May 15, 2024

Futile, Non-Beneficial, & Potentially Inappropriate Treatment

Pivotal Strategies for Avoiding and Resolving Conflict

when & how to **say no**

Thaddeus Mason Pope

JD, PhD, HEC-C

nothing to disclose

STATE OF WASHINGTON
WASHINGTON MEDICAL COMMISSION

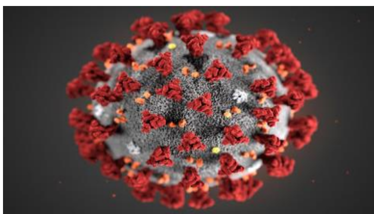
In the Matter of the License to Practice as a Physician and Surgeon of: WEI-HSUNG LIN, MD License No. MD.MD.60207016 Respondent.	No. M2022-202 STIPULATED FINDINGS OF FACT, CONCLUSIONS OF LAW, AND AGREED ORDER

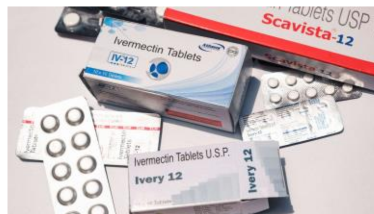
May 2, 2024

$5000 fine

compliance audits

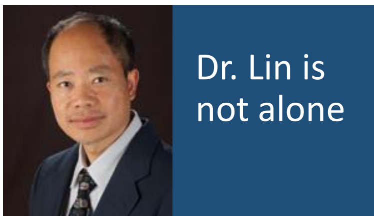
CME





MERCK

no scientific basis …
no meaningful evidence …
concerning **lack** of safety data …

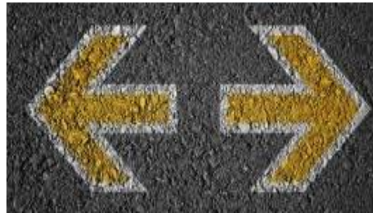


Dr. Lin is not alone

Richard Wilkinson
Michael K Turner
Miguel R. Antonatos
Guito Cassagnol Wingfield

WASHINGTON
Medical Commission
Licensing. Accountability. Leadership.

don't administer ineffective & non-beneficial therapies



"patient has **[no] right** to force a medical provider to provide … treatment against … professional judgment"

no "self-determination right to compel medical treatment"

but

catastrophically

critically ill

clinicians often

recommend **CMO**

surrogates

often **agree**

not always

surrogate driven
over-treatment

surrogate will **not**
consent to CMO
recommendation

clinician	**surrogate**
CMO	LST

appropriate	inappropriate

advisable	inadvisable

proportionate	disproportionate

beneficial

non-
beneficial

effective

ineffective

neglect
to stop Tx

abuse
to continue

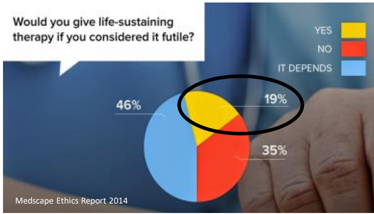
consistent
with
reasonable
medical
standards

contrary
to
reasonable
medical
standards

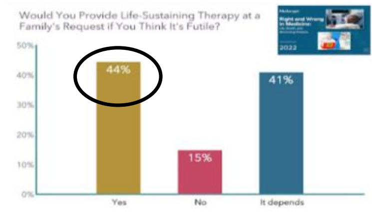
typical
response

cave-in

2014



2022



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

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

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

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

why?

common

“almost all cited **lack of legal support**”

“ethically … comfortable removing life support … but … **lingering concerns about being sued** …”

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

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

physicians round off

nurses bear brunt

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%

here **too**

status quo
= cave in

SO…

better
responses

roadmap

6 parts

1. prevalence
2. prevention

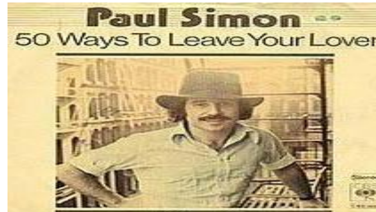
have a conflict

what can you **do**

3. consensus
4. **new** surrogate
5. **new** hospital

if **none** of
that works …

6. withdraw Tx
without consent



6 ways to resolve your NBT conflict

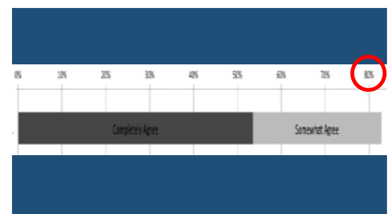
prevalence

intensivists
or
ethicists

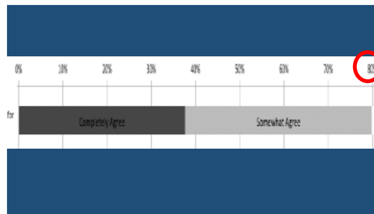
intensivists
measures

700
acute care
clinicians

"NBT is a **problem**"



