Key Strategies for Responding to Requests for Ineffective & Non-beneficial Treatment

Thaddeus Mason Pope, JD, PhD, HEC-C
Huntington Hospital • Sept. 7, 2022

1

Nothing to disclose

2

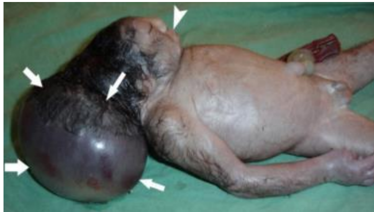
3

4

5

acrania

6



7

recommend abortion
but
refuse perform it

8

9

SO …

10

11

"They said I had to carry my baby to bury my baby."

12

Abortion in Louisiana

About State Laws Find Assistance

Abortion is completely banned in Louisiana travel out of state to get an abort

Abortion is banned in Louisiana.

Abortion is completely banned in Louisiana with very limited exceptions new Louisiana law that went into effect June 24, 2022.

13

criminal (2 years)

civil liability

board discipline

14

BUT

15

"**not include** an abortion … pregnancy … **medically futile**"

Louisiana Rev. Stat. tit. 40, § 1061.1.2(A)(1)(b)(i)

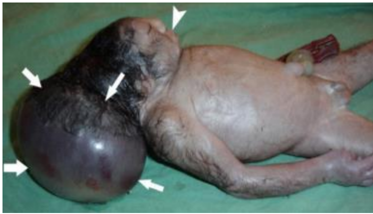
16

When is pregnancy medically futile?

17

"unborn child has a profound and irremediable congenital or chromosomal anomaly … **incompatible with sustaining life** after birth."

18



19

Why didn’t WHBR use this exception?

20

21

22

Department of Health
Office of Public Health
List of Conditions that shall deem an unborn child “Medically Futile”
(LAC 48:I.Chapter 4.101)

The Louisiana Department of Health, Office of Public Health (LDH/OPH), pursuant to the rulemaking authority granted by R.S. 14:87.1, hereby adopts the following emergency rule. This rule is being promulgated in accordance with the Administrative Procedure Act (R.S. 49:950, *et seq.*) generally, and R.S. 49:962 specifically.

23

1. achondrogenesis;
2. anencephaly;
3. acardia;
4. body stalk anomaly;
5. campomelic dysplasia;
6. craniorachischisis;
7. dysencephalia splanchnocystica (M
8. ectopia cordis;
9. exencephaly;
10. gestational trophoblastic neoplasia
11. holoprosencephaly;
12. hydrops fetalis;
13. iniencephaly;
14. perinatal hypophosphatasia;
15. osteogenesis imperfecta (type 2)
16. renal agenesis (bilateral);
17. short rib polydactyly syndrome;
18. sirenomelia;
19. thanatophoric dysplasia;
2. triploidy;
21. trisomy 13;
22. trisomy 16 (full);
23. trisomy 18;
24. trisomy 22; and

24

BUT

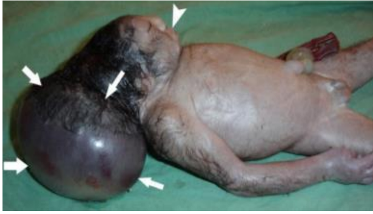
25

acrania **not** on the list

26

25. a profound and irremediable congenital or chromosomal anomaly existing in the unborn child that is incompatible with sustaining life after birth in reasonable medical judgment as certified by two physicians that are licensed to practice in the State of Louisiana.

27



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BUT

29

not 100%

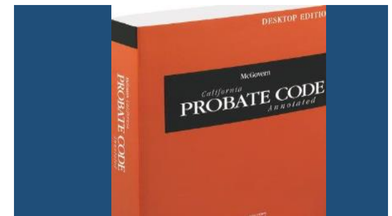
certain acrania is

"medically futile"

30

31

32



33

medical futility exception

34

no duty to provide treatment requested by Pt or surrogate

35

2 **situations**

36

medically ineffective

or

contrary to generally accepted standards

37

BUT

38

39

40

41

42

surrogate driven

over-treatment

43

surrogate will **not** consent to CMO recommendation

44

Clinician	**Surrogate**
CMO	LST

45

Futility is about line drawing

46

appropriate

inappropriate

47

advisable

inadvisable

48

proportionate

disproportionate

49

beneficial

non-beneficial

50

effective

ineffective

51

consistent with generally accepted health care standards

contrary to generally accepted health care standards

52

53

54

Roadmap

55

7 parts

56

1. Prevalence
2. Causes
3. Prevention

57

Have a conflict

What can you **do**

58

4. Consensus
5. New provider
6. New surrogate

59

If none of that works …

60

7. Withhold or withdraw Tx **without** consent

61

62

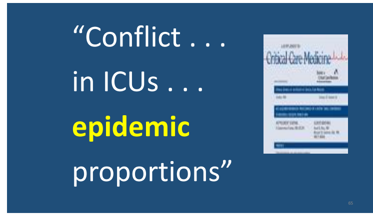
This is **not** legal advice

See your **own** OGC or RM

63

Prevalence

64



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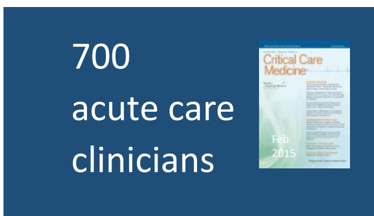

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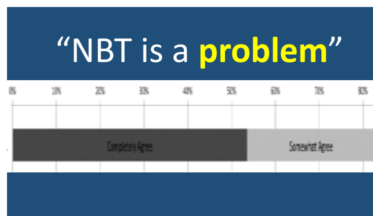

