Medical Futility

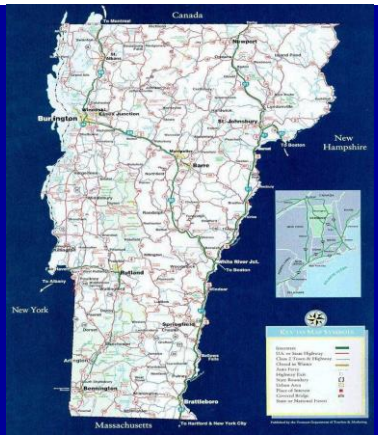
Legal Tools & Limits for Resolving Disputes over Inappropriate Life-Sustaining Treatment

Yale Medicine • March 27, 2014

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

NO relevant personal financial relationships or intent to discuss an off-label / investigative use of a commercial product or device.

Preface



STATE OF CONNECTICUT

General Assembly

Raised Bill No. 5326

February Session, 2014

LCO No. **1569**

*01569_____PH_*

Referred to Committee on PUBLIC HEALTH

Introduced by:

(PH)

AN ACT CONCERNING COMPASSIONATE AID IN DYING FOR TERMINALLY ILL PATIENTS.

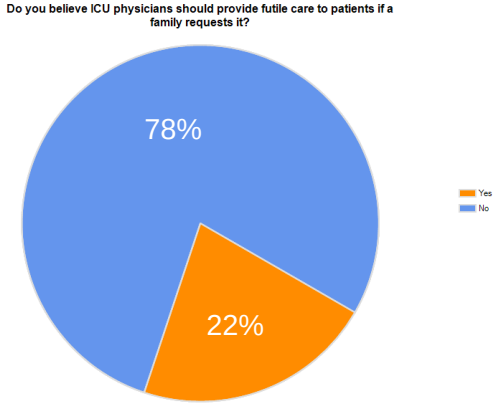
Liberty to hasten

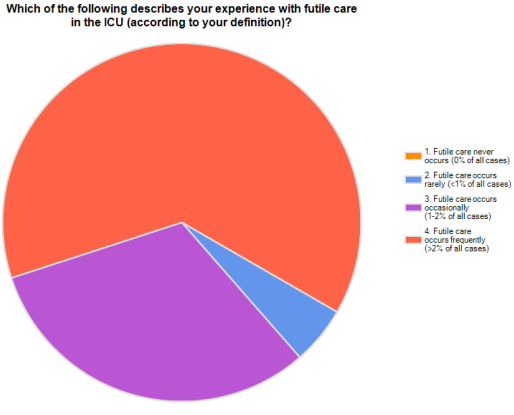
Liberty to prolong

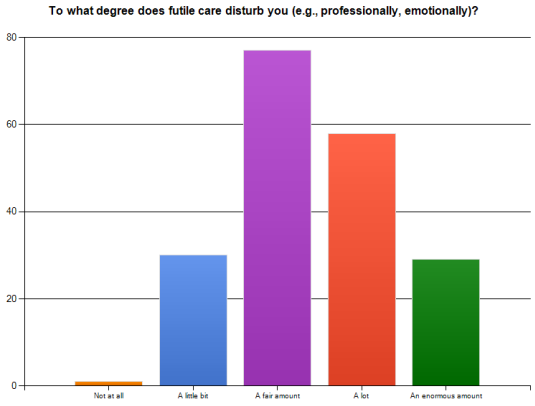
2010

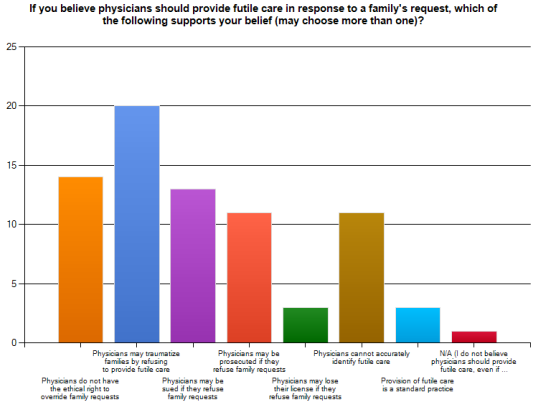
~200
attendings
residents
nurses

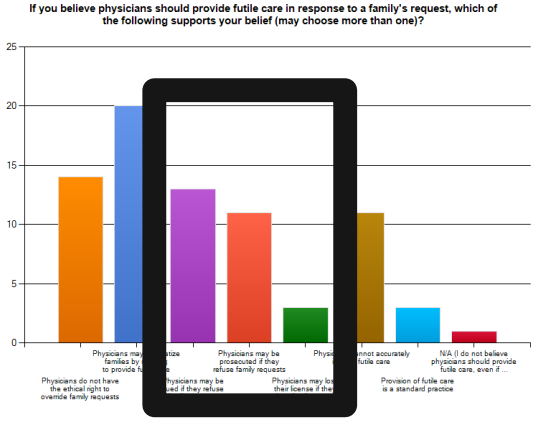
10











Orientation

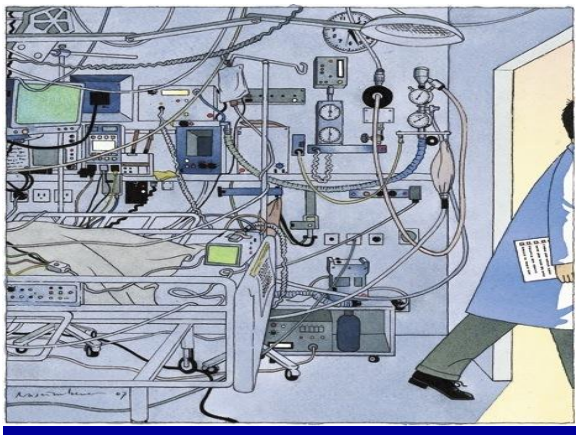
17

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

Surrogate driven over-treatment

19

Clinician	Surrogate
CMO	LSMT



1. Vocabulary
2. Prevalence

3. Causes

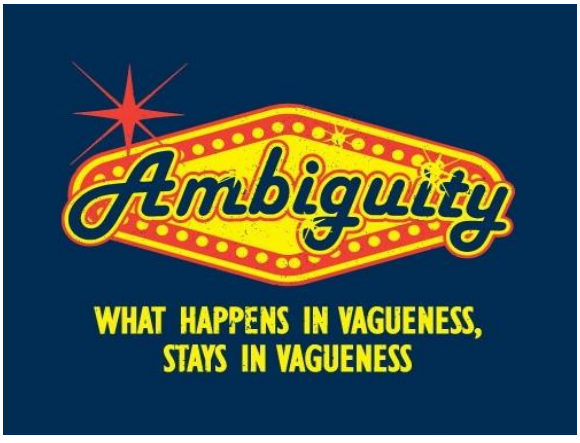
4. Prevention

5. Consensus

6. Intractable

Vocabulary

27



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

DRAFT

1. Futile
2. Inappropriate
3. Potentially inappropriate

35

Futile treatment	Interventions that cannot accomplish the intended physiological goals	1) Clinicians should explain that the requested treatment is ineffective and explore the surrogates' reasons for the request. 2) If conflict persists or if there is any doubt about the futility determination, clinicians should consult another qualified provider to evaluate the case. 3) Clinicians should consider expert consultation to mediate the conflict. 4) Institutions should retrospectively review the case to identify opportunities to prevent future similar occurrences.	1. A surrogate requests antibiotics as treatment for an acute MI in a critically ill patient. 2. A clinician refuses to provide CPR in a patient with rigor mortis.

Inappropriate Treatment	Treatments which may accomplish an effect desired by the patient, but for which there are widely accepted rules that prohibit their use	1) Clinicians should work to understand the reason for the request and clearly communicate the rule that governs the request. 2) Clinicians should involve individuals with expertise in interpreting existing regulations to ensure the rule is correctly interpreted and applied. 3) Clinicians should consider involving expert consultants to assist in clear communication and psychosocial support. 4) Institutions should retrospectively review these cases to identify opportunities to prevent future similar occurrences.	1. A surrogate requests long term ventilator support to a patient who is brain dead (in a state in which there are statutes permitting unilateral cessation of treatment in brain dead patients). 2. A surrogate requests that clinicians circumvent the lung organ allocation policy to help a critically ill patient get faster access to an organ for transplantation. 3. A patient requests a prescription for a lethal dose of barbiturates (in states where PAS is illegal).

