Medical Futility: Top Two Formal Mechanisms for Resolving Intractable Disputes

Department of Population Health, NYU Langone Medical Center • Feb. 26, 2015

Thaddeus Mason Pope, J.D., Ph.D.
Hamline University Health Law Institute

Must a Death Panel be a Star Chamber?

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Should we delegate the resolution of treatment disputes to a tribunal **other** than a court?

Quinlan yes

Saikewicz no

"questions of life and death . . . require . . . detached but passionate investigation and decision that forms the ideal on which the **judicial branch** . . . was created . . . not to be entrusted to any other group"

What do we want that alternative tribunal to look like?

Prefatory Remarks

No relevant conflicts to declare

ThaddeusPope.com

Roadmap

Background & Context

- Definition
- Prevalence
- Typical dispute resolution (informal)

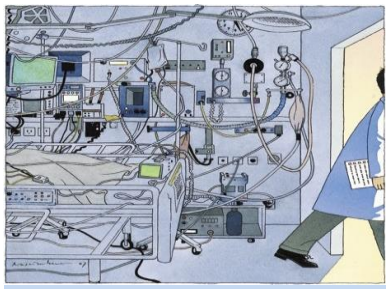
TADA

CCB

What is a medical futility dispute

Surrogate driven over-treatment

3 key attributes



Clinician	Surrogate
CMO	LSMT

Disputed treatment **might** keep patient alive.

Value laden

E.g. dialysis for permanently unconscious patient

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

Prevalence

"Conflict . . . in ICUs . . . epidemic proportions"

13%

ethics consults

MEMORIAL SLOAN-KETTERING CANCER CENTER

J. Oncology Practice (June 2013)

> 33%

ethics consults

University of Michigan Health System

Physician Executive Journal (37 no. 6)

> 50%

ethics consults

Lucile Packard Children's Hospital AT STANFORD

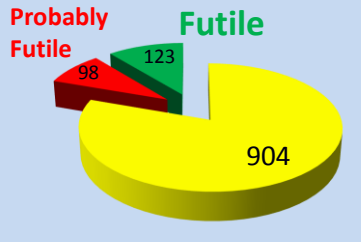
Am. J. Bioethics (Apr. 2009)

Original Investigation

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

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

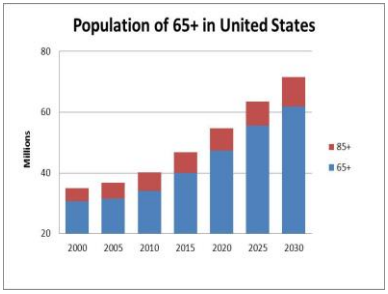
JAMA Intern Med. 2013;173(20):1887-1894. doi:10.1001/jamainternmed.2013.10261
Published online September 9, 2013.



Views About End-of-Life Treatment Over Time

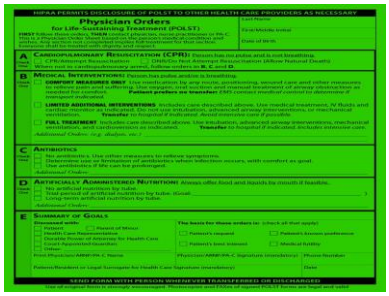
% of U.S. adults

	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	



Prevent Disputes

Most patients do **NOT** want futile treatment


HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

A CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.

B MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.

C ANTIBIOTICS

D ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food and liquids by mouth if feasible.

E SUMMARY OF GOALS

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED


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

PCIA

18-29	15%
30-49	33%
50-64	38%
65-74	61%
75+	58%

30%

want LSMT

Disputes

will arise

Typical dispute resolution

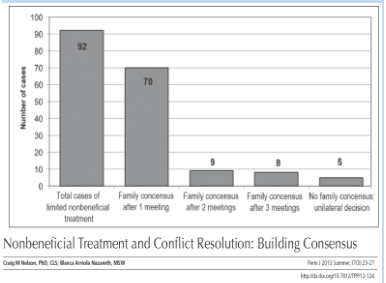
Consensus

Intractable

Negotiation

Mediation

95%



Nonbeneficial Treatment and Conflict Resolution: Building Consensus

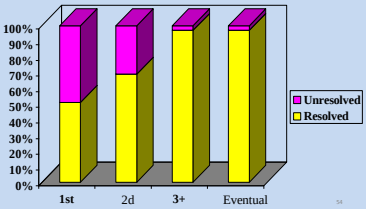
Prendergast (1998)