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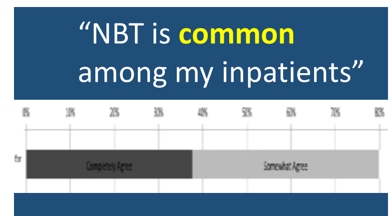

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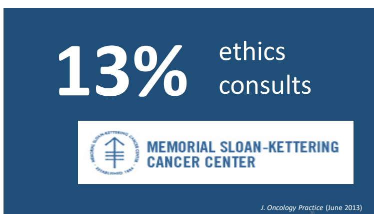

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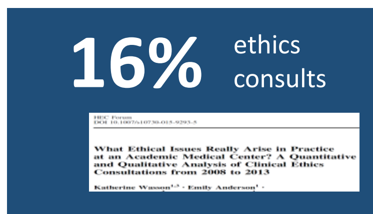

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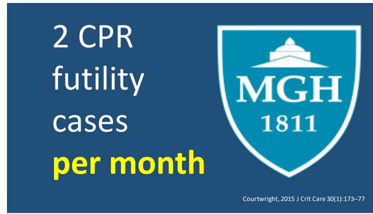


74

75

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

Thanh N. Huynh, MD, MSHS; Eric C. Kleerup, MD; Joshua F. Wiley, 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.

76

77

PewResearchCenter

NUMBERS, FACTS AND TRENDS SHAPING THE WORLD

NOV. 21, 2013

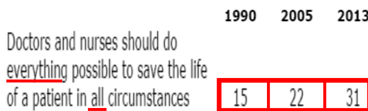
Views on End-of-Life Medical Treatments

Growing Minority of Americans Say Doctors Should Do Everything Possible to Keep Patients Alive

78

Views About End-of-Life Treatment Over T

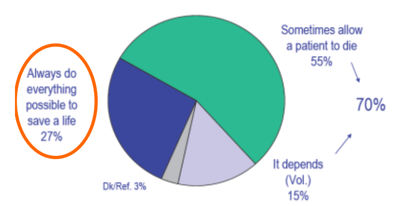
% of U.S. adults



	1990	2005	2013
Doctors and nurses should do everything possible to save the life of a patient in all circumstances	15	22	31

79

80



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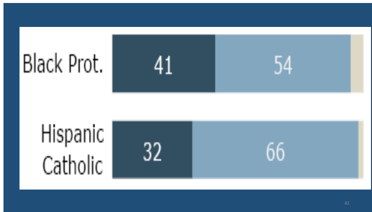


82

83

Causes

84

85

86

Why surrogates **demand**	Why providers **resist**

87

Surrogate demand

88

misunderstanding

89

90

confusion

91

92

Iatrogenic

inadequate communication

uncoordinated, conflicting

93

mistrust

94

95

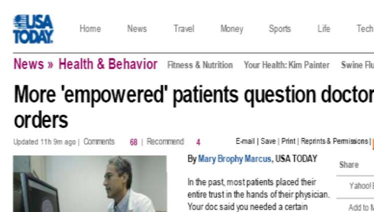
96

97

IN THE SUPERIOR COURT OF THE STATE OF CALIFORNIA
IN AND FOR SAN BERNARDINO COUNTY

GERARDO CANEDO JR., M.D.,) Case No.: CIV SB 2212130
Plaintiff,)
vs.) COMPLAINT FOR DAMAGES
) JURY TRIAL DEMANDED
VICTOR VALLEY HOSPITAL ACQUISITION, INC. DBA VICTOR VALLEY GLOBAL MEDICAL CENTER)

98



USA TODAY Home News Travel Money Sports Life Tech

News » Health & Behavior Fitness & Nutrition Your Health: Kim Painter Swine Flu

More 'empowered' patients question doctors orders

By Mary Brophy 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

99

emotional barriers

100

101

102

103

psychological barriers

104

105

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107

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111

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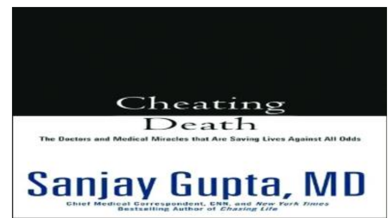
113



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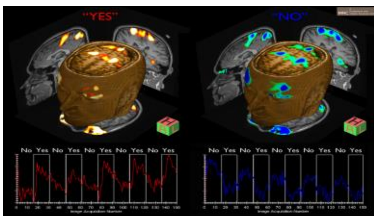


115

religion

116

117

Trauma Death

Views of the Public and Trauma Professionals on Death and Dying From Injuries

Lenworth M. Jacobs, MD, MPH; Karyl Burns, RN, PhD; Barbara Bennett Jacobs, RN, MPH, PhD, CHPN

Arch Surg. 2008;143(8):730-735

118

Question and Responses[a]	Public, % (n=1006)	Professionals, % (n=774)
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?		
Yes	57.4	19.5
No	35.5	61.1

119

some reasons

surrogates

demand NBT

120

cognitive

psychological

emotional

religion

mistrust

121

Externality

122

clinicians

resist

123

avoid patient

suffering

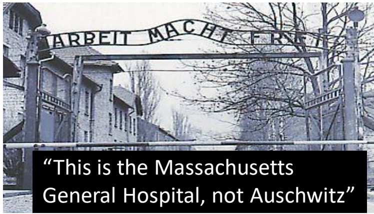
124

125

quotes from

actual cases

126



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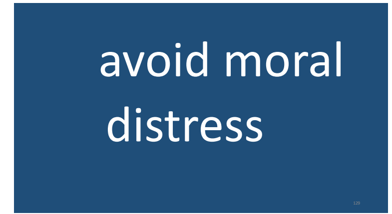

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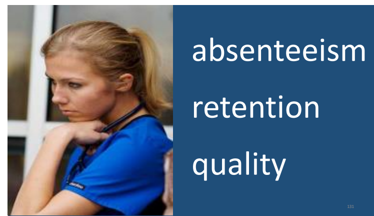


