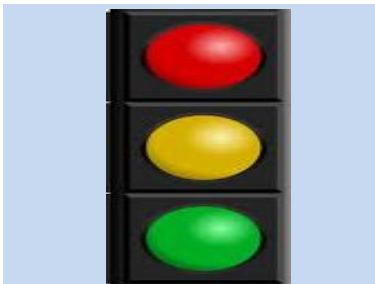
199

May you
write
DNAR?

200

**Traffic
Lights**

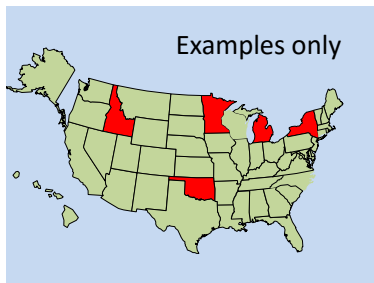
201



203

Consent
always

204



Examples only



Nondiscrimination in Treatment Act November 2013

“health care provider
shall not deny . . .
life-preserving health
care . . . directed by the
patient or [surrogate]”

Medical Treatment Laws Information Act November 2014

Information for Patients and Their Families Your Medical Treatment Rights Under Oklahoma Law

No Discrimination Based on Mental Status or Disability:

Medical treatment, care, nutrition or hydration may not be withheld or withdrawn from an incompetent patient because of the mental disability or mental status of the patient.

Required by Section 3380.5(B) of Title 63 of the Oklahoma Statutes

What Are Your Rights if A Health Care Provider Denies Life-Preserving Health Care?

* If a patient or person authorized to make health care decisions for the patient directs **life-preserving** treatment that the health care provider gives to other patients, your health care provider **may not deny** it.

Report suspected violations of any of the laws summarized in this brochure based above, or attempts to violate any such laws, to the state Licensing Board of the profession(s) of all health care providers involved in the violation.

Oklahoma Board of Medical Licensure and Supervision

www.okmedicalboard.org

405-962-1400

1-800-361-4519 (Toll free outside the 405 area code)

Oklahoma Health Care Providers' Responsibilities and Rights Under Certain Medical Treatment Laws



I hereby certify that I have read this brochure in its entirety and that I understand my legal duties pursuant to the laws described in it.

Printed name _____

Licensing entity _____

Employer _____

Date _____

Signature _____

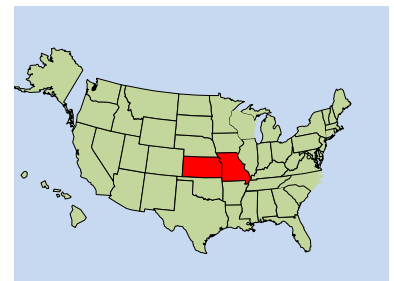
Please complete all information requested above the signature line.

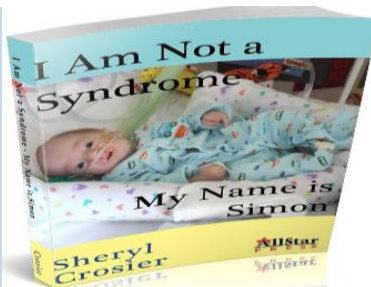
Once complete give to your employer to be placed in your personnel file for a minimum of four (4) calendar years.

Review & sign
once per year

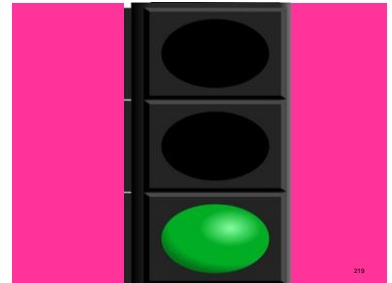


SB 172, HB 309 (2012)