57% agree immediately

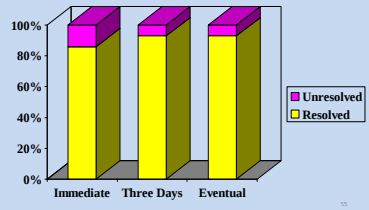
90% agree within 5 days

96% agree after more meetings

Garros et al. (2003)



Fine & Mayo (2003)



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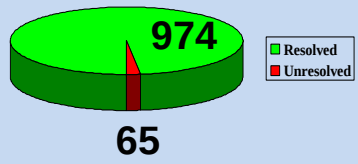
Hooser (2006)



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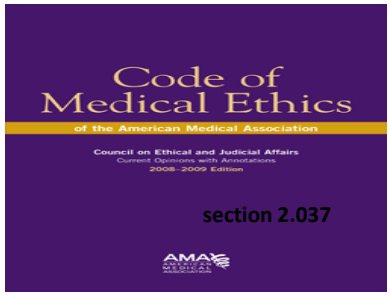
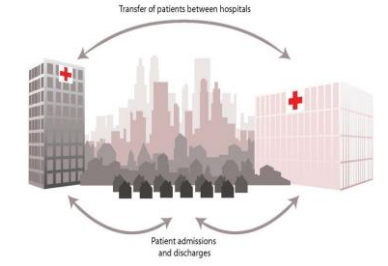


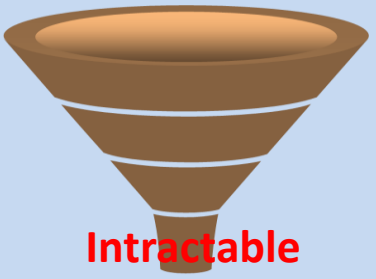
5%

58

Transfer

59

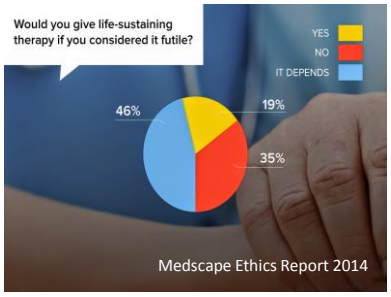


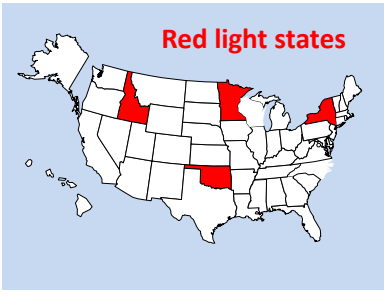


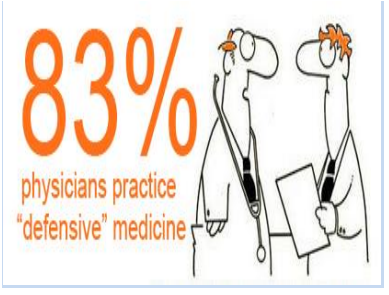
Cave-in

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

CMAJ 2007;177(10):1201-8





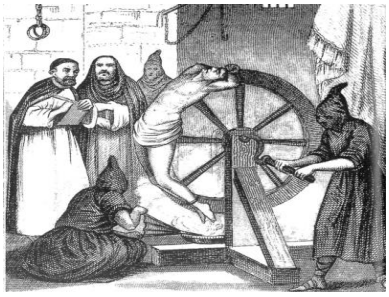


Patient will die soon

Provider will round off

Nurses bear brunt

Bad results



"This is the Massachusetts General Hospital, not Auschwitz."