"NBT is **common** among **my** inpatients"



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.

frontiers | Frontiers in Pediatrics

2024

Perceived potentially inappropriate treatment in the PICU: frequency, contributing factors and the distress it triggers

Amrita Sarpal, Michael R. Miller, Claudio M. Martin, Robert W. Sibbald and Kathy N. Speechley

Independent review: Disagreements in the care of critically ill children

Healthcare professionals' perspectives

NUFFIELD COUNCIL BIOETHICS

09/18/23

Disagreements and how they arise

New disagreements do not arise very frequently, but take up considerable time when they do

52%

78%

"conflict . . . in ICUs . . . **epidemic** proportions"

Critical Care Medicine

ethicists

measures

33% ethics consults

University of Michigan Health System

Physician Executive Journal (37 no. 6)

20% ethics consults

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

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

Katherine Wasson[1,2] · Emily Anderson[1] ·

15% ethics consults

2 futility cases **per month**

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

Ethics Consult Service Summary

Goal conflicts
- Team wants to stop treatment, family wants to continue (12)
- Team want to continue treatment, family wants to stop (4)
- Disagreement between family about course of treatment/goals of care (2)
- Internal disagreement between care team members (5)

Treatment decisions:
- Code Status (11)
- Discharge disposition (13)
- Goals of care, futility, non-beneficial or inappropriate treatment (20)
- Hastening death (3)
- Withholding/Withdrawing Treatment (8)

2 reasons

reason **1**

PewResearchCenter

NUMBERS, FACTS AND TRENDS SHAPING THE WORLD

NOV. 21, 2013

Views on End-of-Life Medical Treatments

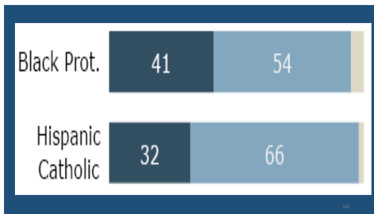
Growing Minority of Americans Say Doctors Should Do Everything Possible to Keep Patients Alive

Doctors and nurses should do everything possible to save the life of a patient in all circumstances

1990 15%

2005 22%

1990 15%
2005 22%
2013 31%



reason **2**

31%
Trust the US healthcare system as a whole

in sum

significant NBT

too much

prevention

most patients do **not want** NBT

JAMA Internal Medicine

JAMA Intern Med. 2020 Jun; 180(6): 907–909. PMCID: PMC713
Published online 2020 Apr 6. doi: 10.1001/jamainternmed.2020.0681 PMID: 3225

Seriously Ill Patients' Willingness to Trade Survival Time to Avoid High Treatment Intensity at the End of Life

Emily B. Rubin, MD, JD, MSHP, Anna Buehler, BA, and Scott D. Halpern, MD, PhD

9/10 **give up** year of life to avoid dying in ICU

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

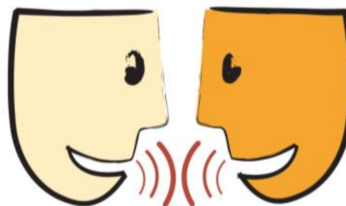
Question and Responses[a]	Public, % (n=1006)	Professionals, % (n=774)
If doctors believe there is no hope of recovery, which would you prefer?		
Life-sustaining treatments should be stopped and should focus on comfort	72.8	92.6

most surrogates
and clinicians want
the **same** thing

how
assure congruence

patient
or
surrogate

patient
interventions



preferences
goals
values

surrogate

interventions

1

ensure surrogate understands Pt **prognosis**

Journal of the Neurological Sciences 444 (2023) 120523

Contents lists available at ScienceDirect

Journal of the Neurological Sciences

journal homepage: www.elsevier.com/locate/jns

ELSEVIER

An evaluation of surrogate decision maker health literacy in the neurology ward and neuroscience ICU

Elizabeth Carroll[a,*], Julie Giles[a], Ariane Lewis[a,b]