Provisionally Inappropriate Treatment	Treatments that have at least some chance of accomplishing the effect sought by the patient or surrogate and are not prohibited by an existing rule, but medical professionals believe that competing ethical considerations justify treatment refusal.	Dispute resolution should be accomplished via the process outlined in recommendation 3 and in **Table 3**.	1. A surrogate requests ongoing mechanical ventilation for a patient with widely metastatic cancer and refractory multi-organ failure with progressive extremity necrosis from high-dose vasopressors. 2. A surrogate requests initiation of dialysis for a patient in a persistent vegetative state

Figure 1- Recommended approach to the management of disputed requests in ICUs

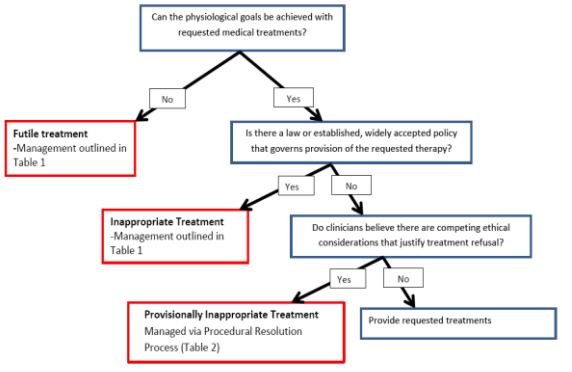


Table 2- Model policy highlighting procedural steps for resolution of conflict regarding life-sustaining treatments

1)	Prior to initiation of and throughout the formal dispute 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 and independent medical opinion to verify the diagnosis and prognosis.
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 appeal to an independent body.
7a)	If 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.
7b)	If the committee 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.

Imminent death

Permanent unconscious

No survive outside ICU

Burdens > benefits

41

Value laden

42

Prevalence

43

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

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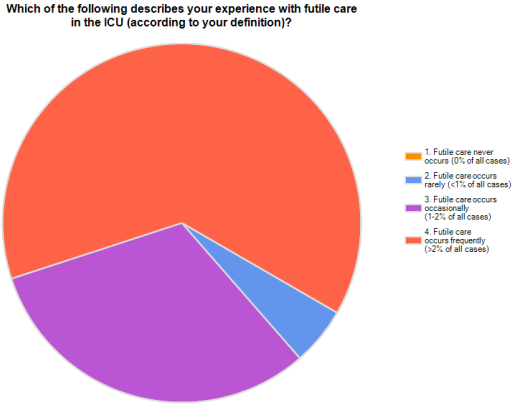
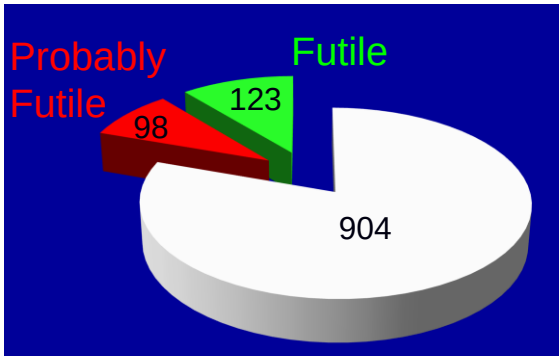


Original Investigation

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.



47

> 33% ethics consults

West Virginia University

University of Michigan Health System

Causes

49

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
All efforts should continue indefinitely	20.6	2.5

1. Surrogate demand
2. Provider resist

51

Surrogate demand

52

Cognitive

53

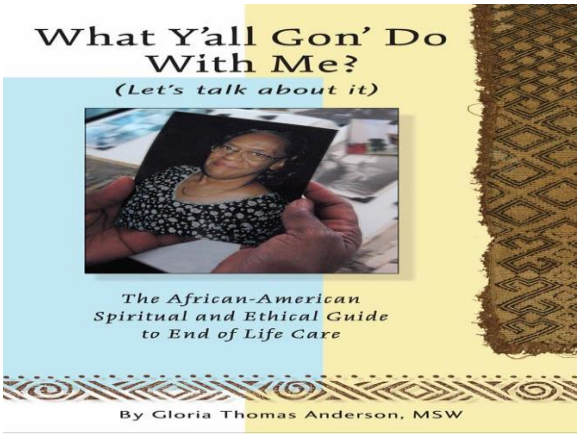
Iatrogenic

- Inadequate communication
- Uncoordinated, conflicting
- Undue pressure

55

Mistrust

56



Emotional Barriers

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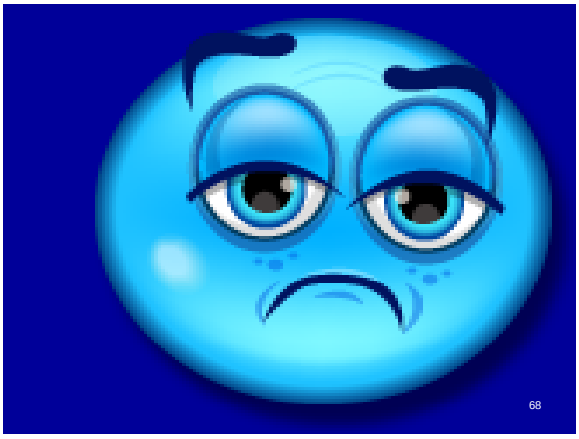
Psychological Barriers

66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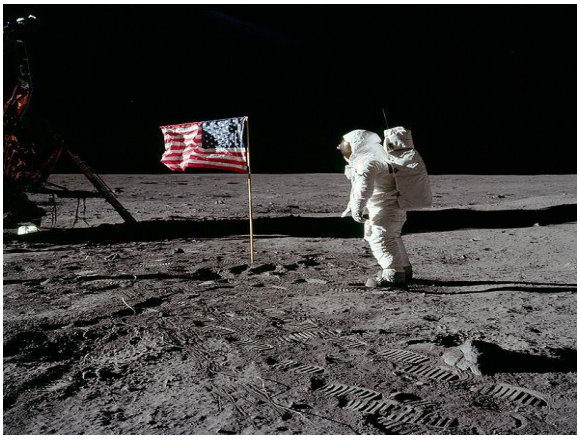
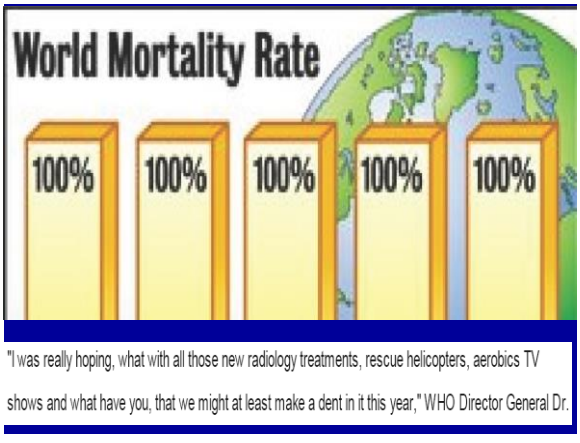
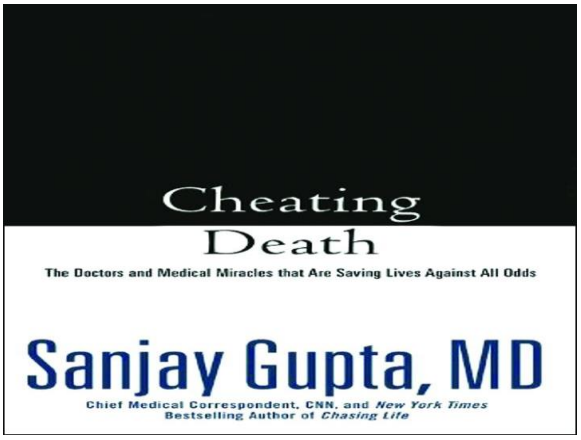
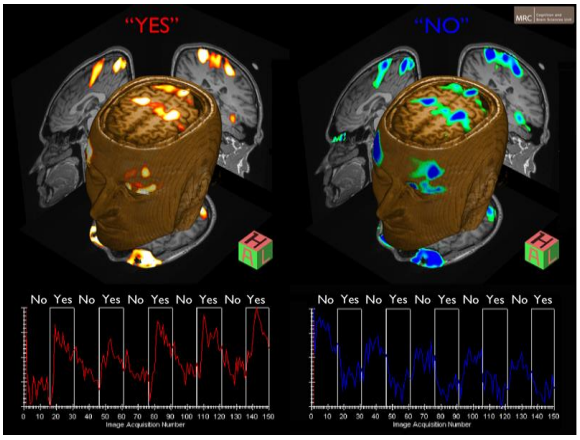
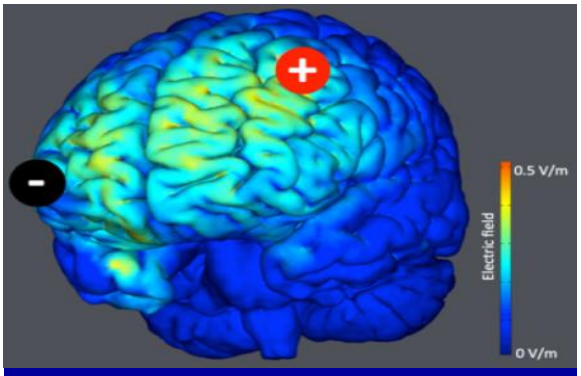