"not . . . much difference . . . atrocities in Bosnia"

ED patients boarded & denied / delayed ICU

Community hospital patients denied / delayed ICU

Feb 2015

700 acute care clinicians

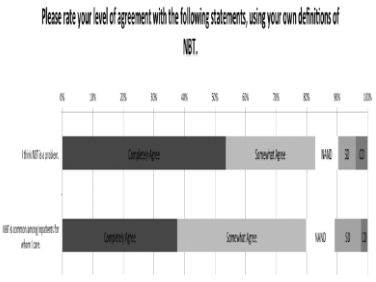


TABLE 3. Support for Proposed Solutions to Nonbeneficial Treatment

Proposed Solution	Effective (% "Somewhat" or "Completely" Agree)	Morally Acceptable (% "Somewhat" or "Completely" Agree)
Creating and implementing committees (with medical and nonmedical representatives) who could be consulted to resolve cases that are felt to be NBT. These committees would issue binding decisions about the care to be provided	61	60

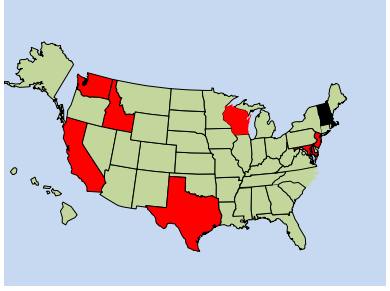
DOI: 10.1097/CCM.0000000000000704

Clinicians want Adjudicators

Cumbersome
Time consuming
Expensive

Custom designed mechanism

Faster
Cheaper
Better



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

CA

Reference Committee E

October 4-6, 2008

WASHINGTON STATE MEDICAL ASSOCIATION
HOUSE OF DELEGATES

WA

Resolution: C-5 (A-09)

Subject: Legal Protection for Physicians When Treatment is Considered Futile

Introduced by: King County Medical Society Delegation

Referred to: Reference Committee C

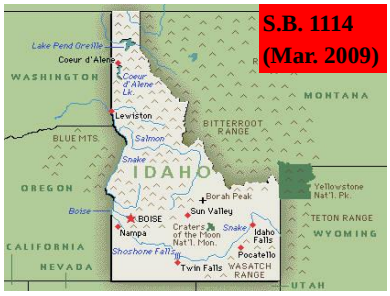
RESOLUTION 1 - 2004
(read about the *action* taken on this resolution)

WI

Subject: Futility of Care

Introduced by: Michael Katzoff, MD and the Medical Society of Milwaukee County

RESOLVED, That the Wisconsin Medical Society, concurrent with a recommendation of the American Medical Association, Medical Futility in End-of-Life Care policy E-2.037, supports the passage of state legislation which establishes a legally sanctioned extra-judicial process for resolving disputes regarding futile care, modeled after the Texas Advanced Directives Act of 1999.



S.B. 1114 (Mar. 2009)

NJHA
NEW JERSEY HOSPITAL ASSOCIATION

MSNJ
MEDICAL SOCIETY of NEW JERSEY
Est. 1766

NYSBA

New York State Bar Association

Health Law Section

Summary Report on Healthcare Costs: Legal Issues, Barriers and Solutions

September, 2009

TADA

Comprehensive legislation on healthcare decisions

M.D. may stop LSMT for

any reason

with immunity

if HEC agrees

Tex. H&S 166.046

6 steps

Step 1

Attending refers to "review committee"

HEC

MARC

Step 2

Hospital provides notice to surrogate

Step 3

Open meeting

Step 4

Review committee decides & serves "written explanation"

Step 5

Attempt to transfer (10 days)

Step 6

Treating hospital may stop LSMT

Safe harbor legal immunity

Texas Medical Association

Fairness problems

There are few **substantive** criteria for identifying inappropriate EOL treatment

- Brain death
- Anencephaly
- Physiological futility

No substantive criteria

↓

Pure procedural justice

If process is **all** you have, it must have **integrity & fairness**

TADA's 6 steps are **not** adequate

TADA decisions too vulnerable to **4 risks**

Corruption

self-interest

Carelessness

ill-considered

ill-supported

Bias

disparaging to certain class

Arbitrariness

Abuse of process norms like notice

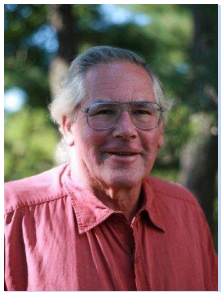
Procedural Due Process

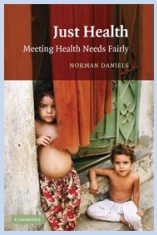
123

Life
Liberty
Property

Notice
Opportunity to present
Opportunity to confront
Statement of decision
Independent decision-maker
Judicial review

Fundamental fairness





Neutral & independent decision maker

<u>Who</u> Makes the decision?