"at least 1 of 5 core elements of shared decision making … **missing** from **95%** … family meetings"

explain patient's condition **prognosis**

elicit or assess **understanding**

robust evidence shows PDAs are highly effective

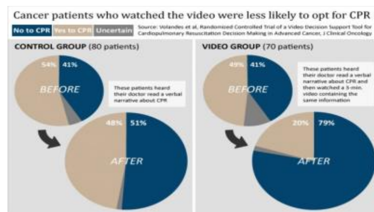
Contents lists available at ScienceDirect

PEC Innovation

journal homepage: www.elsevier.com/locate/pecinn

Measuring decision aid effectiveness for end-of-life care: A systematic review

M. Courtney Hughes, Erin Vernon, Chinenye Egwuonwu, Oluwatoyosi Afolabi



Pilot Randomized Clinical Trial of a Goals-of-Care Decision Aid for Surrogates of Patients With Severe Acute Brain Injury

Susanne Muehlschlegel, MD, MPH,* Kelsey Goostrey, MPH, Julie Flahive, MS, Qiang Zhang, BA, Jolanta J. Pach, BS, and David Y. Hwang, MD*

Neurology® 2022;99:e1446-e1455. doi:10.1212/WNL.0000000000200937

Correspondence
Dr. Muehlschlegel
susanne.muehlschlegel@umassmemorial.org

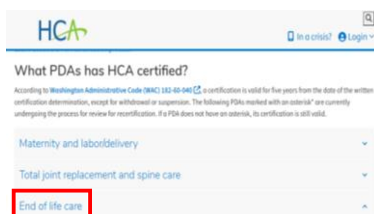
Shared Decision Making in ICUs: An American College of Critical Care Medicine and American Thoracic Society Policy Statement

Alexander A. Kon, MD, FCCM; Judy E. Davidson, DNP, RN, FCCM; Wynne Morrison, MD, MBE, FCCM; Marion Danis, M

available

and

certified



that's #1

ensure surrogate understands Pt **prognosis**

2

ensure surrogate understands **role** of surrogate

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] Deborah E. Barr

Honoring Choices MINNESOTA

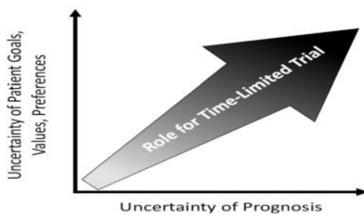
Advance Care Planning Information: Health Care Agent

Advance Care Planning
Knowing your voice is heard when making decisions about health care is important. Advance

Choosing a health care agent
Your health care agent should be someone you know well and trust to follow your wishes about future health care. Ideally, choose 1 health care agent and 1 or 2 backup (alternate) health care agents. A health care agent also is known as power-of-attorney for health care, substitute decision-maker, proxy or surrogate.

Making Medical Decisions for Someone Else: A Maryland Handbook

By
The American Bar Association Commission on Law and Aging



AMERICAN THORACIC SOCIETY DOCUMENTS

Defining the Time-limited Trial for Patients with Critical Illness
An Official American Thoracic Society Workshop Report

Jacqueline M. Kruser, Deepshikha C. Ashana, Katherine R. Courtright, Erin K. Kross, Thanh H. Neville, Eileen Rubin, Yael Schenker, Donald R. Sullivan, J. Daryl Thornton, Elizabeth M. Viglianti, Deena Kelly Costa, Claire J. Creutzfeldt, Michael E. Detsky, Heidi J. Engel, Neera Grover, Aluko A. Hope, Jason N. Katz, Rachel Kohn, Andrew G. Miller, Michael J. Nabozny, Judith E. Nelson, Hasan Shanawani, Jennifer P. Stevens, Alison E. Turnbull, Curtis H. Weiss, M. Jeanne Wirpsa, and Christopher E. Cox; on behalf of the American Thoracic Society Assembly on Behavioral Science and Health Services Research

better
communication

Addressing Futility: A Practical Approach

OBJECTIVES: Limiting or withdrawing nonbeneficial medical care is considered ethically responsible throughout most of critical care and medical ethics literature.

Piroska K. Kopar, MD, FACS
Adrienne Visani, BS

status quo

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.

Intensive life support is keeping her alive, including medicines to maintain her blood pressure and a breathing machine.

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?

Serious Illness Conversation Guide

CONVERSATION FLOW

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

seek **assent**

not consent

announce plan:

"we **are going** to…"

silence = assent

prevention

- AD / ACP
- surrogate training
- better communication

but

limits to prevention

66%

Do not have their wishes for end-of-life medical treatment in written document.

81%

Have never had a conversation with a healthcare provider about their wishes for end-of-life care.

