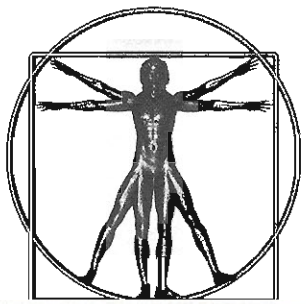
MID-ATLANTIC ETHICS COMMITTEE NEWSLETTER



A Newsletter for Ethics Committee Members in Maryland, The District of Columbia and Virginia
Published by the Law & Health Care Program, University of Maryland School of Law
and the Maryland Health Care Ethics Committee Network

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The Mid-Atlantic Ethics Committee Newsletter is a publication of the Maryland Health Care Ethics Committee Network, an initiative of the University of Maryland School of Law's Law & Health Care Program. The Newsletter combines educational articles with timely information about bioethics activities. Each issue includes a feature article, a Calendar of upcoming events, and a case presentation and commentary by local experts in bioethics, law, medicine, nursing, or related disciplines.

Diane E. Hoffmann, JD, MS
Editor

MEDICAL FUTILITY & MARYLAND LAW

On November 30, 2010, over 200 individuals attended the Maryland Health Care Ethics Committee Network's (MHECN's) symposium on medical futility and Maryland law at the University of Maryland, Baltimore campus. Medical futility typically refers to a type of conflict over end-of-life medical treatment, usually the type of treatment provided in a hospital's intensive care unit. In these disputes, the patient almost never has capacity (sometimes referred to as competence) to understand and make treatment decisions. So, health care decisions are made by the patient's substitute decision makers: whether patient-appointed, court-appointed, or default. The paradigmatic medical futility dispute is one in which the surrogate requests aggressive treatment interventions for an imminently dying or catastrophically chronically ill patient. However, that patient's providers consider such treatment to be medically ineffective (i.e., unable to achieve the desired goal) and/or ethically inappropriate. For example, patients over age 85 undergoing in-hospital cardiopulmonary resuscitation (CPR) have only a 6% chance of surviving to hospital discharge. Those with pre-existing co-morbidities are even less likely to survive. And many of the very few that do survive have significantly poorer neurological and functional states than they did before cardiac arrest. In short, physicians are reluctant to pound on a patient's chest, break ribs, and otherwise cause suffering and burdens, when there is no corresponding benefit to be gained. When death is unavoidable and continued life-sustaining interventions can only make death more uncomfortable, providers frequently determine that palliative care (which focuses on the relief of pain, symptoms and stress of serious illness) is most appropriate.

Fortunately, the vast majority of medical futility disputes are resolved through good communication. When the treatment team meets with the patient's family (often on several occasions) and carefully explains the prognosis, they almost always reach consensus. Toward this end, palliative care teams have made progress at some hospitals. Still, in a small but significant subset of cases, conflict remains intractable. The conference focused primarily upon these intractable cases and whether Maryland's Health Care Decisions Act (HCDA) is effective in providing ethical resolution. The HCDA provides that life-sustaining medical treatment (such as dialysis, a ventilator, artificial nutrition and hydration) may be withheld or withdrawn from incapacitated patients only with the consent of an authorized decision maker, except in two circumstances: (1) where treatment is "medically ineffective" and/or (2) where treatment is "ethically inappropriate." But the statute defines these terms in such a narrow way that these exceptions do not apply to most futility disputes. Furthermore, even when these exceptions do apply, the statute still requires providers to continue complying with treatment decisions unless or until

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Medical Futility

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the patient is transferred to another provider or facility. Since such transfer sites are almost never found, the statute effectively requires providers to comply with surrogate requests for aggressive curative treatment that they consider non-beneficial, burdensome, and even cruel.

A survey conducted by MHECN in 2010 by hospital attorneys, risk managers, and ICU physicians revealed that physicians comply with surrogate requests for medically ineffective treatment for dying patients due, in part, to fear of being sued. Furthermore, there are varying interpretations of the HCDA that create inconsistencies in end-of-life decision-making from one patient and health care provider to the next. In short, the "medically ineffective" and "ethically inappropriate" provisions in the HCDA—either due to the way the law is written or how it is interpreted and applied—do not provide an adequate mechanism for resolving intractable medical futility disputes.