Intramural institutional ethics committee

But the HEC is controlled by the hospital

TADA recognizes need for some "independent" check

- Requires HEC review
- Prohibits referring physician from serving on HEC

1-5 members 48%

5-10 members 34%

Mostly physicians, administrators, nurses

No community member requirement, like IRB

< 10% TX HECs have community member

COI

More documented

More targeted

Ruben Betancourt (NJ)

Brianna Rideout (PA)

James Bland (TX)

Kalilah Roberson-Reese (TX)

Statement of Decision

Provide rationale

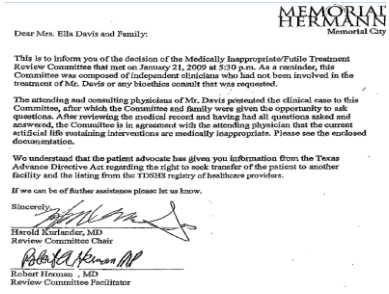
Factual basis

Considered, supported

Issues that were identified and considered:

Seton Family of Hospitals

- The treatment team is in agreement that this [illegible] terminal and irreversible condition which will result in his death.
- There is significant concern that this patient is suffering from pain related to his clinical condition.
- Dr. Wilson, Emilio's current attending physician, other physicians and other members of the patient care team believe Emilio is suffering and that the burdens associated with his current plan of care far outweigh any benefits that Emilio may be receiving.



MEMORIAL HERMANN Memorial City

Dear Mrs. Ella Davis and Family:

This is to inform you of the decision of the Medically Inappropriate/Futile Treatment Review Committee that met on January 21, 2009 at 5:30 p.m. As a reminder, this Committee was composed of independent clinicians who had not been involved in the treatment of Mr. Davis or any bioethics consult that was requested.

The attending and consulting physicians of Mr. Davis presented the clinical case to this Committee, after which the Committee and family were given the opportunity to ask questions. After reviewing the medical record and having had all questions asked and answered, the Committee is in agreement with the attending physician that the current artificial life sustaining interventions are medically inappropriate. Please see the enclosed documentation.

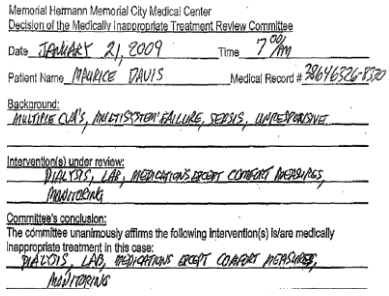
We understand that the patient advocate has given you information from the Texas Advance Directive Act regarding the right to seek transfer of the patient to another facility and the listing from the TDSHS registry of healthcare providers.

If we can be of further assistance please let us know.

Sincerely,

Harold Kurlander, MD
Review Committee Chair

Robert Herman, MD
Review Committee Facilitator



Memorial Hermann Memorial City Medical Center
Decision of the Medically Inappropriate Treatment Review Committee

Date JANUARY 21, 2009 Time 7 PM

Patient Name MAURICE DAVIS Medical Record # 3864652G-8320

Background:
MULTIPLE CVA's, MULTISYSTEM FAILURE, SEPSIS, UNRESPONSIVE

Intervention(s) under review:
DIALYSIS, LAB, MEDICATIONS EXCEPT COMFORT MEASURES, MONITORING

Committee's conclusion:
The committee unanimously affirms the following intervention(s) is/are medically inappropriate treatment in this case:
DIALYSIS, LAB, MEDICATIONS EXCEPT COMFORT MEASURES, MONITORING

TADA specifies no minimum form or content

Other due process problems

Only **48 hours** to prepare for the review committee meeting – notice often on FRI

Surrogate may **attend**.