RESPECTING PATIENTS' PREFERENCES

DOI: 10.1377/hlthaff.2017.0175
HEALTH AFFAIRS 36, NO. 7 (2017): 1244-1251
©2017 Project HOPE— The People-to-People Health Foundation, Inc.

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

systematic review of 150 studies

800,000 people

37%

not completed

even if AD completed

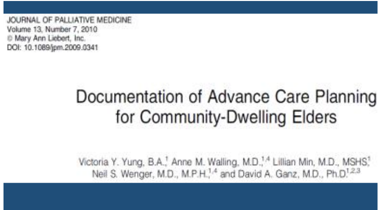
The New York Times
The New Old Age
Caring and Coping

OCTOBER 17, 2013, 6:00 AM
Where's That Advance Care Directive?
By PAULA SPAN

MISSING
Honoring Choices® PACIFIC NORTHWEST
AN INITIATIVE OF
Washington State Hospital Association | WSMA Foundation
PLEASE CALL KEVIN 123-456-789

U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

76% of physicians whose patients **have** ADs do not know they **exist**


JOURNAL OF PALLIATIVE MEDICINE
Volume 13, Number 7, 2010
© Mary Ann Liebert, Inc.
DOI: 10.1089/jpm.2009.0341

Documentation of Advance Care Planning for Community-Dwelling Elders

Victoria Y. Yung, B.A.,[1] Anne M. Walling, M.D.,[1,4] Lillian Min, M.D., MSHS,[1] Neil S. Wenger, M.D., M.P.H.,[1,4] and David A. Ganz, M.D., Ph.D.[1,2,3]

"among patients who … completed an advance directive … **15% … in the medical record**"

complete

≠

have

Pt have

≠

HCP have

plus,

even with

better ACP

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

if cannot **prevent** conflict

---

how can you **resolve** it

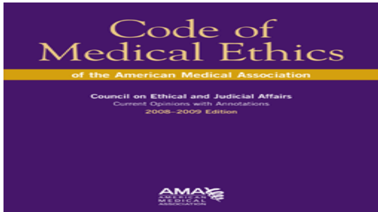
consensus

most hospital policies

most society guidelines

negotiation

mediation



4 of 7 steps

1. earnest attempts … deliberate … **negotiate**

2. **joint** decision making … maximum extent

3. attempts … **negotiate** … reach resolution

4. involve … **ethics committee**

Medically Non-Beneficial Treatment (MNBT)

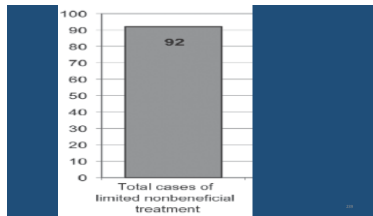
why?

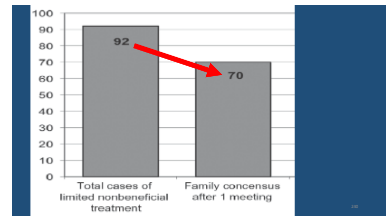
95%

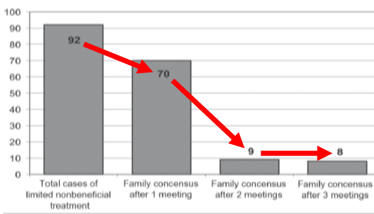
Nonbeneficial Treatment and Conflict Resolution: Building Consensus

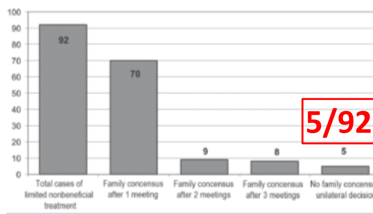
Craig M Nelson, PhD, CLS; Blanca Arriola Nazareth, MSW

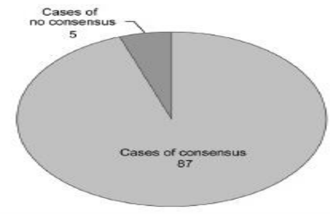
Perm J 2013 Summer;17(3):23-27











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.

57% agree immediately

90% agree within 5 days

96% agree after more meetings

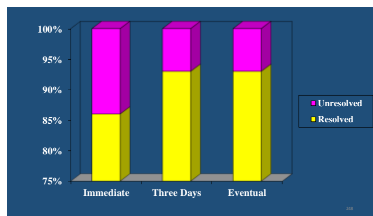
Resolution of Futility by Due Process: Early Experience with the Texas Advance Directives Act

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

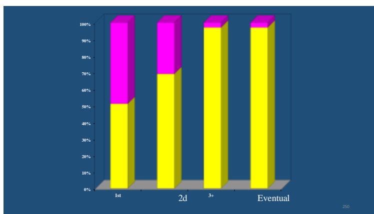
For author affiliations, see end of text.



