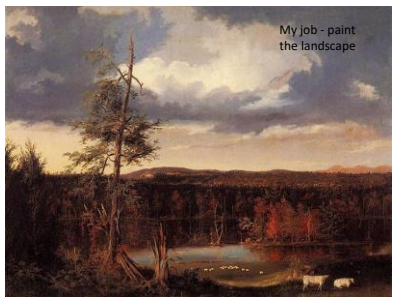
When May You Stop Life-Sustaining Treatment without Consent? Leading Dispute Resolution Mechanisms for Medical Futility Conflicts

Children's Hospitals and Clinics of Minnesota • November 18, 2016

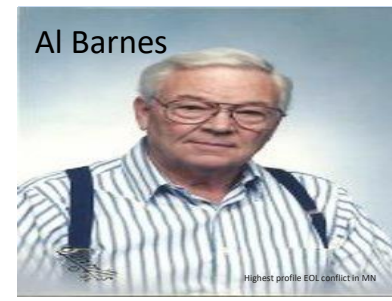
Thaddeus Mason Pope, JD, PhD
Mitchell Hamline School of Law

Nothing to disclose

Co-author on policy statement that will discuss



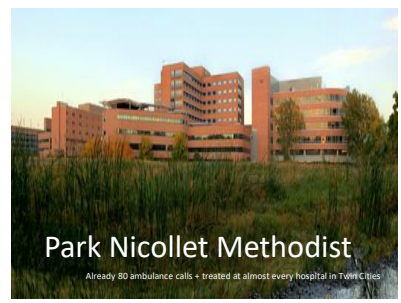
2011

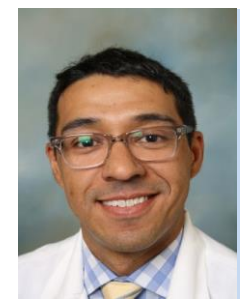


Advanced dementia

end stage kidney disease

chronic respiratory failure





Abel Tello

aggressive treatment is **unethical & painful**

CMO

BUT

3 options

1. Cave-in to Lana
2. Act w/o consent
3. Get new SDM & get their consent

Dispute resolution pathways

Roadmap

2 parts

Part 1

Background

Consent & right to die

What is a medical futility dispute

Prevalence of futility conflicts

Ways to **get** consent

Part 2

When you **cannot** get consent

Stopping LSMT **without** consent

3 types of LSMT

Futile

Proscribed

Potentially inappropriate

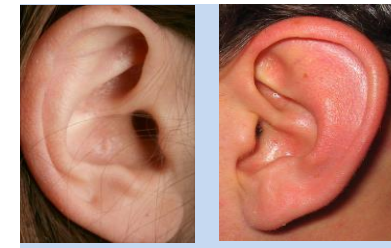
Main **legal** approaches

Right to Die

1 of 8

Clinicians **need** consent

Treat w/o consent is **battery**



Mohr v. Williams (Minn. 1905)

Corollary of right to consent

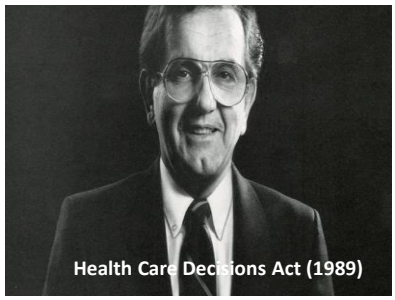
Right to refuse

In the Matter of the CONSERVATORSHIP OF Rudolfo TORRES, Conservatee.

No. C1-84-761.

Supreme Court of Minnesota.

Nov. 2, 1984.



Negative liberty ✓

BUT

Positive liberty ?

Right to demand ?

Our question

What is a medical futility dispute

2 of 8

Surrogate will **not** consent when you think they should

Futility is about line drawing

Appropriate	Inappropriate

Proportionate	Disproportionate

Beneficial	Non-beneficial

Inside the standard of care	Outside the standard of care

"I'm afraid there's really very little I can do."