~~Slow code~~
~~Show code~~
 Short code

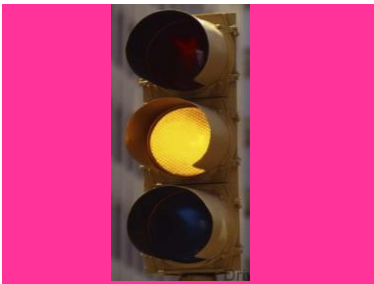
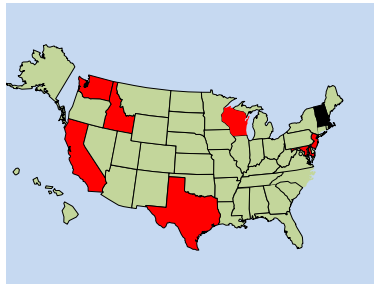


Physician may stop
 LST **without**
 consent for **any**
reason, if review
 committee agrees

Give the
 surrogate

48hr notice RC
 Written decision RC
 10 days to transfer

Write DNAR
 without
 consent




“health care provider . . . that **refuses to comply** . . . make reasonable efforts to **transfer**”
 Fla. Stat. 765.1105

Want to refuse

 Try to transfer

“not been transferred, **carry out the wishes** of the patient or . . . surrogate”
 Fla. Stat. 765.1105

No transfer

 Must comply

But . . .

“unwilling to carry out . . . because of **moral or ethical beliefs**”



Confidential Party v. Confidential Party, No. 14MH165 (Lee County Circuit Court, Mar. 2014)

How to proceed

237

Overt & Open

238



PROPORTION OF PHYSICIANS (n = 726) WHO WITHHELD LIFE-SUSTAINING TREATMENT ON THE BASIS OF MEDICAL FUTILITY

Consent Status	n (%)
Without the written or oral consent of the patient or family	219 (25%)
Without the knowledge of the patient or family	120 (14%)
Despite the objections of the patient or family	28 (3%)

D. Asch, *Am. J. Resp. Crit. Care Med.* (1995)



IIED NIED

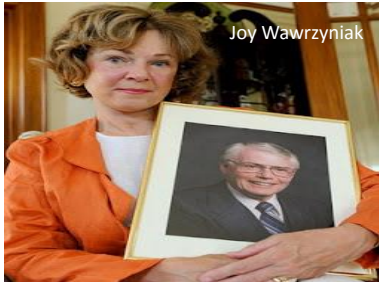
242

Secretive
Insensitive
Outrageous

243

Consultation
expected

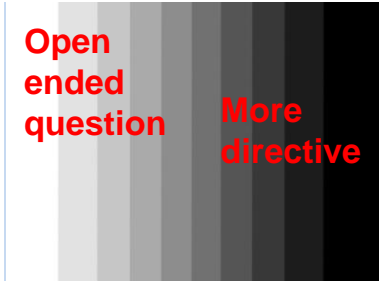
Distress
foreseeable



**Transparent
enough**

Seek assent

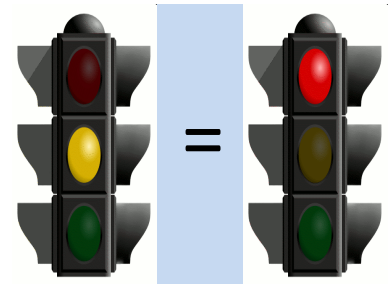
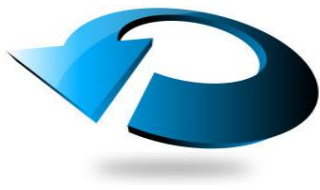
Not consent



Announce plan:
“We are going to...”

Silence = assent

Standard of Care



Thank you

References

Medical Futility Blog

Since July 2007, I have been blogging, almost daily, to medicalfutility.blogspot.com.

This blog reports and discusses legislative, judicial, regulatory, medical, and other developments concerning end-of-life medical treatment conflicts. The blog has received **over one million** direct visits. Plus, it is distributed through RSS, email, Twitter, and re-publishers like Westlaw, Bioethics.net, Wellsphere, and Medpedia.

2015 – 2016

202

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2012 – 2014

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273

Thaddeus Mason Pope, JD, PhD

Director, Health Law Institute
Mitchell Hamline School of Law
875 Summit Avenue
Saint Paul, Minnesota 55105

T 651-695-7661

C 310-270-3618

E Thaddeus.Pope@mitchellhamline.edu

W www.thaddeuspope.com

B medicalfutility.blogspot.com

274