Circumstances Surrounding End of Life in a Pediatric Intensive Care Unit

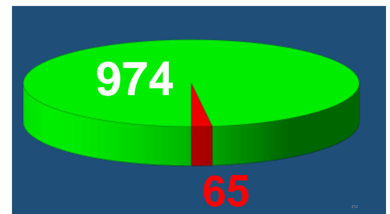
Daniel Garros, MD*; Rhonda J. Rosychuk, PhD‡; and Peter N. Cox, MD*

PEDIATRICS Vol. 112 No. 5 November 2003



Dallas Morning News

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



not always

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] ·

Bioethical Inquiry
https://doi.org/10.1007/s11673-023-10270-7

ORIGINAL RESEARCH

Declining to Provide or Continue Requested Life-Sustaining Treatment: Experience With a Hospital Resolving Conflict Policy

Emily B. Rubin · Ellen M. Robinson ·
M. Cornelia Cremens · Thomas H. McCoy ·
Andrew M. Courtwright

Original research

Can mediation avoid litigation in conflicts about medical treatment for children? An analysis of previous litigation in England and Wales

Veronica Neefjes

2023

Arch Dis Child: first published a

95%

darn good

consensus

intractable

5%

but

tried reach consensus

intensive communication

mediation

still no consent

surrogate	clinician		
		stop	go
	stop		
	go	X	

replace surrogate

get consent from **new** surrogate

substituted judgment

best interests

Rev. Code Wash.

§ 11.25.140

agents

health care agent must "act **in accordance** with the principal's reasonable expectations . . . otherwise, in … best interest"

Rev. Code Wash.

§ 7.70.065

default surrogate

"first determine … that **patient … would** … in the patient's best interests"

Rev. Code Wash.

§ 11.130.325

guardian

"decision the … **adult would make** if … able … in accordance with the best interests"

responsibility of the surrogate

act **consistently** with patient's known desires

otherwise, act in patient's **best interest**

but

~ 60%
accurate

more
aggressive
treatment

surrogates
often make
bad decisions

incongruent
patient wishes
or
patient best interests

Code of
Medical Ethics
of the American Medical Association

"surrogate's decision …
almost always accepted"

educate
support

Pilot Randomized Clinical Trial of a Goals-of-Care Decision Aid for Surrogates of Patients With Severe Acute Brain Injury

Susanne Muehlschlegel, MD, MPH,* Kelsey Goostrey, MPH, Julie Flahive, MS, Qiang Zhang, BA, Jolanta J. Pach, BS, and David Y. Hwang, MD*

Neurology® 2022;99:e1446-e1455. doi:10.1212/WNL.0000000000200937

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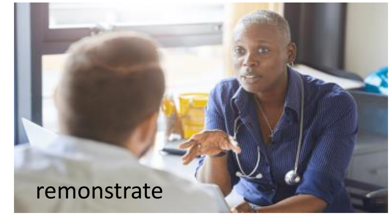
Dr. Muehlschlegel
susanne.muehlschlegel@umassmemorial.org

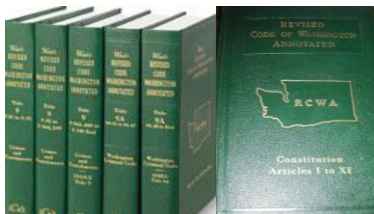
Advance Care Planning
Knowing your voice is heard when making decisions about health care is important. Advance

Choosing a health care agent
Your health care agent should be someone you know well and trust to follow your wishes about future health care. Ideally, choose 1 health care agent and 1 or 2 backup (alternate) health care agents. A health care agent also is known as *power-of-attorney for health care, substitute decision-maker, proxy* or *surrogate.*



but

clinicians should **not** follow "bad" surrogates



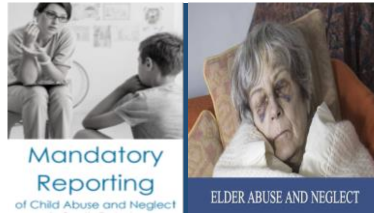
Rev. Code Wash. § 11.25.140

terminate agents

surrogate replacement **works**

models

for this

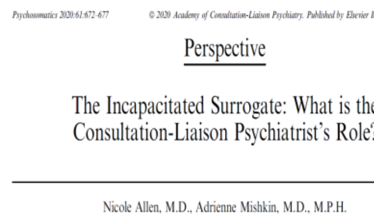


reasons

to challenge

surrogate lacks

capacity



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.