World Mortality Rate
100%
100%
100%
100%
100%
"I was really hoping, what with all those new radiology treatments, rescue helicopters, aerobics TV shows and what have you, that we might at least make a dent in it this year," WHO Director General Dr.


Never give in, never give in,
never, never, never, never, . . .







transcranial direct-current stimulation 75

Religion

79

Question and Responses[a]	Public, % (n=1006)	Professionals, % (n=774)
If the doctors treating your family member said futility had been reached, would you believe that divine intervention by God could save your family member?		
Yes	57.4	19.5
No	35.5	61.1

Zier et al., 2009
Chest 136(1):110-7

MORE surrogate demand

83

PewResearchCenter

NUMBERS, FACTS AND TRENDS SHAPING THE WORLD

NOV. 21, 2013

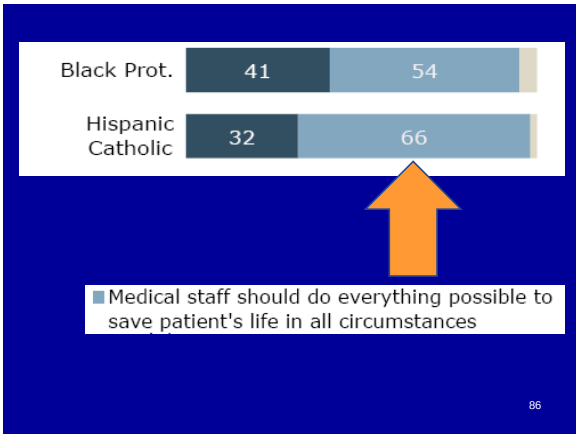
Views on End-of-Life Medical Treatments

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	



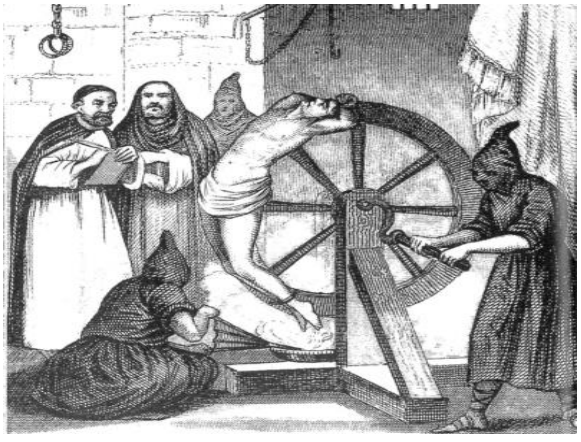
86

Clinicians resist

87

Avoid patient suffering

88



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

Moral distress

92

Absenteeism

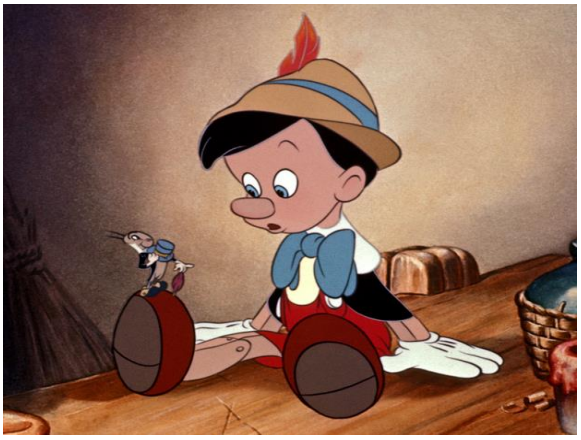
Retention

Quality

94

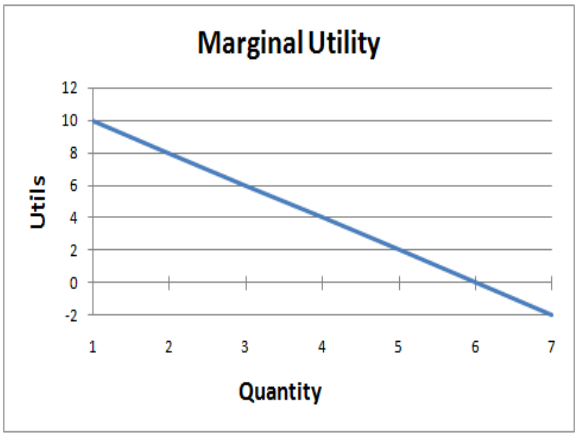
Integrity of profession

95



Stewardship

98



Distrust surrogate

101

66% accurate

50% = pure chance

103

Quick etiology

104

Prevention

105

Most patients do NOT want futile treatment

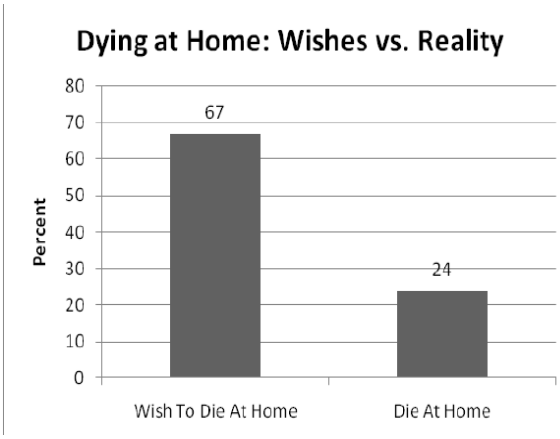
106

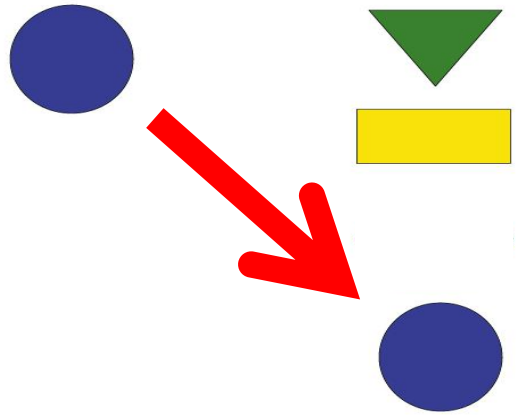
71%: "More important to enhance the **quality** of life for seriously ill patients, even if it means a **shorter life.**"

National Journal (Mar. 2011)

107

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
All efforts should continue indefinitely	20.6	2.5





More ACP

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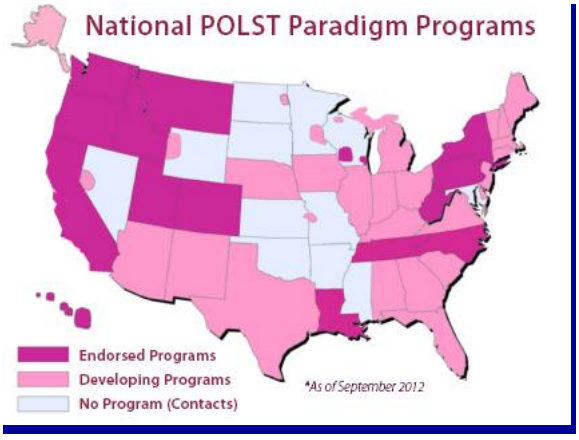

STATE OF CONNECTICUT

General Assembly

Raised Bill No. 413

February Session, 2014

LCO No. **2057**

Referred to Committee on PUBLIC HEALTH

Introduced by:
(PH)

113TH CONGRESS
1ST SESSION

H. R. 1173

To amend the Social Security Act to provide for coverage of voluntary advance care planning consultation under Medicare and Medicaid, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MARCH 14, 2013

Mr. BLUMENAUER (for himself, Mr. HANNA, Mr. ROE of Tennessee, Mr. REED, Ms. SCHWARTZ, Mr. KIND, Mr. GEORGE MILLER of California, Mr. MCDERMOTT, Mr. BERA of California, Ms. SCHAKOWSKY, and Mrs. CAPPS) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend the Social Security Act to provide for coverage of voluntary advance care planning consultation under Medicare and Medicaid, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; FINDINGS; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Personalize Your Care Act of 2013".