131

132

133

134

135

136

distrust

surrogate

137

138

JOURNAL OF PALLIATIVE MEDICINE
Volume 25, Number 6, 2022
© Mary Ann Liebert, Inc.
DOI: 10.1089/jpm.2021.0283

Origina

Surrogate Decision Makers Need Better Preparation for Their Role: Advice from Experienced Surrogates

Brian M. Bakke, BS,[1] Mariko A. Feuz, BS,[1,2] Ryan D. McMahan, MD,[1,3,i] Deborah E. Barr

139

60%

accurate

140

Patient does **not** **want** this LST

141

Protect Pt from their surrogate

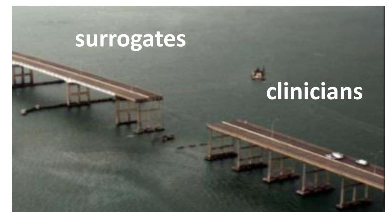
142

some reasons

clinicians

resist NBT

143



144

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Arch Surg. 2008;143(8):730-735

145

Question and Responses[a]	Public, % (n=1006)	Professionals (n=774)
If doctors believe there is no hope of recovery, which would you prefer?		
All efforts should continue indefinitely	20.6	2.5

146

147

148

Prevention

149

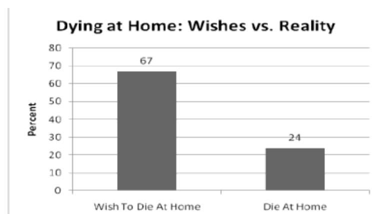
Most patients do **not** want NBT

150

71%: "More important to enhance … **quality** of life … even if it means **shorter** life"

National Journal (Mar. 2011)

151



152

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Views of the Public and Trauma Professionals on Death and Dying From Injuries

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Arch Surg. 2008;143(8):730-735

153

Question and Responses[a]	Public, % (n=1006)	Professionals, (n=774)
If doctors believe there is no hope of recovery, which would you prefer?		
Life-sustaining treatments should be stopped and should focus on comfort	72.8	92.6

154

how

assure congruence

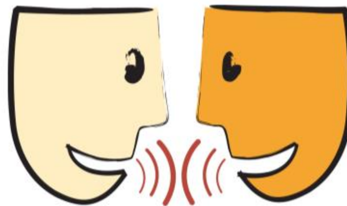
155

patient

interventions

156

157

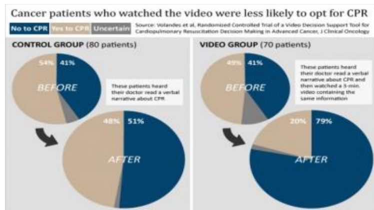


158

IPDAS

International Patient Decision Aid Standards Collaboration

159



160

surrogate

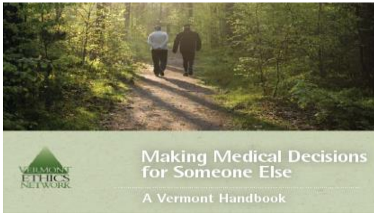
interventions

161

Make sure surrogate **understands**

1. patient's prognosis
2. **role** of surrogate

162



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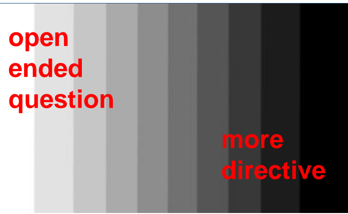


164

165

Physician: "Mr. Smith, your wife is very ill. She suffered extensive brain damage when her heart stopped a week ago, and it is unlikely she will ever regain brain function. Right now, intensive life support is keeping her alive, including medicines to maintain her blood pressure and a breathing machine.

166

Physician: Now, her kidneys have failed as well. Should we start dialysis if her kidneys do not improve?"

Mr. Smith: tearfully: "Of course, Doctor. Won't she die if you don't?

167

Serious Illness Conversation Guide

CONVERSATION FLOW

1. Set up the conversation
   - Introduce purpose
   - Prepare for future decisions
   - Ask permission

ARIADNE LABS

168

seek **assent**

not consent

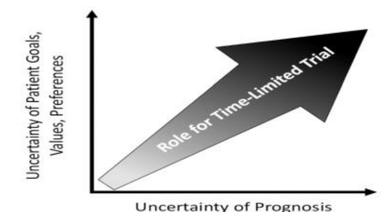
169

Announce plan:

"We are going to…"

Silence = assent

170



171

Limits to prevention

172

RESPECTING PATIENTS' PREFERENCES

By Kuldeep N. Yadav, Nicole B. Gabler, Elizabeth Cooney, Saida Kent, Jennifer Kim, Nicole Herbst, Adjoa Mante, Scott D. Halpern, and Katherine R. Courtright

Approximately One In Three US Adults Completes Any Type Of Advance Directive For End-Of-Life Care

173

Systematic review of 150 studies

800,000 people

174

37%

175

PewResearchCenter

NOV. 21, 2013

Views on End-of-Life Medical Treatments

Growing Minority of Americans Say Doctors Should Do Everything Possible to Keep Patients Alive

176

If cannot **prevent** conflict

How can you **resolve** it

177

Consensus

178

most hospital policies

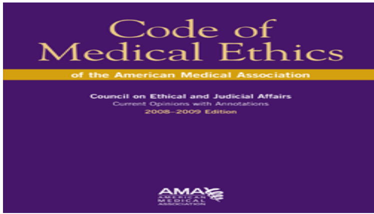
most society guidelines

179

negotiation

mediation

180



181

4 of 7 steps

182

1. Earnest attempts … deliberate … negotiate
2. Joint decision making … maximum extent

183

3. Attempts … negotiate … reach resolution
4. Involve … ethics committee

184

why?