But unclear right to **participate**

TADA is **silent** not only on substantive criteria but also on procedures and methodology

- *E.g.* quorum
- *E.g.* voting

No judicial review

HEC is forum of last resort

CCB

Ontario

Consent and Capacity Board

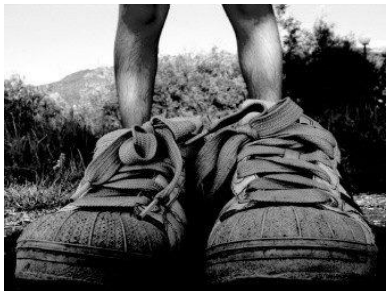
149

1995

Health Care Consent Act
Mental Health Act
Substitute Decisions Act
Long-Term Care Act

150

Surrogate replacement



Substituted judgment

Best interests

154

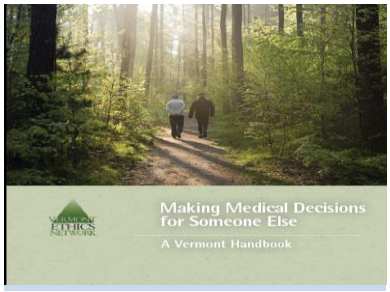
~ 60%

accuracy

More

aggressive treatment

156



Ontario

Consent and Capacity Board

159

Surrogate	Advance directive
GO	STOP

160

Surrogate	Known wishes
GO	STOP

161

Surrogate	Best interests
GO	STOP

162

Responsive

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APPLICATION TO DETERMINE SDM COMPLIANCE WITH REGARD TO TREATMENT (FORM G)

The Applicant believes that the SDM is not complying with the principles for giving or refusing substitute consent. (See s. 21 (1), (2), HCCA)

How is the SDM not complying with the principles for giving or refusing substitute consent?

Hearing within 7 days

165

Decision within 1 day of hearing

166

Independent

Neutral

167

Psychiatrist
Lawyer
Public member

168

Board members are trained

169

Rules of procedure

170

Ontario

CONSENT AND CAPACITY BOARD
RULES OF PRACTICE

5.4 If it appears to the Board, prior to the commencement of or at any time during the hearing, that the subject of the application will not have legal representation at the hearing, the Board may exercise its powers under section 81 of the *Health Care Consent Act, 1996* to arrange legal representation for that person.

High quality written decisions

172

Judicial review

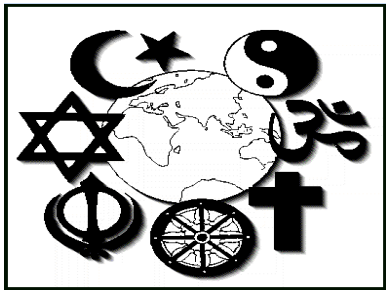
173

Limits

175

Surrogates

loyal & faithful

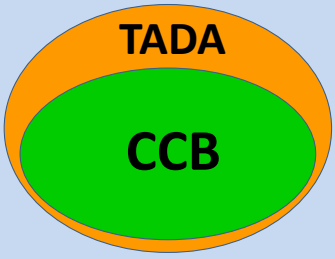


CCB can only replace “bad” surrogates

180

Under TADA can determine a "good" surrogate has made a "bad" decision

CCB evaluates only the decision **maker** not the decision itself



CA IL
NY NJ

DDNC accommodation

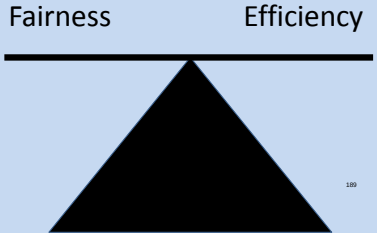
Most benefits TADA **without** the affront to principles

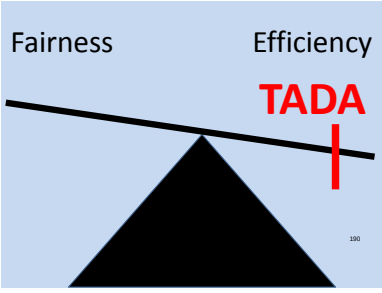
Conclusion

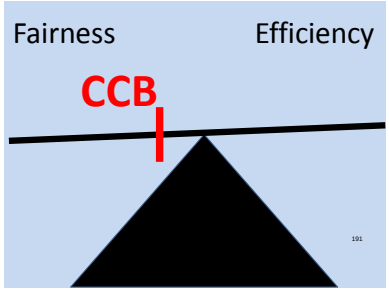
2 objectives for DR mechanisms

Fair

Efficient







As states look for models to follow, CCB beats TADA

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B medicalfutility.blogspot.com

References

Medical Futility Blog

Since July 2007, I have been blogging, almost daily, to **medicalfutility.blogspot.com**. This blog is focused on reporting and discussing legislative, judicial, regulatory, medical, and other developments concerning medical futility and end-of-life medical treatment conflict. The blog has received over 750,000 direct visits. Plus, it is distributed through RSS, email, Twitter, and re-publishers like Westlaw, Bioethics.net, Wellsphere, and Medpedia.