Earlier ACP

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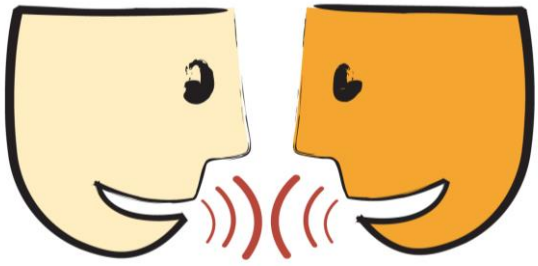

EOL disclosures (NY, CA, MI, VT)

ASCO® American Society of Clinical Oncology

Making a world of difference in cancer care

Limited effectiveness

Side effects

Options

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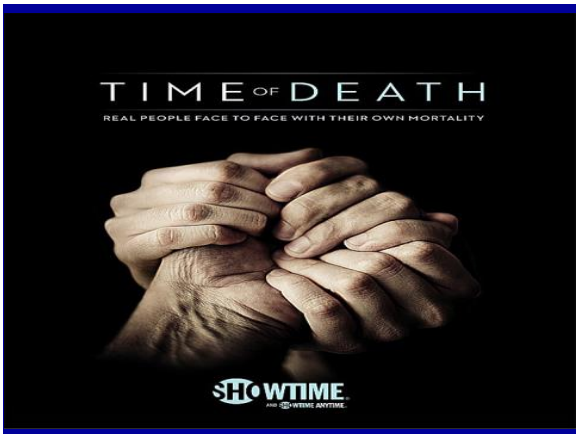
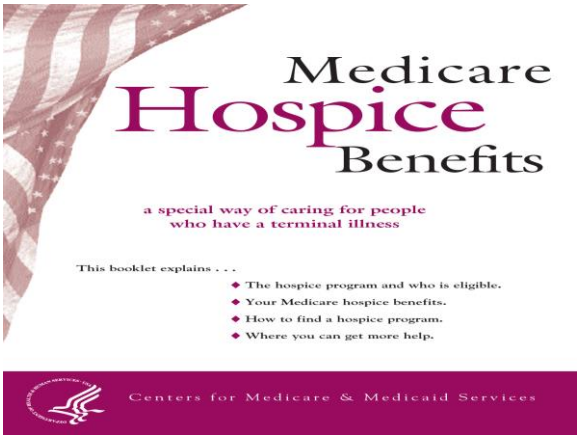
Choosing Wisely®

An initiative of the ABIM Foundation





Better ACP

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IPDAS

International Patient Decision Aid Standards Collaboration

Nudge

Limits to Prevention

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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

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

Pew Research Center, November 2013, "Views on End-of-Life Medical Treatments"

128

30%

129

Consensus

130

1. Negotiation & Mediation
2. Transfer
3. New Surrogate

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Negotiation

Mediation

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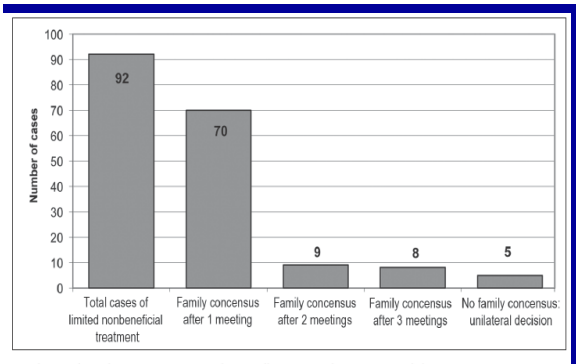
	Clinician	
Surrogate	Stop	Go
Stop		
Go		

135

95%

136



Nonbeneficial Treatment and Conflict Resolution: Building Consensus

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

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

http://dx.doi.org/10.7812/TPP/12-124

Prendergast (1998)

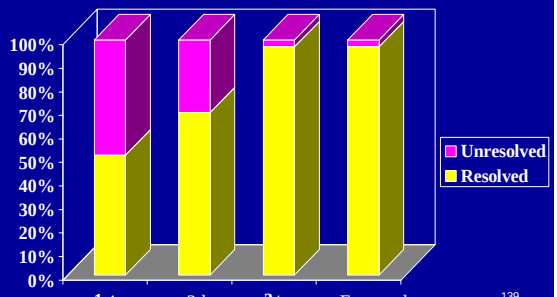
57% agree immediately

90% agree within 5 days

96% agree after more meetings

138

Garros et al. (2003)



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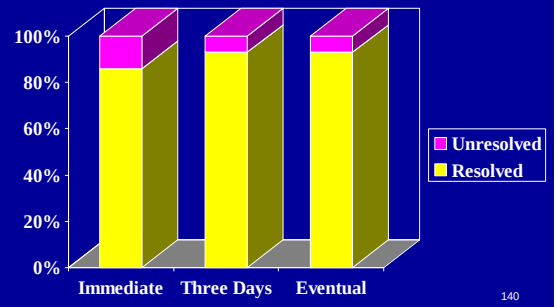
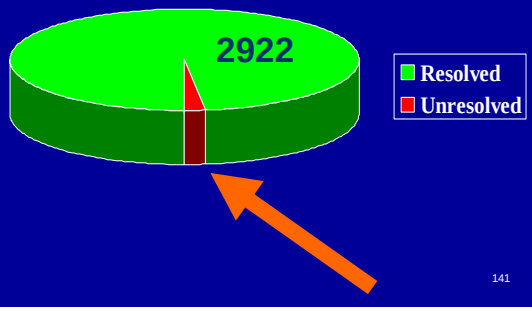
Fine & Mayo (2003)



140

Hooser (2006)



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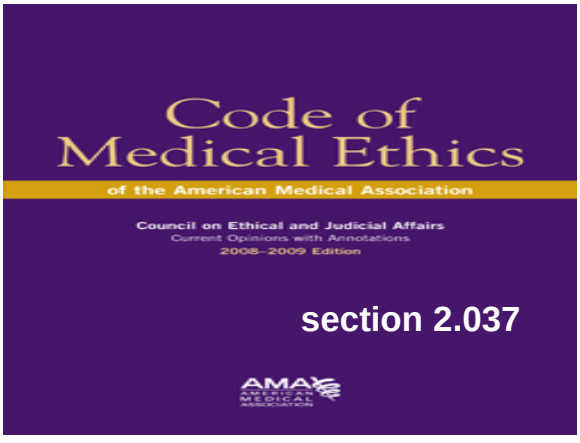

1. Earnest attempts . . .
   deliberate . . .
   negotiate . .
2. **Joint** decision-making
   . . . maximum extent . .

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3. Attempts . . .
   negotiate . . .
   reach resolution . . .
4. Involvement . . .
   ethics committee . . .