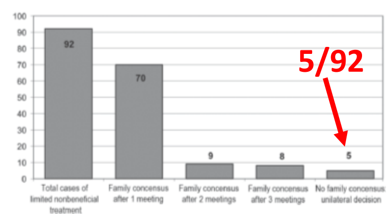
185

186

95%

187

188



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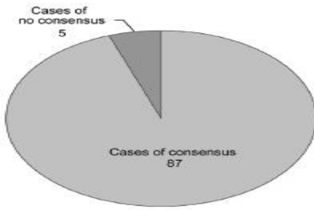


190

Am J Respir Crit Care Med. 1997 Jan;155(1):15-20.

Increasing incidence of withholding and withdrawal of life support from the critically ill.

Prendergast TJ, Luce JM.

191

57% agree immediately

90% agree within 5 days

96% agree after more meetings

192

Resolution of Futility by Due Process: Early Experience with the Texas Advance Directives Act

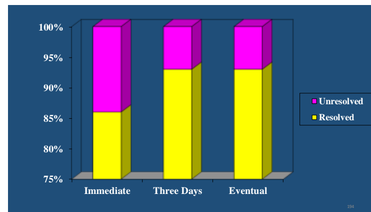
Robert L. Fine, MD, and Thomas Wm. Mayo, JD

Every U.S. state has developed legal rules to address end-of-life decision making. No law to date has effectively dealt with medical futility—an issue that has engendered significant debate in the medical and legal literature, many court cases, and a formal opinion from the American Medical Association's Council on Ethical and Judicial Affairs. In 1999, Texas was the first state to adopt a law regulating end-of-life decisions, providing a legislatively sanctioned, extrajudicial, due process mechanism for resolving medical futility disputes and other end-of-life ethical disagreements. After 2 years of practical experience with this law, data collected at a large tertiary care teaching hospital strongly suggest that the law represents a first step toward practical resolution of this controversial area of modern health care. As such, the law may be of interest to practitioners, patients, and legislators elsewhere.

Ann Intern Med. 2003;138:743-746. www.annals.org

For author affiliations, see end of text.

193



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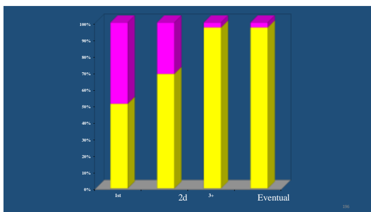
Circumstances Surrounding End of Life in a Pediatric Intensive Care Unit

Daniel Garros, MD*; Rhonda J. Rosychuk, PhD‡; and Peter N. Cox, MD*

PEDIATRICS Vol. 112 No. 5 November 2003

195



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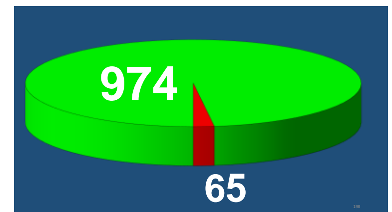
Dallas Morning News

"Bills challenge care limits for terminal patients: Some say 10 days to transfer isn't enough before treatment ends"
(February 15, 2007)

197



198

not always

199

HEC Forum (2022) 34:73

Experience with a Revised Hospital Policy on Not Offering Cardiopulmonary Resuscitation

Andrew M. Courtwright[1,2] · Emily Rubin[2,3] · Kimberly S. Erler[2,4] ·

200

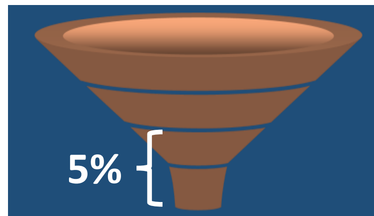
5%

201

consensus

intractable

202



203

tried reach consensus

intensive communication
mediation

204

still no consent

205

	Clinician		
Surrogate		Stop	Go
	Stop		
	Go	X	

206

Replace surrogate

207

get consent
from **new**
surrogate

208

209

Substituted judgment

Best interests

210

Cal. Prob. Code
§§ 4684, 4714

211

"in **accordance** …
instructions …
wishes … otherwise
… best interest"

212

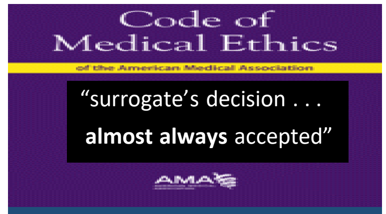
BUT

213

~ 60%
accurate

214

215



216

217

educate

support

218

219

220

Cal. Prob. Code

§ 4766

221

"petition … whether … surrogate … **consistent** … patient's desires … best interest"

222

and

223

224

No agent or conservator

⬇

"**provider** … may choose"

225

Reasons
to replace

226

Psychosomatics 2020:61:672-677 © 2020 Academy of Consultation-Liaison Psychiatry. Published by Elsevier Inc.

Perspective

The Incapacitated Surrogate: What is the Consultation-Liaison Psychiatrist's Role?

Nicole Allen, M.D., Adrienne Mishkin, M.D., M.P.H.

227

228

229

230

231

Bernstein v. Superior Court of Ventura County (Feb. 2, 2009).

COUNTY OF VENTURA CALIFORNIA

232

Option

Duty

233

USC University Hospital

More than a hospital. An academic medical center.