surrogate has material **COI**

AD →

← surrogate

known wishes →

← surrogate

“**dad** would not have wanted X”

“but **I**, just can’t let go”

5

if no AD or known wishes

best interest →
← surrogate

sometimes surrogates should be **challenged**

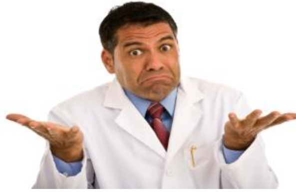
sometimes surrogate should even be **replaced**

but

limits to surrogate replacement

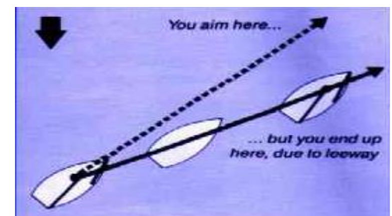
1

providers **cannot** show deviation

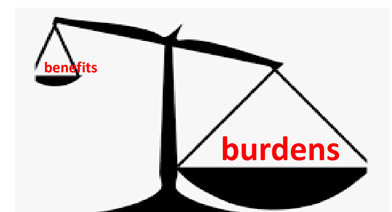


2

surrogates get benefit of doubt



SO...



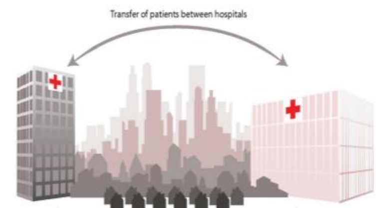
3

surrogates
are **faithful**

no new surrogate?

try new **hospital**

transfer



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

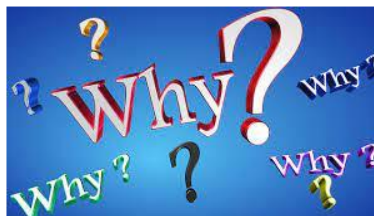
Lois Snyder Sulmasy, JD, and Thomas A. Bledsoe, MD; for the ACP Ethics, Professionalism and Human Rights Committee*

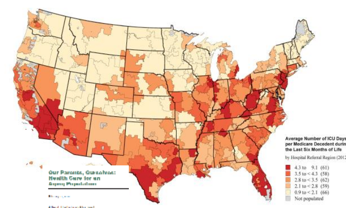
340

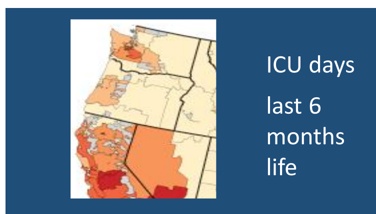
rare

but

possible





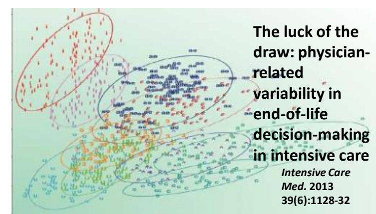


ICU days

last 6 months life

physician

variability



What does "futility" mean? An empirical study of doctors' perceptions

Ben White et al
Med J Aust 2016; 204 (8):318
doi: 10.5694/mja15.01103

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, < 0.1% to 10%)	18 (19%)
Below numeric threshold of success applicable to all cases (range of answers, < 0.1% to 10%)	4 (4%)
Not worth the resources	17 (18%)

hospital
variability

July 3, 2023
Hospital Culture and Intensity of End-of-Life Care at 3 Academic Medical Centers
Elizabeth Dzeng, MD, PhD, MPH[1,2,3]; Jason N. Batten, MD, MA[4,5]; Daniel Dohan, PhD[2]; et al
Author Affiliations
JAMA Intern Med. Published online July 3, 2023. doi:10.1001/jamainternmed.2023.2450

[Humanities in CHEST Medicine Original Research] CHEST
Hospital Policy Variation in Addressing Decisions to Withhold and Withdraw Life-Sustaining Treatment
Gina M. Piscitello, MD; Patrick G. Lyons, MD; Valerie Gutmann Koch, JD; William F. Parker, MD, PhD; and Michael T. Huber, MD