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Consensus

Intractable

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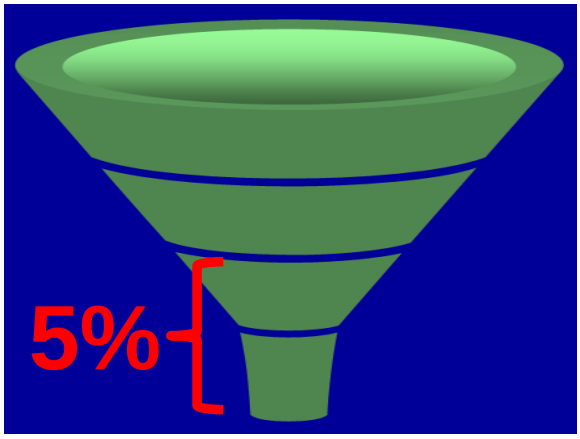

Transfer

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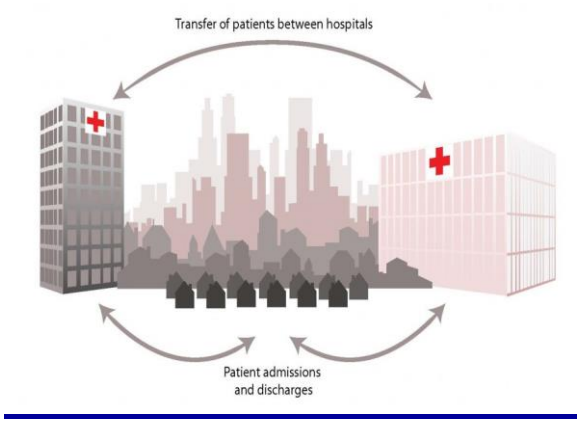

	Clinician	
Surrogate	Stop	Go
Stop		
Go		→

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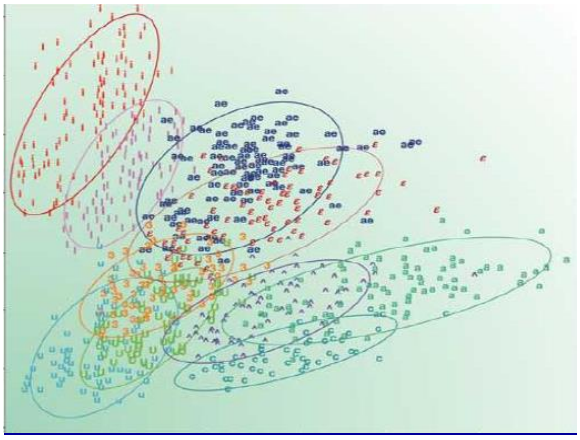
Rare, but possible

150



Replace Surrogate

152

	Clinician	
Surrogate	Stop	Go
Stop		
Go		

153

Substituted judgment

Best interests

154

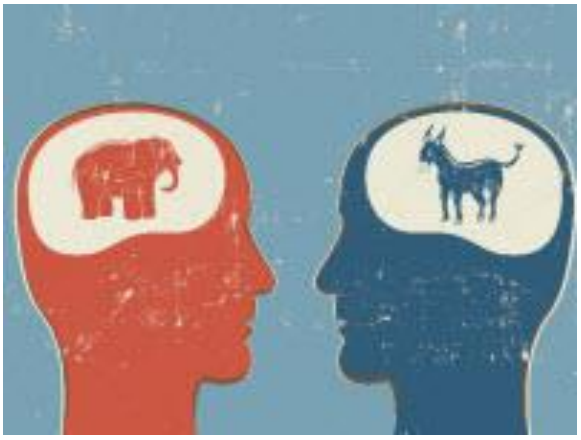
Conn. Gen. Stat.

19a-580e(a)

19a-575a(a)

19a-577

156



~ 60%

accuracy

More

aggressive treatment

159

Improve Surrogate Accuracy

Code of Medical Ethics

of the American Medical Association

Council on Ethical and Judicial Affairs

Current Opinions with Annotations

2013–2015 Edition

2.20: "surrogate's decision . . . **almost always** be accepted"

AMA

Making Medical Decisions for Someone Else

A Vermont Handbook

VERMONT ETHICS NETWORK

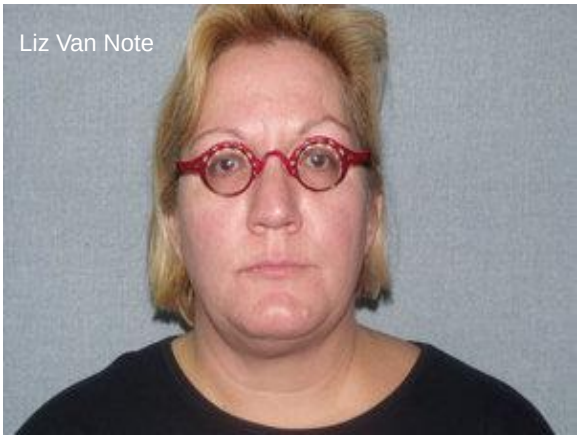
Conn. Gen. Stat. 19a-580c(b)

"claim that the actions of the person named as health care representative would interfere"

164

Reasons to Replace

165



Surrogate	Advance directive
GO	STOP

170

State of Minnesota
County of Hennepin

FILED
11 FEB -4 PM 1:32
BY: PROBATE/MENTAL HEALTH
FOURTH DISTRICT COURT

District Court
Probate Division
Judicial District: Fourth
Court File No. 27-GC-PR-111-16

In Re: Emergency Guardianship of

Albert N. Barnes,
Respondent

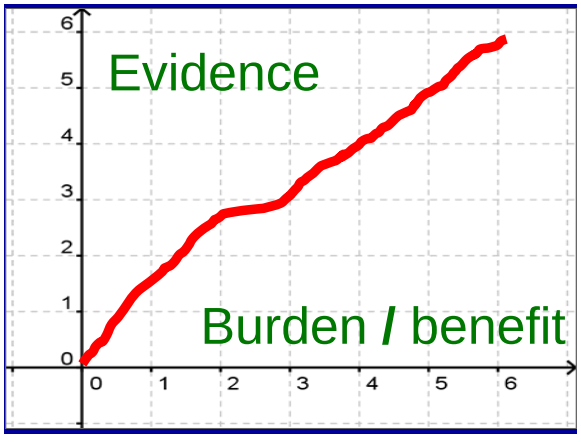
Order Appointing Emergency Guardian

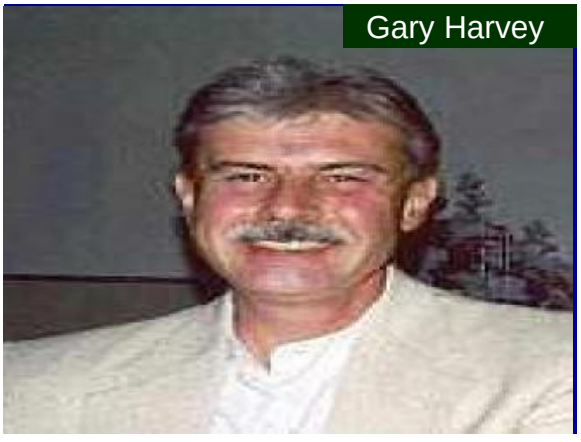
This matter came on for hearing on February 2, 2011 before the District Court on a petition seeking an emergency appointment of a guardian for the Respondent named above. The matter, having been considered by the Court and the Court being duly advised in the premises now makes the following:

FINDINGS OF FACT

Surrogate	Best interests
GO	STOP

176





"failed to follow medical advice"

"failed to use good judgment"

Your own personal issues are “impacting your decisions”

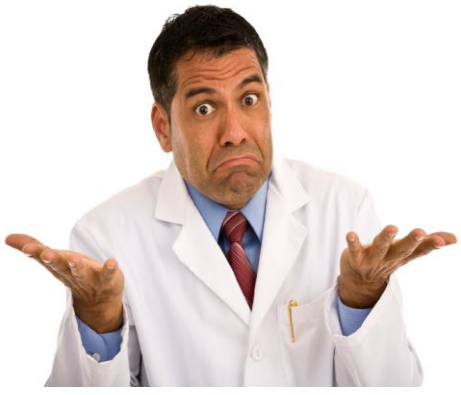
“Refocus your assessment”