234

Plascentia McDonald

74yo

235

Advance directive

1. Bobby is agent
2. Cynthia is alternate
3. “Do No prolong life if incurable condition”

236

Aug. 14

Surgery
thoracoabdominal aneurysm

Post-op infections

237

Aug. 30

Sepsis, non-cognitive

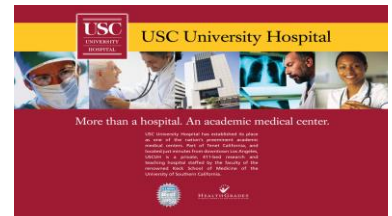
Continued LSMT

3 additional surgeries

Disagrees w/ brother

238

239



240

Probate Code 4740 **immunizes** providers who “in good faith **comply with** a health care decision made by one whom they believe authorized.”

241

242

“no”

243

"Compliance with agent's decision ... **at odds** with the patient's ... AD . . . **not** ... good faith."

244

Agent **not** authorized to depart from AD

USC should have known that

245

limits

to surrogate replacement

246

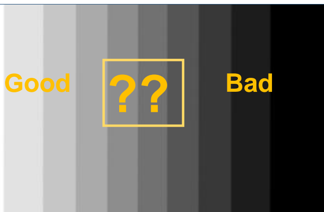
Providers **cannot** show deviation

247

248

Surrogates get benefit of doubt

249



250

Surrogates are **faithful**

251

No new surrogate?

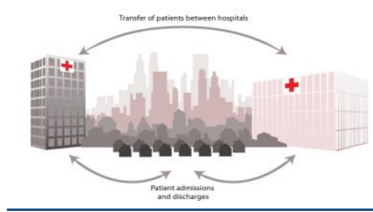
↓

try new **hospital**

252

Transfer

253



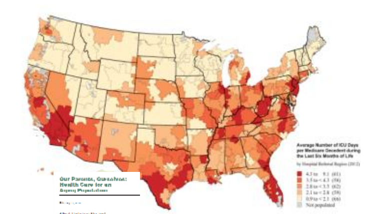
254

rare

255

but
possible

256



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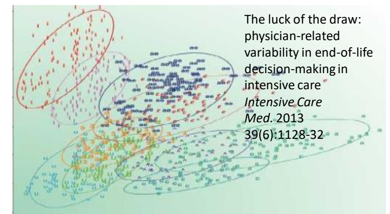


258

Medical Futility in End-of-Life Care
Report of the Council on Ethical and Judicial Affairs

Council on Ethical and Judicial Affairs, American Medical Association

Use of life-sustaining or invasive interventions in patients vegetative state or who are terminally ill may only prolong

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

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

Annals of Internal Medicine — SUPPLEMENT

American College of Physicians Ethics Manual
Seventh Edition

259

BUT

260

261

Hospital	Days
San Diego	3
Glendale	10
Torrance	5
Texas law	10
Virginia law	14

262

no consent

no new surrogate

no transfer

263

Intractable conflict

264

Normally, clinicians must **follow** patient & surrogate decisions

265

Cal. Prob. Code § 4733

266

"provider … **shall … comply** with a … decision … made by a person then authorized"

267

BUT

268

Cal. Prob. Code § 4654

269

"**not … require** … health care contrary to generally accepted health care standards"

270

Cal. Prob. Code § 4735

271

"provider … **may decline to comply** with … decision that … requires"

272

either

273

"**medically ineffective** health care"

274

or

275

"health care **contrary** to generally accepted health care **standards**"

276

plus

277

immunity when "declining to comply" per section 4735

278

Cal. Prob. Code § 4740

279

"**not subject** to civil **or** criminal liability **or** to discipline for unprofessional conduct"

280

recap

281

4735 permits **not following** decisions contrary to GAHCS

282

4735 permits **not following** decisions for ineffective HC

283

4740 offers **immunity** for using 4735

284

plus

285

Cal. Prob. Code § 4781.2

286

287

You want to **decline to comply** with a health care decision

288

Whose decision
What decision
When

289

whose decisions

290

Cal. Prob. Code § 4735

291

“decline to comply with … **instruction** or … **decision**”

292

Cal. Prob. Code § 4617

293

Patient with capacity
Advance directive
POLST

294

Agent
Conservator
Surrogate

295

whoever
however

296

what decisions

297

Cal. Prob. Code § 4617

298

"regarding the patient's health care, including … provide, **withhold, or withdraw** … all … forms of health care"

299

Surrogate may ask
start Tx
continue TX

300

Decline request to start Tx

Decline request to continue Tx

301

4735 permits overriding surrogate

302

withhold
or
withdraw

303

304

not start dialysis

stop dialysis

305

omit
or
cease

306

Physician Certification of
Medically Ineffective Treatment

The Physician Certification of Medically Ineffective Treatment must be completed by the attending physician and a second physician prior to withholding or withdrawing life sustaining treatment (including CPR) on the basis that the treatment would be medically ineffective.

(Place √ by treatments deemed medically ineffective):

- ☐ CPR / Defibrillation
- ☐ Endotracheal Intubation and Mechanical Ventilation
- ☐ BiPAP or cPAP
- ☐ Reintubation
- ☐ IV Vasoactive Drugs
- ☐ IV Anti-arrhythmic Drugs
- ☐ Cardioversion
- ☐ Blood Products
- ☐ Other ______
- ☐ TPN
- ☐ Tube feeding
- ☐ Antibiotics
- ☐ Dialysis
- ☐ Labs / Including fingersticks
- ☐ Surgery/Invasive procedure
- ☐ Fluid boluses
- ☐ Automatic cardiac defibrillator

A) I, ______, M.D., am a physician licensed by the State of Maryland. I hereby certify based upon the current medical condition of this patient, ______, the above indicated treatment(s) will not prevent or reduce the deterioration of the health of this individual or prevent his or her impending death.

Physician Signature ______ Date ______ Time a.m./p.m.

307

when

308

requested health care is

309

medically ineffective

310

or

311

contrary to generally accepted health care standards

312

When is health care MI or contrary to GAHCS?