Surrogate driven overtreatment

Clinician	Surrogate
CMO	LSMT

Surrogate will **not** consent to CMO recommendation

Prevalence

3 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[1,3] · Emily Anderson[1] ·

> 33%

ethics consults

University of Michigan Health System

Physician Executive Journal (37 no. 6)

MGH 1811

2 CPR futility cases per month

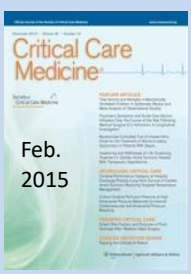
Courtwright, 2015 J Crit Care 30(1):173–77

Original Investigation

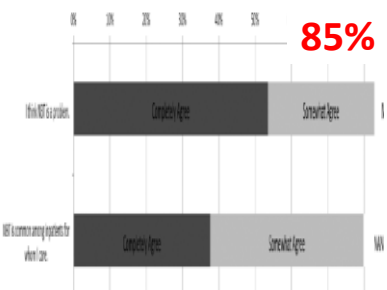
The Frequency and Cost of Treatment Perceived to Be Futile in Critical Care **20%**


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. doi:10.1001/jamainternmed.2013.10261
Published online September 9, 2013.



700 acute care clinicians



UNIVERSITY OF TORONTO

"top healthcare challenge"

6 BMC Med. Ethics (2005)

Big problem – moral distress, etc

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

Views About End-of-Life Treatment Over Time

% of U.S. adults

	1990	2005	2013	Diff. 90-13
Which comes closer to your view?				
There are circumstances in which a patient should be allowed to die	73	70	66	-7
Doctors and nurses should do everything possible to save the life of a patient in all circumstances	15	22	31	+16
Don't know	12	8	3	-9
	100	100	100	

Getting consent

4 of 8

4

mechanisms

PDA

Negotiation

Mediation

Replace

Surrogate

73

Transfer

74

1

PDA

Robust evidence shows PDAs are highly effective

> 130 RCTs

THE COCHRANE COLLABORATION®

Accurate

Complete

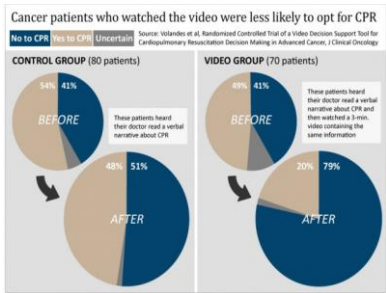
Understandable

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

Alexander A. Kon, MD, FCCM[1]; Judy E. Davidson, DNP, RN, FCCM[2]; Wynne Morrison, MD, MBE, FCCM[3]; Marion Danis, MD,

DOI: 10.1097/CCM.0000000000001398
Critical Care Medicine

Informed surrogates request **less** aggressive treatment



2

Negotiation

Mediation

95%

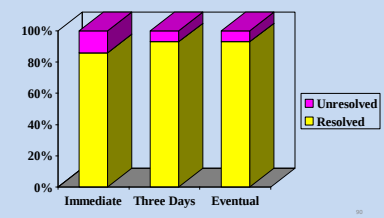
Prendergast (1998)

57% agree immediately

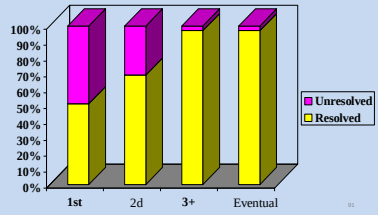
90% agree within 5 days

96% agree after more meetings

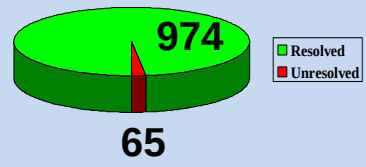
Fine & Mayo (2003)

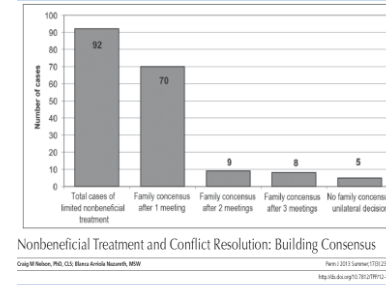


Garros et al. (2003)



Hooser (2006)





Nonbeneficial Treatment and Conflict Resolution: Building Consensus

5%

3

Replace Surrogate

PDA mediation

Still no consent

Get consent from **new** surrogate

Minn. Stat. 145C.07(3)

Health care agent must "act in the best interests . . . considering . . . the principal's personal values to the extent known"

Substituted judgment

Best interests

~ 60%

accuracy

More

aggressive treatment

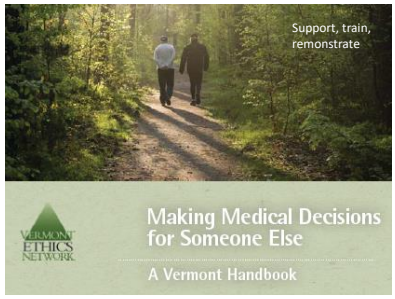
Code of Medical Ethics

of the American Medical Association

"surrogate's decision . . .