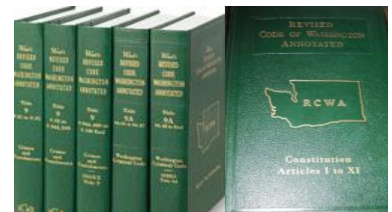
can find & make transfers

but

no consent
no new surrogate
no transfer

intractable conflict

normally, clinicians must follow surrogate decisions



but

exceptions

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

when

easier cases

start with vocabulary

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,

We help the world breathe

PULMONARY • CRITICAL CARE • SLEEP

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4 terms

- futile
- legally proscribed
- legally discretionary
- potentially inappropriate

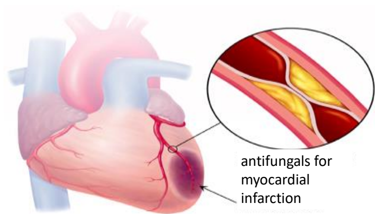
futile

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

scientific impossibility

example 1

example 2



example 3

example 4

example 5

"futile"

value free
---
objective

may clinicians stop LST?

"futile"

may & should refuse

~~Futile~~

Legally Proscribed

Legally Discretionary

Potentially inappropriate

legally proscribed

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

>0%

not "futile"

prohibited by … laws, judicial precedent, or widely accepted public policies

example 1

might “work”

but **illegal**

example 2

example 3

if treatment request is legally **proscribed** →

may & should refuse

~~Futile~~

Legally ~~Proscribed~~

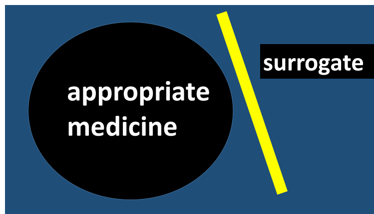
Legally Discretionary

Potentially inappropriate

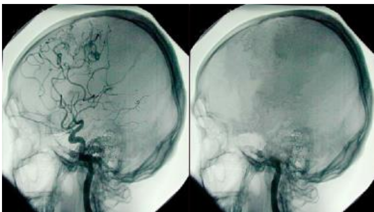
legally discretionary

opposite of proscribed

laws, judicial precedent, or policies … give physicians **permission** to refuse to administer them



example 1



example 2

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

Washington POLST
Portable Orders for Life-Sustaining Treatment
A Participating Program of National POLST

LAST NAME / FIRST NAME / MIDDLE NAME/INITIAL
DATE OF BIRTH / /
GENDER (optional)
PRONOUNS (optional)

This is a medical order. It must be completed with a medical professional. Completing a POLST is always voluntary.
IMPORTANT: See page 2 for complete instructions.

MEDICAL CONDITIONS/INDIVIDUAL GOALS:
AGENCY INFO / PHONE (if applicable)

A **Use of Cardiopulmonary Resuscitation (CPR):** When the individual has NO pulse and is not breathing.
CHECK ONE
☐ **YES – Attempt Resuscitation / CPR** *(choose FULL TREATMENT in Section B)*
☐ **NO – Do Not Attempt Resuscitation (DNAR) / Allow Natural Death**
When not in cardiopulmonary arrest, go to Section B.

C **Signatures:** A legal medical decision maker *(see page 2)* may sign on behalf of an adult who is not able to make a choice. An individual who makes their own choice can ask a trusted adult to sign on their behalf, or clinician signature(s) can suffice as witnesses to verbal consent. A guardian or parent must sign for a person under the age of 18. Multiple parent/decision maker signatures are allowed but not required. Virtual, remote, and verbal consents and orders are addressed on page 2.

Discussed with:
☐ Individual ☐ Parent(s) of minor
☐ Guardian with health care authority
☐ Legal health care agent(s) by DPOA-HC
☐ Other medical decision maker by 7.70.065 RCW

X **SIGNATURE** – MD/DO/ARNP/PA-C **(mandatory)** | DATE **(mandatory)**
PRINT – NAME OF MD/DO/ARNP/PA-C **(mandatory)** | PHONE
X **SIGNATURE(S)** – INDIVIDUAL OR LEGAL MEDICAL DECISION MAKER(S) **(mandatory)** | RELATIONSHIP | DATE **(mandatory)**
PRINT – NAME OF INDIVIDUAL OR LEGAL MEDICAL DECISION MAKER(S) **(mandatory)** | PHONE

Individual has: ☐ Durable Power of Attorney for Health Care ☐ Health Care Directive (Living Will)
Encourage all advance care planning documents to accompany POLST.