313

314

Easier cases

315

start with vocabulary

316

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, Thaddeus M. Pope, Gordon D. Rubenfeld, Bernard Lo, Robert D. Truog, Cynda H. Rushton,

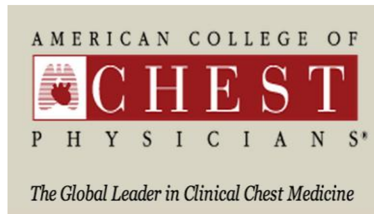
317

We help the world breathe

PULMONARY • CRITICAL CARE • SLEEP

318

319



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321

322

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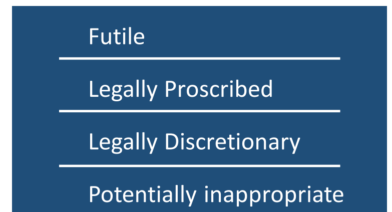


324

Futile

325

Intervention **cannot** (at all) accomplish physiological goals

326

scientific impossibility

327

328

329

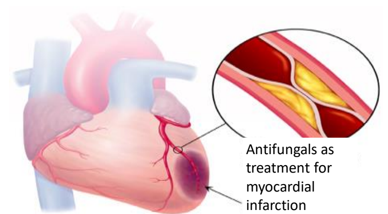
example 1

330

331

example 2

332



333

example 3

334

CPR when show rigor mortis or dependent lividity

335

example 4

336

Even EMS protocols for "futility"

337

example 5

338

2022

339

340

"**not a single state** has recognized … a right to force a medical provider to provide … medical treatment against … professional judgment"

DE IL FL TX MN

341

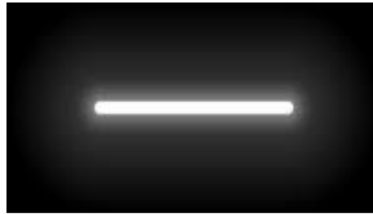
"futile"

342

value free

objective

343



344

BUT

345

346

May the clinician stop LST?

347

"futile"

348

may & should refuse

349

"futile" treatment
is
"medically ineffective"

350

Cal. Prob. Code § 4735

351

~~Futile~~

Legally Proscribed

Legally Discretionary

Potentially inappropriate

352

Legally proscribed

353

Treatment **may accomplish** effect desired by the patient

354

>0%

355

not "futile"

356

Prohibited by applicable laws, judicial precedent, or widely accepted public policies

357

example 1

358

359

Might "work"

But illegal

360

example 2

361

362

example 3

363

364

If treatment request is legally **proscribed** →

365

may & should refuse

366

"proscribed" treatment is "contrary to GAHCS"

367

Cal. Prob. Code § 4735

368

~~Futile~~

~~Legally Proscribed~~

Legally Discretionary

Potentially inappropriate

369

Legally discretionary

370

opposite of proscribed

371

372

373

Laws, judicial precedent, or policies that give physicians **permission** to refuse to administer them

374

example 1

375

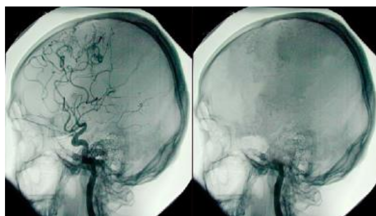
376

1. achondrogenesis;
2. anencephaly;
3. acardia;
4. body stalk anomaly;
5. campomelic dysplasia;
6. craniorachischisis;
7. dysencephalia splanchnocystica (M
8. ectopia cordis;
9. exencephaly;
10. gestational trophoblastic neoplasia
11. holoprosencephaly;
12. hydrops fetalis;
13. iniencephaly;
14. perinatal hypophosphatasia;
15. osteogenesis imperfecta (type 2)
16. renal agenesis (bilateral);
17. short rib polydactyly syndrome;
18. sirenomelia;
19. thanatophoric dysplasia;
2. triploidy;
21. trisomy 13;
22. trisomy 16 (full);
23. trisomy 18;
24. trisomy 22; and

377

example 2

378



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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**"

380

example 3

381

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

CINCINNATI AREA

MEDICAL ORDERS FOR LIFE-SUSTAINING TREATMENT (MOLST)

Person's Last Name

First Name/Middle Initial

Date of Birth / /

Last 4 numbers of SSN

BASIS FOR ORDERS AND SIGNATURES

These orders were discussed with:
- ☐ Patient
- ☐ Health Care Agent (DPOA-HC)
- ☐ Next of Kin/Surrogate
- ☐ Court-Appointed Guardian
- ☐ Parent of a minor
- ☐ Other: ______

These documents were reviewed / location of copies:
- ☐ Living Will: *(location of copy)* ______
- ☐ Durable Power of Attorney-HC: ______
- ☐ Ohio DNR form **(ATTACH A SIGNED COPY)**
- ☐ Other documents: ______

Physician/PA/APRN printed name | Signature (required) | Date

Patient/Surrogate printed name | Signature (required) | Relationship ("self" if pa

382

383

DNR/COLST

CLINICIAN ORDERS

for DNR/CPR and OTHER LIFE SUSTAINING TREATMENT

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.

384

"imminent death"

3 days

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

385

386

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 an other life-sustaining treatment options for a specific patient. It is valid in all health care facilities and programs throughout Maryland. This order for shall be kept with other active medical orders in the patient's medical record. The physician or nurse practitioner must accurately and legibly complet 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 othe 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 mu 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:
- ______ other legal authority in accordance with all provisions of the Health Care Decisions Act. All supportin

387

"[not] prevent
… **impending**
death"

388

May the
clinician
stop LSMT?