almost always accepted"

AMA



State of Minnesota

County of Hennepin

FILED

11 FEB -4 PM 1:32

District Court

Probate Division

Judicial District: Fourth

Court File No. 27-GC-PR-111-16

In Re: Emergency Guardianship of

Albert N. Barnes,

Respondent

Order Appointing Emergency Guardian

Beyond what is identified above, Mrs. Barnes has not acted in the best interest of Mr. Barnes and has failed to appropriately advocate for Mr.

Mrs. Barnes continues to demand unnecessary, inappropriate, and in some cases harmful testing and treatment for Mr. Barnes. Mrs. Barnes

BUT

Surrogates

loyal & faithful

State of Minnesota
District Court—Probate
Court Division
County of Hennepin
Fourth Judicial District

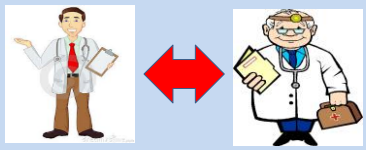
In Re: The Conservatorship of
Helga M. Wanglie

File No. PX-91-283

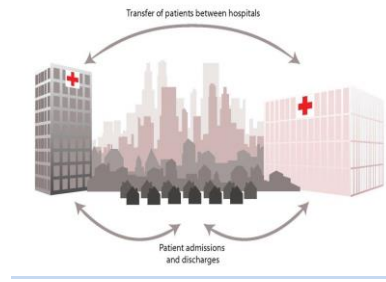
Findings of Fact:
Conclusions of Law And Order

4

Transfer



New provider



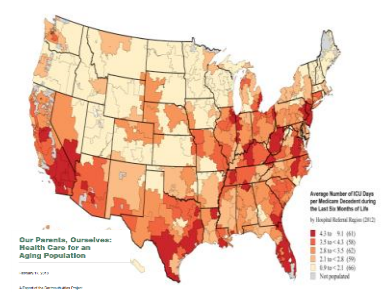
Rare

120

but

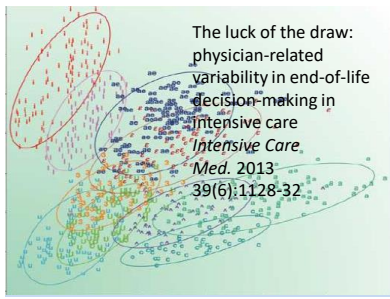
possible

121



1 Elements in 96 doctors' definitions of futility

Element of futility	Number of doctors
Nature of patient benefit	96 (100%)
Level of benefit	89 (93%)
Burdens outweigh benefits	75 (78%)
No benefit (will not work)	59 (61%)
Insignificant benefit (not sustained, not meaningful)	42 (44%)
Type of benefit	84 (88%)
Inadequate quality of life (independent of quantity of life)	76 (79%)
Does not provide quantity or quality of life	40 (42%)
No gain in physical functioning or symptom control	20 (21%)
Does not lengthen life (independent of quality of life)	14 (15%)
Overall outcome	81 (84%)
Death is imminent	66 (69%)
Would not address underlying terminal condition or change ultimate outcome	60 (63%)
Not reversible	28 (29%)
Investigation would not change management	5 (5%)
Does not achieve a goal of treatment (patient, family, doctor)	45 (47%)
Benefit generally (not further defined)	27 (28%)
Prospect of patient benefit	70 (73%)
Insignificant or low chance of benefit	59 (61%)
No chance of benefit	31 (32%)
Below numeric threshold of success for specific cases (range of answers, <0.9% to 10%)	18 (19%)
Below numeric threshold of success applicable to all cases (range of answers, <0.9% to 10%)	4 (4%)
Not worth the resources	17 (18%)



The luck of the draw: physician-related variability in end-of-life decision-making in intensive care *Intensive Care Med.* 2013 39(6):1128-32

Fail

No consent

No replacement

No transfer

When may / should / must a clinician stop LSMT <u>without</u> consent?