LIMITS of surrogate replacement

182

1

Providers cannot show deviation



2

Surrogates get benefit of doubt

3

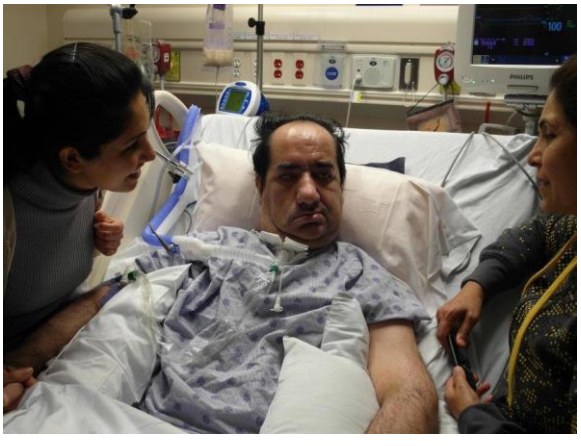
Surrogates

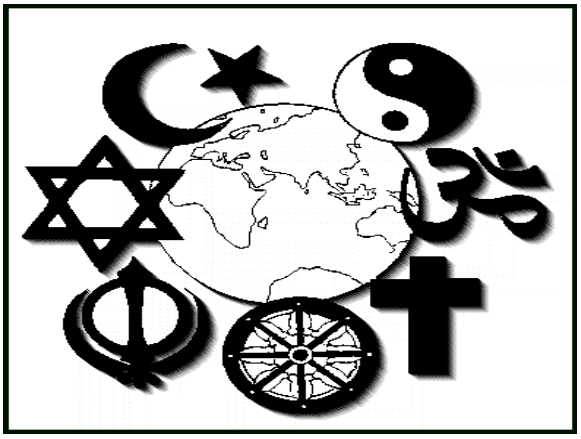
loyal & faithful

Ontario

Consent and Capacity Board

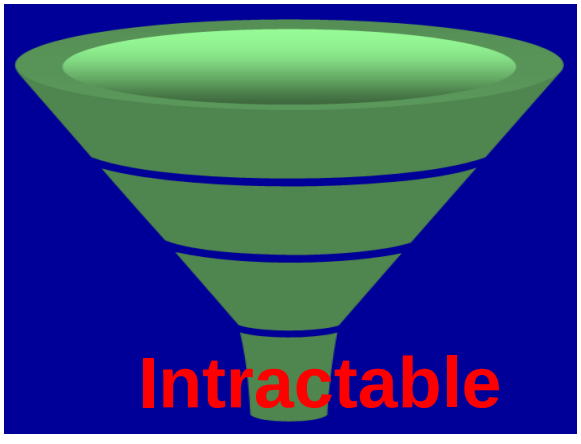
190





Intractable Conflict

194



1. Covert
2. Cave-in
3. Act w/o consent

Covert

199

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)

Providers have **won almost every single** damages case for unilateral w/h, w/d

203

IIED

NIED

204

Secretive

Insensitive

Outrageous

205

Consultation expected

Distress foreseeable

206

O'Connell v. Bridgeport Hosp. (Conn. Super. 2000)

BRIDGEPORT HOSPITAL
YALE NEW HAVEN HEALTH

Valentin v. St. Francis Hosp. (Conn. Super. Hartford 2005)

SAINT FRANCIS
Hospital and Medical Center

Marsala v. YNHH (Conn. Super. 2013)

YALE-NEW HAVEN HOSPITAL

Cave-in

210

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

"Why they follow the . . . SDMs instead of doing what they feel is appropriate, almost all cited a **lack of legal support.**"

211

"Remove the ___, and I will **sue you**."

212

Easier to cave-in

- Patient will die soon
- Provider will round off
- Nurses bear brunt

215

Civil liability

- Battery
- Medical malpractice
- Informed consent
- State HCDA
- EMTALA

217

Licensure discipline

Criminal liability

e.g. homicide

218

Legal Risk

219

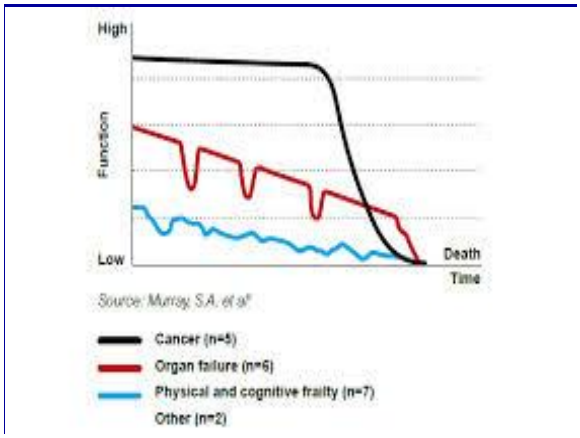
Few cases

220

222

$250,000

223



Few successful

226

BUT

228

Risk > 0

229

Manning (Idaho 1992)
Rideout (Pa. 1995)
Bland (Tex. 1995)
Wendland (Iowa 1998)
Causey (La. 1998)

230

ALLIANCE DEFENSE FUND
Defending Our First Liberty

232

Liability averse

Litigation averse

233

Process = punishment

Even prevailing parties pay **transaction costs**

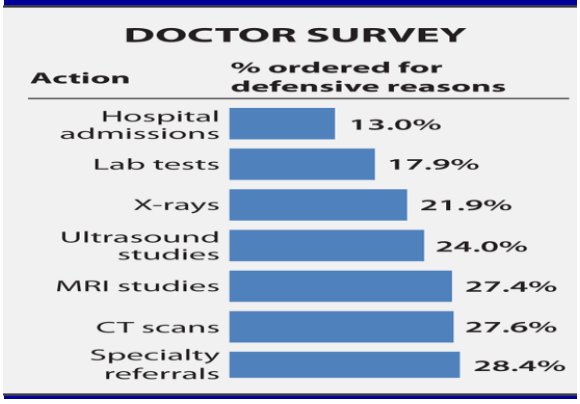
- Time
- Emotional energy

234

Defensive Medicine

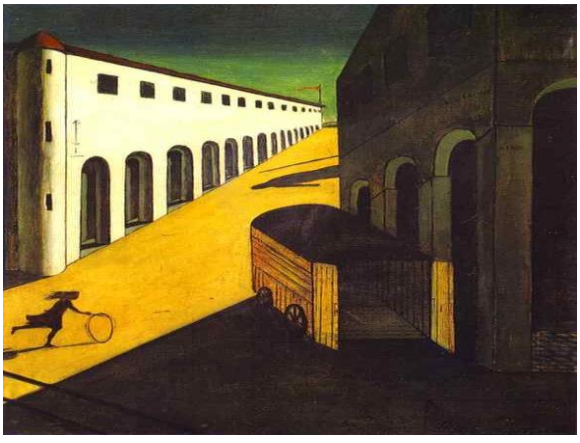
235

Mass. Med. Society (Nov. 2008)



Bad law

237



Safe Harbor®

Covert Cave-in

240

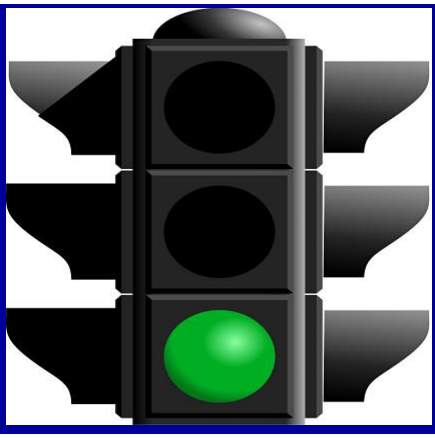
Stop without consent

241

242

Green

243



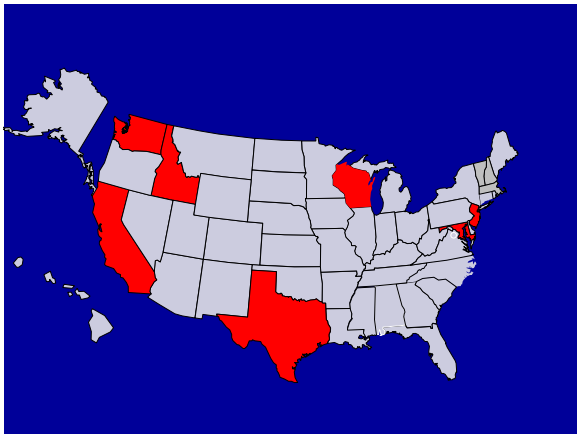
244

You may stop LSMT for **any reason**

- with immunity
- if your HEC agrees

Tex. H&S 166.046

1. 48hr notice HEC
2. Written decision
3. 10 day transfer



Resolution 505-08 TITLE: LEGAL SUPPORT FOR NONBENEFICIAL TREATMENT DECISIONS

Author: H Hugh Vincent, MD;
William Anderegk, 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

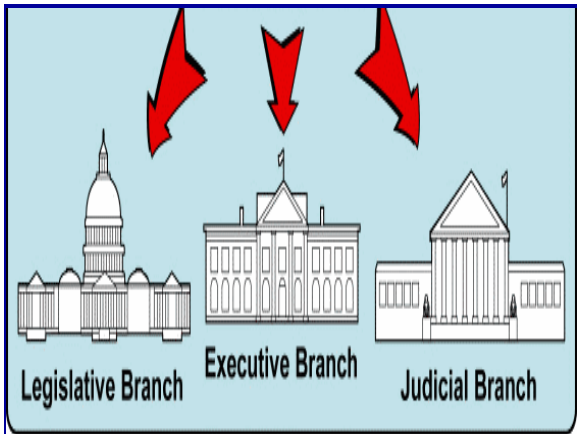
RESOLUTION 1 - 2004
(read about the *action* taken on this resolution)

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.