389

Legally
discretionary

390

may & should
refuse

391

"discretionary" treatment
is
"contrary to GAHCS"

392

appropriate
medicine

surrogate

393

Cal. Prob.
Code § 4735

394

~~Futile~~

~~Legally Proscribed~~

~~Legally Discretionary~~

Potentially inappropriate

395

396

Harder cases

397

potentially inappropriate treatment

398

Some chance of accomplishing the effect sought by patient or surrogate

399

Not “futile” because **might** “work”

400

examples

401

dialysis for permanently unconscious

402

MV for widely metastatic cancer

403

We call these “futility disputes”

404

BUT

405

disputed Tx
might keep
patient alive

406

407

Is that chance
or outcome
worthwhile

408

Not a
medical
judgment

409

Value
judgment

410

"potentially"

411

vet & confirm
your judgment

412

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.

413

2nd opinion

interdisciplinary
institutional committee

414

Helps consensus

Assures carefully considered

415

BUT

416

417

Futile
Proscribed
Discretionary
→ Refuse

418

Potentially inappropriate → ?

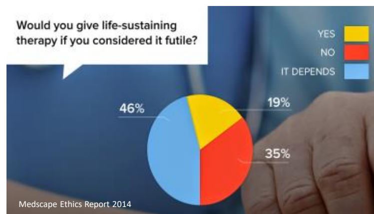
419

Typical response

420

cave-in

421



422

Perceptions of "futile care" among caregivers in intensive care units

Robert Sibbald MSc, James Downar MD, Laura Hawryluck MD MSc

CMAJ 2007;177(10):1201-8

423

"follow … SDMs **instead** of … what they feel is appropriate"

424

425

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

Reference Committee E

October 4-6, 2008

426

"**common** for physicians … provide … non-beneficial or futile treatments … **against** their best medical judgment"

427

why?

428

429

"almost all cited a **lack of legal support**"

430

431

"ethically … comfortable removing life support … but … **lingering concerns about being sued** -- even with the blessings of the Ethics Committee."

432

“even a case that … eventually gets thrown out is a major **stressor, time drain and hassle**.”

433

“Remove the __, and I will **sue you**”

434

435

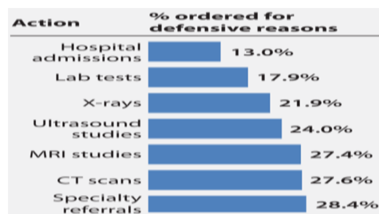
436

Physicians round off

Nurses bear brunt

437

438



Action	% ordered for defensive reasons
Hospital admissions	13.0%
Lab tests	17.9%
X-rays	21.9%
Ultrasound studies	24.0%
MRI studies	27.4%
CT scans	27.6%
Specialty referrals	28.4%

439

440

441

Low risk

442

Few cases brought

443

Almost **none** even **want** to sue

444

445

Even if surrogate wants to sue, attorneys **decline**

446

Unlikely to win
- Immunity
- Judicial deference

447

Damages **too low**
<$250,000

448

Few cases brought

449

In rare instances cases filed, **providers win**

450

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

451

"**no successful legal suits** against physicians and institutions who … appropriately invoked such policies"

452

"**appropriately** invoked such policies"

453

Providers lose only **one type** lawsuit re NBT/MIT

454

IIED

NIED

455

secretive

insensitive

outrageous

456

457

slow code

show code

Hollywood code

458

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)

459

consultation expected

distress foreseeable

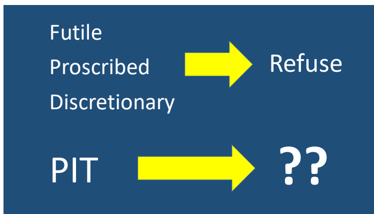
460

461

Despite

low risk

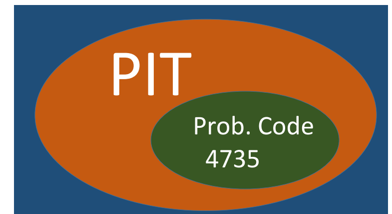
462



463

BUT

464



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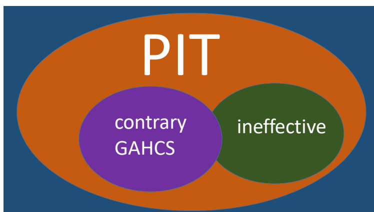
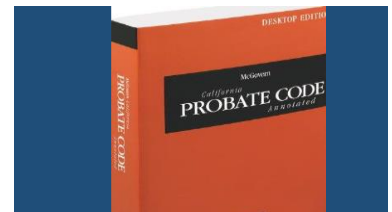


466

medically

ineffective

467



468

“not offer any significant benefit”

469

470

MI 1

471

imminent demise

472

advanced metastatic disease

advanced multi-system organ failure from sepsis

473

active clinical deterioration

474

475

Not futile

might be able to restart circulation

476

BUT

477

478

actively dying

death impending imminent - hours

479

cardiac arrest just the start of an inexorable dying process that cannot be prevented

480

Elizabeth Alexander

481

482

70 years old

end-stage pancreatic cancer

483

transferred from SNF

484

"clearly an individual who should **not** undergo aggressive resuscitation"

485

"frail, debilitated, ... metastasis ... extensive"

486

BUT

487

POLST
AD
Agent

488

"**all** measures
to prolong life"

489

appropriate
care
committee

490

DNR

491

Alexander
died next day

492

493

494

"medically
ineffective"

495

SUPERIOR COURT OF CALIFORNIA, COUNTY OF SAN DIEGO

CENTRAL DIVISION

ESTATE OF ELIZABETH ALEXANDER, and CLENTON ALEXANDER, HEIR,

Plaintiffs,

v.