It depends

3 types of LSMT

Futile

Proscribed

Potentially inappropriate

AMERICAN THORACIC SOCIETY DOCUMENTS

Categories outlined in a new multi-society policy statement

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,

AMERICAN THORACIC SOCIETY 1905 ATS

We help the world breathe

PULMONARY • CRITICAL CARE • SLEEP

Society of Critical Care Medicine

The Intensive Care Professionals

AMERICAN COLLEGE OF CHEST PHYSICIANS

The Global Leader in Clinical Chest Medicine

AACN

ESICM
EUROPEAN SOCIETY OF INTENSIVE CARE MEDICINE

"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."

Conceptual clarity

↓

Ethical clarity

Futile

Proscribed

Potentially inappropriate

Futile

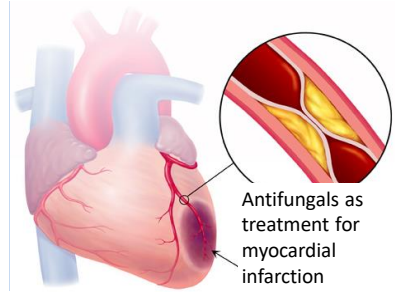
5 of 8

Interventions **cannot** accomplish physiological goals

Scientific impossibility

Example 1

Example 2

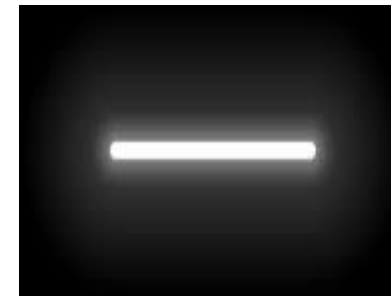


Example 3

Example 4

“Futile”

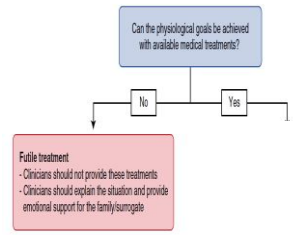
Value free objective



May the clinician stop LSMT?

“Futile”

May & should refuse



Futile

Proscribed

Potentially inappropriate

Proscribed

6 of 8

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

Not "futile"

Laws or public policies

Prohibit

or

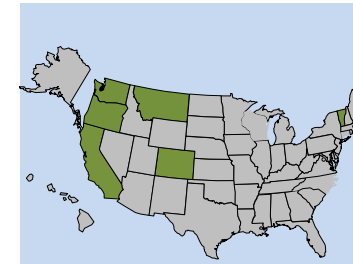
Permit limiting

Prohibited provision

Example 1

Example 2

Example 3



Proscribed

2

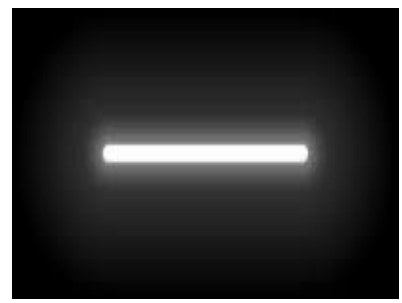
Laws or public policies

Prohibit

or

Permit limiting

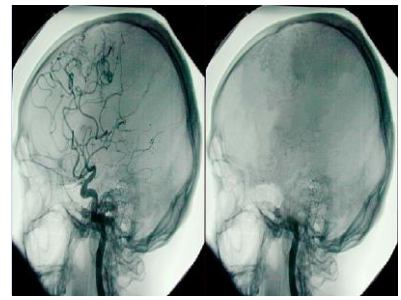
Permitted limiting



Surrogate

Appropriate medicine

Example 1



total brain failure = death

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**."

Example 2

Trisomy 18

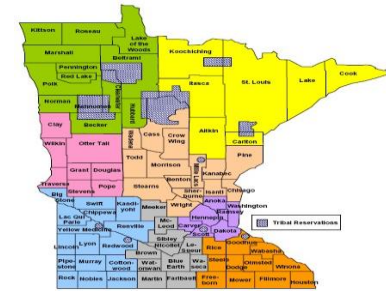
22-week gestation

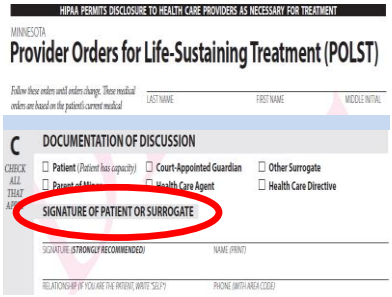
ECMO

Example 3

Also disaster plans

Example 4




HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT

MINNESOTA

Provider Orders for Life-Sustaining Treatment (POLST)

Follow these orders until orders change. These medical orders are based on the patient's current medical