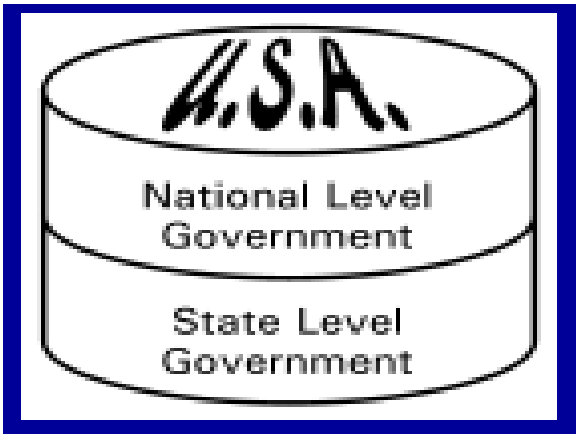

Legislative Branch
Executive Branch
Judicial Branch


S.B. 1114
(Mar. 2009)
Lake Pend Oreille
Coeur d'Alene
WASHINGTON
Coeur d'Alene Lk.
MONTANA
Lewiston
BITTERROOT RANGE
BLUE MTS.
Salmon
Snake
IDAHO
OREGON
Borah Peak
Yellowstone Nat'l. Pk.
Boise
Sun Valley
BOISE
TETON RANGE
Craters of the Moon Nat'l. Mon.
Snake
WYOMING
Nampa
Idaho Falls
CALIFORNIA
Shoshone Falls
Pocatello
NEVADA
Twin Falls
WASATCH RANGE
UTAH


MEDICAL FUTILITY &
MARYLAND LAW
Tuesday, November 30, 2010


NJHA
NEW JERSEY HOSPITAL ASSOCIATION
MSNJ
MEDICAL SOCIETY
of NEW JERSEY
Est. 1766


258



Treat 'til transfer

262

Miss. Code § 41-107-3

263

L.B. 564 (2013)

41

Mich. S.B. 136 (2013)

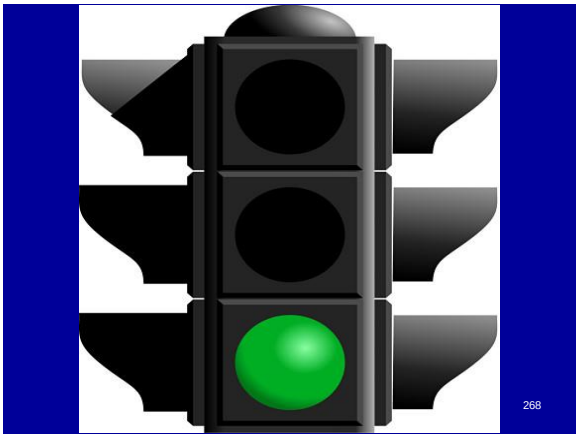
42

H.B. 279 (2013) (over veto)

40

Okla. H.B. 2460 (2012)

267



268

HIPAA PERMITS DISCLOSURE OF COLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

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)

Signature (If Available)

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:

MM 2 2012 Page 1 of 2

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.

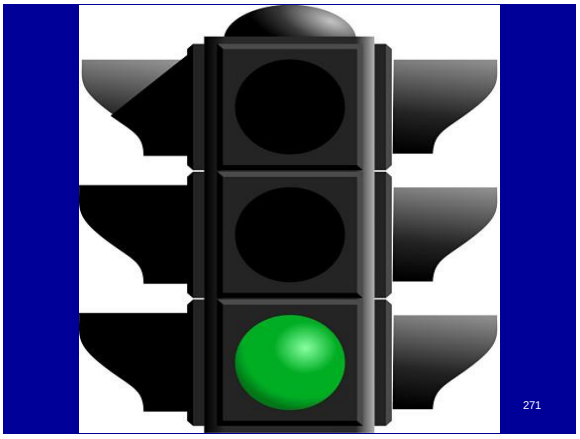
CERTIFICATION FOR THE BASIS OF THESE ORDERS: Mark any and all that apply.

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 Heath Care Decisions Act; or
_____ if the patient is a minor, the patient's legal guardian or another legally authorized adult.

Or, I hereby certify that these orders are based on:

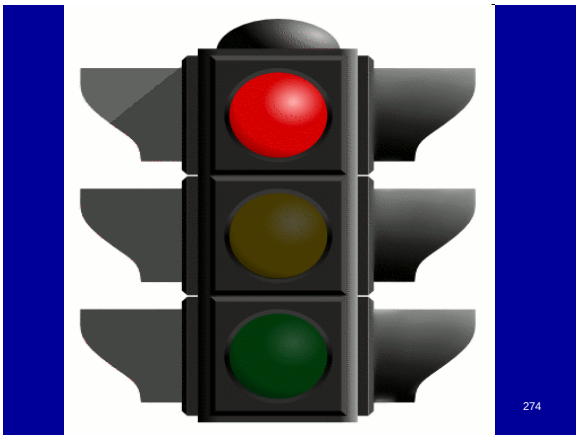
_____ instructions in the patient's advance directive; or
_____ other legal authority in accordance with all provisions of the Health Care Decisions Act. All supporting documentation must be contained in the patient's medical records.



271

Red

273



274

Ontario

Consent and Capacity Board

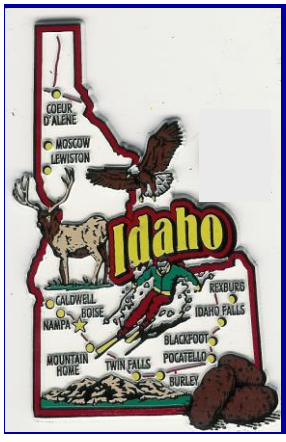
276

Consent **always**

278

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

280

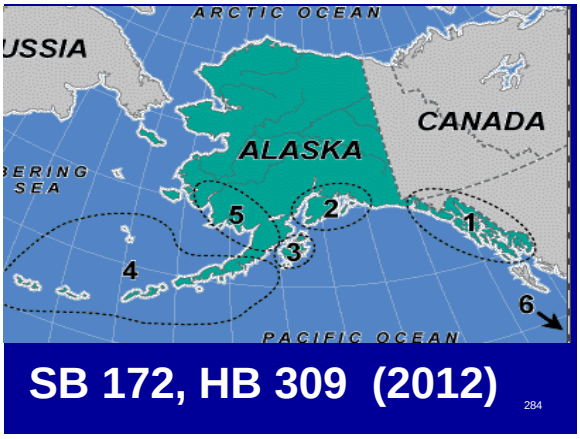


Discrimination in Denial of Life Preserving Treatment Act

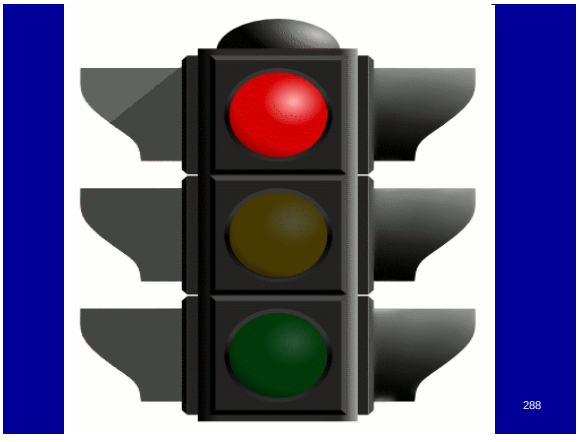
281

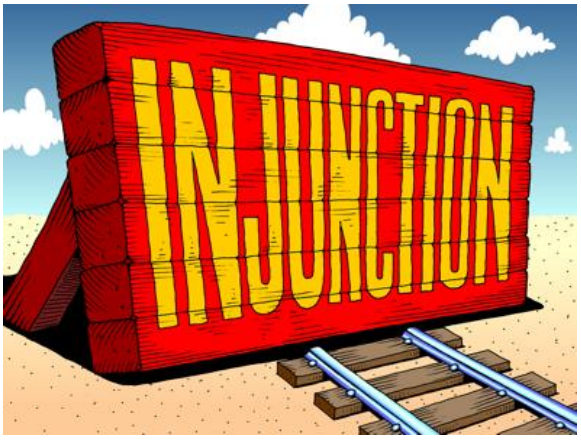
"Health care . . . **may not be** . . . **denied** if . . . directed by . . . surrogate"