Pope TM & White DB, *Patient Rights, in* OXFORD TEXTBOOK OF CRITICAL CARE (2d ed., Webb et al., eds., forthcoming 2014).

Pope TM & White DB, *Medical Futility, in* OXFORD HANDBOOK OF DEATH AND DYING (Robert Arnold & Stuart Younger eds., forthcoming 2014).

Pope, TM, *Legal Briefing: Brain Death and Total Brain Failure,* 25(3) J. CLINICAL ETHICS (2014)

Pope TM, *Dispute Resolution Mechanisms for Intractable Medical Futility Disputes,* 58 N.Y.L. SCH. L. REV. 347-368 (2014).

Pope TM, *The Growing Power of Healthcare Ethics Committees Heightens Due Process Concerns*, 15 CARDOZO J. CONFLICT RESOLUTION 425-447 (2014).

White DB & Pope TM, *The Courts, Futility, and the Ends of Medicine,* 307(2) JAMA 151-52 (2012).

Pope TM, *Physicians and Safe Harbor Legal Immunity,* 21(2) ANNALS HEALTH L. 121-35 (2012).

Pope TM, *Medical Futility, in* GUIDANCE FOR HEALTHCARE ETHICS COMMITTEES ch.13 (MD Hester & T Schonfeld eds., Cambridge University Press 2012).

Pope TM, *Review of* LJ Schneiderman & NS Jecker, Wrong Medicine: Doctors, Patients, and Futile Treatment, 12(1) AM. J. BIOETHICS 49-51 (2012).

Pope TM, *Responding to Requests for Non-Beneficial Treatment*, 5(1) MD-ADVISOR: A J FOR THE NJ MED COMMUNITY (Winter 2012) at 12-17.

Pope TM, *Legal Fundamentals of Surrogate Decision Making*, 141(4) CHEST 1074-81 (2012).

199

Pope TM, *Legal Briefing: Medically Futile and Non-Beneficial Treatment*, 22(3) J. CLINICAL ETHICS 277-96 (Fall 2011).

Pope TM, *Surrogate Selection: An Increasingly Viable, but Limited, Solution to Intractable Futility Disputes*, 3 ST. LOUIS U. J. HEALTH L. & POL'Y 183-252 (2010).

Pope TM, *Legal Briefing: Conscience Clauses and Conscientious Refusal,* 21(2) J. CLINICAL ETHICS 163-180 (2010).

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Pope TM, *The Case of Samuel Golubchuk: The Dangers of Judicial Deference and Medical Self-Regulation*, 10(3) AM. J. BIOETHICS 59-61 (Mar. 2010).

Pope TM, *Restricting CPR to Patients Who Provide Informed Consent Will Not Permit Physicians to Unilaterally Refuse Requested CPR*, 10(1) AM. J. BIOETHICS 82-83 (Jan. 2010).

Pope TM, *Legal Briefing: Medical Futility and Assisted Suicide*, 20(3) J. CLINICAL ETHICS 274-86 (2009).

201

Pope TM, *Involuntary Passive Euthanasia in U.S. Courts: Reassessing the Judicial Treatment of Medical Futility Cases*, 9 MARQUETTE ELDER'S ADVISOR 229-68 (2008).

Pope TM, *Institutional and Legislative Approaches to Medical Futility Disputes in the United States,* Invited Testimony, President's Council on Bioethics (Sept. 12, 2008).

202

Pope TM, *Medical Futility Statutes: No Safe Harbor to Unilaterally Stop Life-Sustaining Treatment*, 75 TENN. L. REV. 1-81 (2007).

Pope TM, *Mediation at the End-of-Life: Getting Beyond the Limits of the Talking Cure*, 23 OHIO ST. J. ON DISP. RESOL. 143-94 (2007).

Pope TM, *Philosopher's Corner: Medical Futility,* 15 MID-ATLANTIC ETHICS COMM. NEWSL, Fall 2007, at 6-7

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