LAST NAME FIRST NAME MIDDLE INITIAL

C DOCUMENTATION OF DISCUSSION

CHECK ALL THAT AP

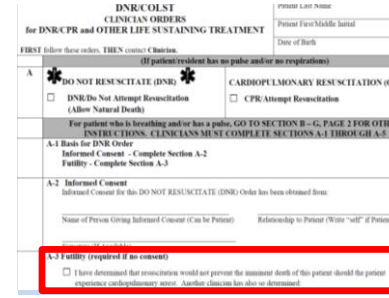
☐ Patient (Patient has capacity) ☐ Court-Appointed Guardian ☐ Other Surrogate

☐ Health Care Agent ☐ Health Care Directive

SIGNATURE OF PATIENT OR SURROGATE

SIGNATURE (STRONGLY RECOMMENDED) NAME (PRINT)

RELATIONSHIP (IF YOU ARE THE PATIENT, WRITE "SELF") PHONE (WITH AREA CODE)


DNR/COLST

CLINICIAN ORDERS for DNR/CPR and OTHER LIFE SUSTAINING TREATMENT

Patient Last Name

Patient First/Middle Initial

Date of Birth

FIRST follow these orders, THEN contact Clinician.

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

A

✱DO NOT RESUSCITATE (DNR)✱

☐ DNR/Do Not Attempt Resuscitation (Allow Natural Death)

CARDIOPULMONARY RESUSCITATION (CPR)

☐ CPR/Attempt Resuscitation

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

A-1 Basis for DNR Order

Informed Consent - Complete Section A-2

Futility - Complete Section A-3

A-2 Informed Consent

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

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

A-3 Futility (required if no consent)

☐ I have determined that resuscitation would not prevent the imminent death of this patient should the patient experience cardiopulmonary arrest. Another clinician has also so determined

Not ATS "futility"

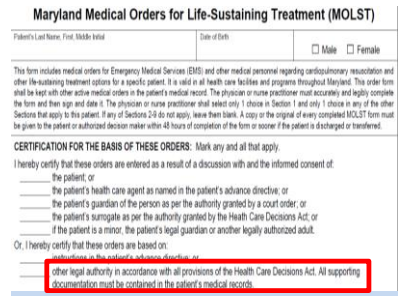
Might restore CP function

"imminent death"

3 days

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

Permitted limiting



Maryland Medical Orders for Life-Sustaining Treatment (MOLST)

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

This form includes medical orders for Emergency Medical Services (EMS) and other medical personnel regarding cardiopulmonary resuscitation and other life-sustaining treatment options for a specific patient. It is valid in all health care facilities and programs throughout Maryland. This order form shall be kept with other active medical orders in the patient's medical record. The physician or nurse practitioner must accurately and legibly complete the form and then sign and date it. The physician or nurse practitioner shall select only 1 choice in Section 1 and only 1 choice in any of the other Sections that apply to this patient. If any of Sections 2-9 do not apply, leave them blank. A copy or the original of every completed MOLST form must be given to the patient or authorized decision maker within 48 hours of completion of the form or sooner if the patient is discharged or transferred.

CERTIFICATION FOR THE BASIS OF THESE ORDERS: Mark any and all that apply.

I hereby certify that these orders are entered as a result of a discussion with and the informed consent of:

_____ the patient; or
_____ the patient's health care agent as named in the patient's advance directive; or
_____ the patient's guardian of the person as per the authority granted by a court order; or
_____ the patient's surrogate as per the authority granted by the Health 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 supporting documentation must be contained in the patient's medical records.

"medically ineffective"

"[not] prevent the **impending death**"

imminent **=** impending

Permitted limiting

Laws or public policies

Prohibit

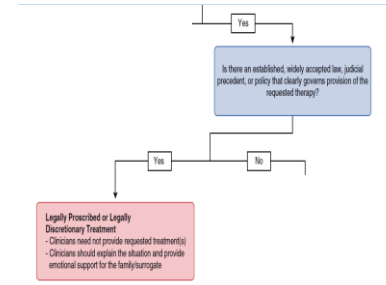
or

Permit limiting

May the clinician stop LSMT?

Proscribed

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"

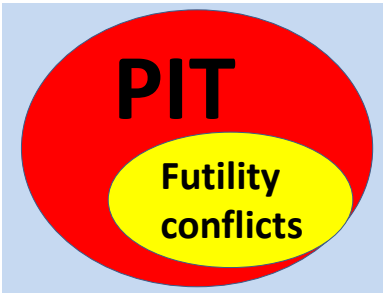
. . . BUT . . .