282



SDM	Red Light
Agent / POA	Yes
Default surrogate	No; Maybe
Guardian	No; Maybe





"I . . . come in . . . and use the law to say stop"

Life & death stakes

Unclear facts

Unclear law

TRO

Yellow

295

Not
red

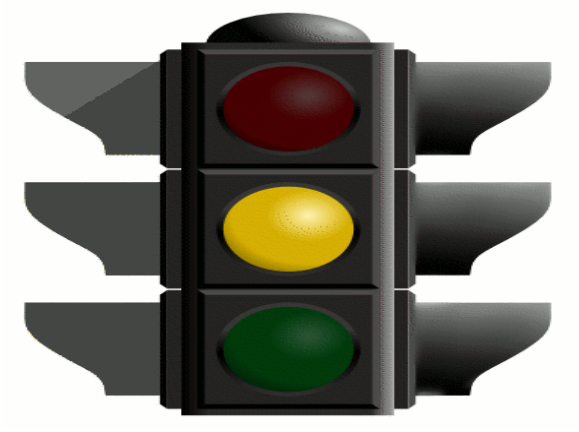
297

Not
green
either

298

Yellow

299



Physician “withholds, removes . . . life support . . . of an incapacitated patient **shall not be liable** provided (1) . . . (2) . . . (3) . . .”

301

(2)

terminal condition

or

permanently unconscious

303

(3)

“attending physician has **considered** the patient's wishes”

305

~~“informed consent of NOK”~~

306

Marsala v. YNHH
(Conn. Super. 2013)

YALE-NEW HAVEN HOSPITAL

"No current law exists that will give . . . immunity . . . If you refuse to treat a certain way."

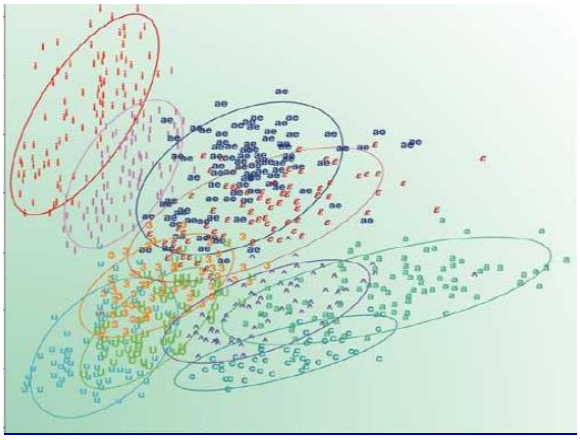
Probate Judge Robert K. Killian Jr.

(1)

"best medical judgment of the attending physician"

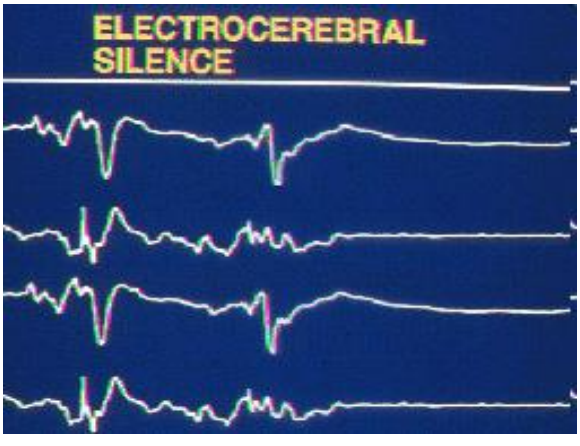
"in accordance with the usual and customary standards of medical practice"

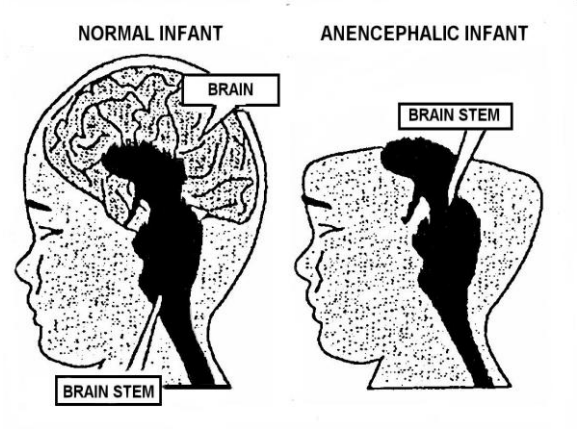
312

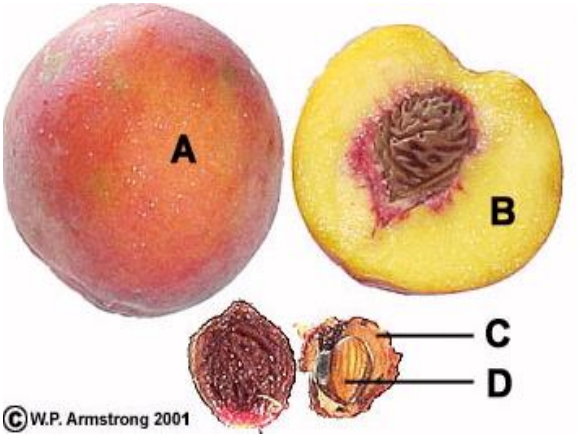



Standard
of Care
S


Standard
of Care
S


ELECTROCEREBRAL
SILENCE


NORMAL INFANT
ANENCEPHALIC INFANT
BRAIN
BRAIN STEM
BRAIN STEM



Bad

321

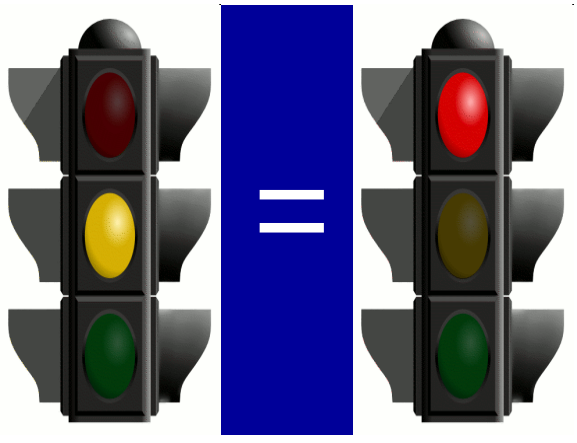
Safe Harbor®

Safe harbor attributes

- Clear
- Precise
- Concrete
- Certain

323

TX	CT
Measurable procedures	Vague substantive standards



Worse

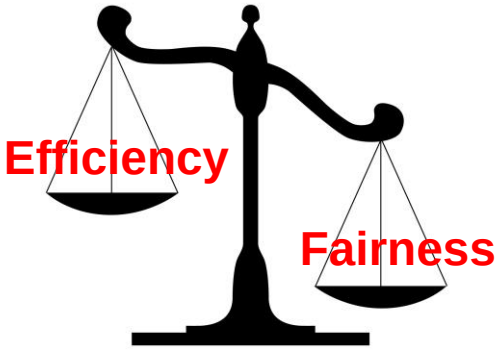
328

Future

333

RPA

Renal Physicians Association



Thaddeus Mason Pope

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1536 Hewitt Avenue
Saint Paul, Minnesota 55104
T 651-523-2519
F 901-202-7549
E tpope01@hamline.edu
W www.thaddeuspope.com
B medicalfutility.blogspot.com

337

References

338

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 550,000 direct visits. Plus, it is distributed through RSS, email, Twitter, and republishers like Westlaw, Bioethics.net, Wellsphere, and Medpedia.

339

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