SCRIPPS MEMORIAL HOSPITAL LA JOLLA, a California corporation; DONALD RITT, an individual; GUSTAVO LUGO, an individual; CHRISTOPHER WIESNER, an individual; PREETI MEHTA, an individual; MARIE SHIEH, an individual; SHAWN EVANS, an individual; MARIE SHIEH, an individual; AYANA BOYD KING, an individual; ERNEST PUND, an individual; CHARLES ETTARI, an individual; KAREN

CASE NO. 37-2014-00016257-CU-MM-CTL

NOTICE OF MOTION AND MOTION FO SUMMARY JUDGMENT OR, IN THE ALTERNATIVE, SUMMARY ADJUDICATION BY SCRIPPS DEFENDANTS

IMAGED FILE

DATE: June 3, 2016
TIME: 11 a.m.
DEPT: C-70
IC JUDGE: Hon. Randa Trapp

CASE FILED: May 20, 2014
TRIAL DATE: September 9, 2016

496

COURT OF APPEAL, FOURTH APPELLATE DISTRICT

DIVISION ONE

STATE OF CALIFORNIA

CHRISTOPHER ALEXANDER et al.,

Plaintiffs and Appellants,

v.

SCRIPPS MEMORIAL HOSPITAL LA JOLLA et al.,

Defendants and Respondents.

D071001

(Super. Ct. No. 37-2014-00016257-CU-MM-CTL)

497

498

499

"cannot **reasonably** accomplish the patient's goals"

500

"no **realistic chance** of returning the patient to a level permitting survival outside the acute care setting"

501

502

No reasonable expectation patient will improve sufficiently to survive **outside the acute care setting**

503

No reasonable expectation patient's neurologic function will improve sufficiently to allow the patient to **perceive the benefits of treatment**

504

irreversible coma

never leave ICU

505

506

"community standard"

2022

507

and

508

CALIFORNIA MEDICAL ASSOCIATION

509

510

511

imminent death

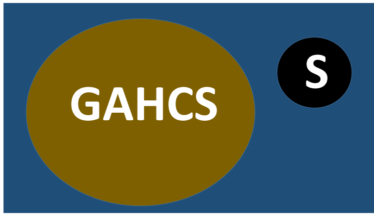
irreversible coma

never leave ICU

512

Contrary to GAHCS

513



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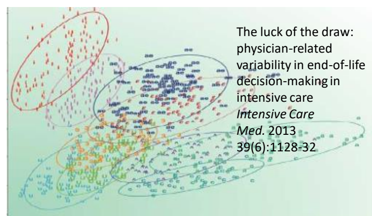

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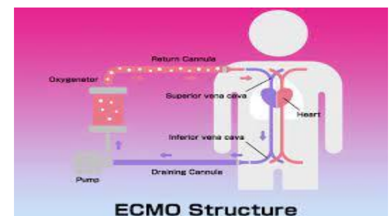

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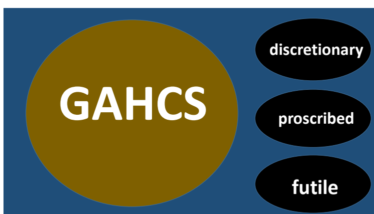

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Document #3456
Responding to Requests for Non-Beneficial Treatment

CMA Legal Counsel, January 2022

523

3. Does California law support physicians who decline to provide medically ineffective or non-beneficial treatment?

Yes. California law contains broad immunities for physicians and healthcare institutions who decline

524

Cal. Prob. Code § 4740

525

"not subject to civil **or** criminal liability **or** to discipline for unprofessional conduct"

526

6 conditions

527

1

528

"act in good faith"

529

2

530

"act … in accordance with generally accepted health care standards"

531

3

532

"**inform** the patient, if possible, and any person then authorized to make health care decisions"

533

4

534

"make all reasonable efforts to assist in the **transfer**"

535

5

536

"Provide **continuing care** … until a transfer can be accomplished or until it appears that a transfer cannot be accomplished"

537

6

538

"continue … appropriate pain relief and palliative care"

539

Does it work?

540

Elizabeth Alexander

541

542

"**immune** from liability under section 4740"

543

COURT OF APPEAL, FOURTH APPELLATE DISTRICT

DIVISION ONE

STATE OF CALIFORNIA

CHRISTOPHER ALEXANDER et al.,
Plaintiffs and Appellants,
v.
SCRIPPS MEMORIAL HOSPITAL LA JOLLA et al.,
Defendants and Respondents.

D071001

(Super. Ct. No. 37-2014-00016257-CU-MM-CTL)

544

safe harbor immunity **works**

545

Conclusion

546

Intractable conflict

547

could not **prevent**

with better communication
with documentation pt wishes

548

could not get **consensus**

with more family meetings
with EC, palliative, chaplaincy…

549

could not
replace
surrogate

550

could not
transfer to
another facility

551

Withdraw LST
without consent
from surrogate?

552

yes

553

Unwanted by
the patient

554

Futile
physiologically
ineffective

555

Proscribed
prohibited by
laws, rules

556

Discretionary
permitted by
laws, rules

557

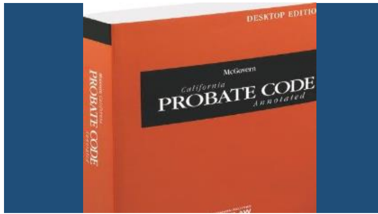
Imminent demise
dying hours/days
- even with Tx

558

irreversible coma ?

never leave ICU ?

559



560

561

clear

precise

measurable

562

563

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Materials from this presentation are available

thaddeuspope.com/medicalfutility

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Medical Futility Blog

Since July 2007, I have been blogging, almost daily, to **medicalfutility.blogspot.com**. This blog focuses on reporting and discussing legislative, judicial, regulatory, medical, and other developments concerning medical futility and end-of-life medical treatment conflicts. The blog has received nearly **5 million** direct visits. Plus, it is distributed through RSS, Twitter, and re-publishers like WestlawNext.

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