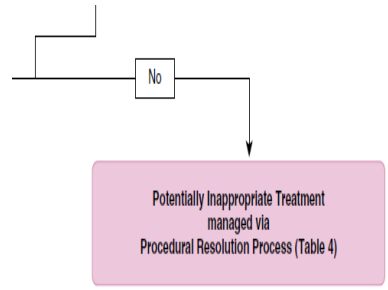
Disputed treatment **might** keep patient alive.

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

Not a medical judgment

Value judgment





"potentially"

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.

Turn to

Legal focus

Clinician family conflict

231

Not futile

Not proscribed

232

Potentially inappropriate

233

No surrogate consent

No "new" surrogate

No transfer

234

May you stop LSMT?

235

Traffic Lights

236

Many clinicians want a green light

238

1999

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

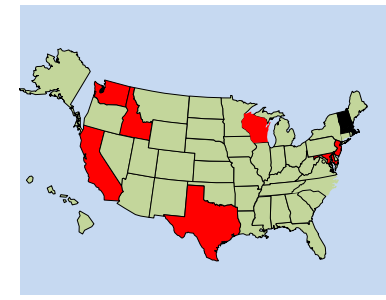
Give the surrogate

48hr notice RC

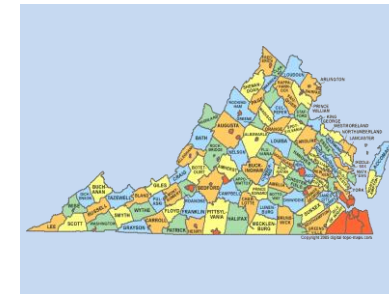
Written decision RC

10 days to transfer

Stop LSMT without consent



BUT



Consent **always**

254

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 3080.5(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 listed 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

1-800-381-4519 (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 _____

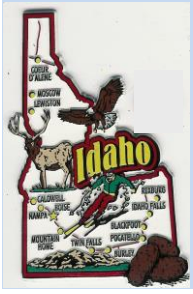
Signature _____

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

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

264

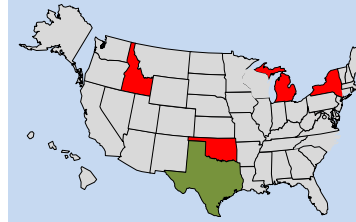


Discrimination in Denial of Life Preserving Treatment Act

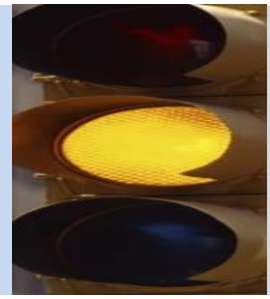
265

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

266



Everywhere else not sure



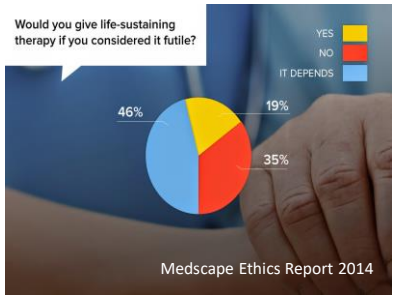
No explicit permission

No explicit prohibition

Typical response

"follow the . . . SDMs **instead** of doing what they feel is appropriate . . ."

CMAJ 2007;177(10):1201-8



Patient will die soon

Provider will round off

Nurses bear brunt

How to proceed

280

1

281

Overt & Open

282

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

286

Secretive

Insensitive

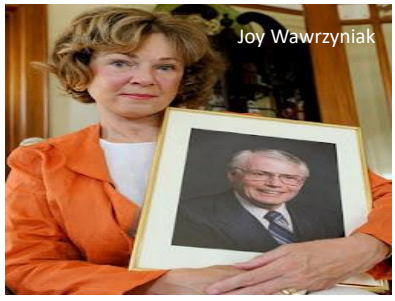
Outrageous

287

Consultation expected

Distress foreseeable

288



2

293

Transparent enough

294

Seek assent

Not consent

295

Announce plan:
"We are going to…"

Silence = assent

296

Open ended question

More directive

3

Standard of Care

Very little judicial, legislative, or regulatory guidance

Sept. 2016

Society of Critical Care Medicine

The Intensive Care Professionals

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

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

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

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