Speakers at the November 30 symposium described alternatives to Maryland's HCDA. Charlie Sabatino, J.D., Director of the American Bar Association's Commission on Law and Aging, reviewed state laws related to medical futility. One example is Texas's law, which allows physicians to withhold or withdraw treatment considered "ethically inappropriate" after a period of ten days, providing that certain due process standards are met.

Lawrence Schneiderman, M.D., Professor Emeritus in the Department of Family and Preventive Medicine and Adjunct Professor in the Department of Medicine at the University of California, San Diego, described the approach taken by a consortium of California hospitals. They sought a community standard of medical futility among local hospitals. University of California San Diego (UCSD) Medical Center adopted the resulting majority

The Maryland Healthcare Ethics Committee Network (MHECN) is a membership organization, established by the Law and Health Care Program at the University of Maryland School of Law. The purpose of MHECN is to facilitate and enhance ethical reflection in all aspects of decision making in health care settings by supporting and providing informational and educational resources to ethics committees serving health care institutions in the state of Maryland. The Network works to achieve this goal by:

- Serving as a resource to ethics committees as they investigate ethical dilemmas within their institution and as they strive to assist their institution to act consistently with its mission statement;
- Fostering communication and information sharing among Network members;
- Providing educational programs for ethics committee members, other healthcare providers, and members of the general public on ethical issues in health care; and
- Conducting research to improve the functioning of ethics committees and ultimately the care of patients in Maryland.

REPLACE THE SURROGATE?

A separate Maryland Health Care Decisions Act (HCDA) provision may be of some use in intractable futility disputes between a surrogate and health care providers. When a surrogate makes a treatment decision that clearly contradicts what the patient would have wanted, the provider need not comply with that decision. The HCDA provides: "Any person authorized to make health care decisions for another under this section shall base those decisions on the wishes of the patient and, if the wishes of the patient are unknown or unclear, on the patient's best interest." In other words, surrogates must make decisions that reflect the patient's values, preferences, or best interests. Otherwise, they act outside the scope of their authority. Surrogates who are not faithful agents can and should be replaced. While effective and functional in some cases, surrogate replacement is hardly a complete solution to medical futility disputes. Most patients have not completed any advance care planning. Of the 34% of Marylanders who have completed advance directives, those directives are usually unavailable when needed. And even when available, those directives usually fail to speak to the patient's current clinical circumstances. In short, there is often no evidence of patient preferences. Consequently, it is impossible to demonstrate any contradiction between those preferences and surrogate decisions. While we know, statistically, that few of us would want to live in an extremely compromised condition, particularly if cognitively unaware, providers often do not know what any particular patient is willing to live with. In such cases, there are rarely grounds to replace a surrogate requesting treatment that providers determine is inappropriate.

Thaddeus Mason Pope, JD

community standard, which defines medical futility in their institutional policy as: "Any treatment without a realistic chance of providing an effect that the patient would ever have the capacity to appreciate as a benefit, such as merely preserving the physiologic functions of a permanently unconsciousness patient, or has no realistic chance of achieving the medical goal of returning the patient to a level of health that permits survival outside the acute care setting of UCSD Medical Center." UCSD also offers a process for compassionate dispute resolution and effective comfort care. This policy defines the professional standard of practice at UCSD Medical Center and serves to inform the public and as a guideline for the courts. A hospital could also adopt a minority standard in which it defines futility differently and/or chooses not to limit life-sustaining treatment. Accordingly, it should declare this as its professional standard of practice, formalize it as policy to inform the public as well as a guideline for the courts. Importantly, such a hospital should also accept transferred patients desiring treatments considered medically futile at other hospitals.

In the afternoon sessions at the November 30th symposium, attendees shared their ideas and suggestions for how to improve conflict resolution related to medical futility disputes. Most participants seemed to agree that revisions to the Maryland HCDA are in order. Providers need to be able to "stand up" for their patients. The tough work is designing a dispute resolution mechanism that can act with the real-time speed these cases demand, yet include sufficient safeguards to ensure due process protections like neutral and unbiased adjudication. "Next steps" based on round table discussions from the November 30 symposium are currently being explored by University of Maryland School of Law professors Diane Hoffmann, J.D., M.S. and Jack Schwartz, J.D., and Maryland Assistant Attorney General Paul Ballard, J.D.

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