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)** | **CARDIOPULMONARY RESUSCITATION (CPR)**
☐ **DNR/Do Not Attempt Resuscitation (Allow Natural Death)** | ☐ **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:

imminent
demise

Model Policy on "Non-beneficial Treatment"

Lynette Cederquist, MD, July 2009 "San Diego Physician" • Ethics in Medicine

advanced metastatic disease

advanced multi-system organ failure from sepsis

active clinical deterioration

not futile

might be able to restart circulation

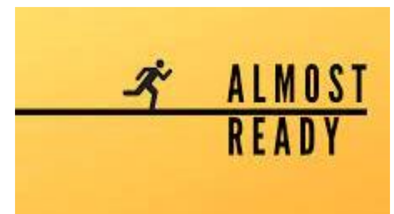
but

actively dying

death impending
imminent - hours

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

example 5



irreversible coma

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

those are

possible **additions**
legally discretionary

Trisomy 18

22-week gestation

ECMO

may clinicians stop LST?

legally discretionary

may & should refuse

~~Futile~~

~~Legally Proscribed~~

~~Legally Discretionary~~

Potentially inappropriate

harder cases

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potentially inappropriate treatment

some chance of accomplishing effect sought by surrogate

not "futile"
because
might "work"

examples

MV for widely metastatic cancer

dialysis for permanently unconscious

any LST for irreversible coma

we call these "futility disputes"

but

disputed Tx
might keep
patient alive

is that chance
or outcome
worthwhile

not a
medical
judgment

value
judgment

"potentially"
inappropriate treatment

vet & confirm
your judgment

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

1. Before initiation of and throughout the formal conflict-resolution procedure, clinicians should enlist expert consultation to aid in achieving a negotiated agreement.
2. Surrogate(s) should be given clear notification in writing regarding the initiation of the formal conflict-resolution procedure and the steps and timeline to be expected in this process.
3. Clinicians should obtain a second medical opinion to verify the prognosis and the judgment that the requested treatment is inappropriate.
4. There should be case review by an interdisciplinary institutional committee.
5. If the committee agrees with the clinicians, then clinicians should offer the option to seek a willing provider at another institution and should facilitate this process.
6. If the committee agrees with the clinicians and no willing provider can be found, surrogate(s) should be informed of their right to seek case review by an independent appeals body.

7a. If the committee or appellate body agrees with the patient or surrogate's request for life-prolonging treatment, clinicians should provide these treatments or transfer the patient to a willing provider.

7b. If the committee agrees with the clinicians' judgment, no willing provider can be found, and the surrogate does not seek independent appeal or the appeal affirms the clinicians' position, clinicians may withhold or withdraw the contested treatments and should provide high-quality palliative care.

2nd opinion

interdisciplinary institutional committee

reason for

due diligence

due process

helps get **consensus**

95%

assures **carefully** considered

One more thing…

FEDERAL REGISTER

Vol. 89 Thursday,
No. 91 May 9, 2024

Pages 39531–40358

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Part 84

RIN 0945–AA15

Nondiscrimination on the Basis of Disability in Programs or Activities Receiving Federal Financial Assistance

AGENCY: U.S. Department of Health and Human Services.

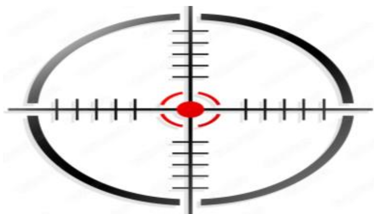
ACTION: Final rule.

effective

July 8, 2024

84.56

“no … individual with a **disability** shall … be subjected to **discrimination** in medical treatment …”



“discrimination is particularly salient in the context of **medical futility**”

“may not deny or limit … treatment … based on … belief … **life with a disability is not worth living**”

but

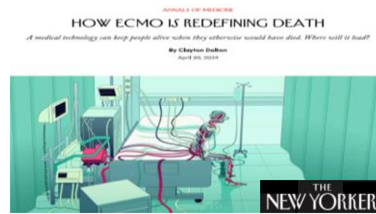
NBT
PIT

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%)

Ben White et al
Med J Aust 2016; 204 (8):318
doi: 10.5694/mja15.01103

widely **endorsed**
basis NBT / PIT

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



but

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"discriminatory … deny … treatment [because it] cannot end **dependence on intensive … care**"

"idea … treatment cannot end **dependence on intensive … care** … used to deny care … likely … discriminatory"

so…

PIT

conclusion

you **will** see these conflicts

try to **prevent**

w/ better communication
w/ documentation Pt wishes

try to reach **consensus**

with more family meetings
with EC, palliative, chaplaincy…

no consensus?

more DR

try **transfer** to another facility

try to **replace** surrogate

use your fair multidisciplinary review process

Thank you!

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