Medical Futility
Law and Ethics: Where Are We Now?

Thaddeus Mason Pope, J.D., Ph.D.

HealthPartners & Regions Hospital

Quarterly Ethics Grand Rounds

December 10, 2013

1

Thaddeus Pope, J.D. Ph.D. indicated **NO** relevant personal financial relationships or intent to discuss an off-label / investigative use of a commercial product or device.

2

ACCME Core Competencies

Patient Care: Practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease and at the end of life.
Medical Knowledge: Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and the education of others.
Practice Based Learning and Improvement: Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care.
Interpersonal and Communication Skills: Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families and other members of the health care teams.
Professionalism: Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, and understanding and sensitivity to diversity, and a responsible attitude towards their patients, their profession, and society.
Systems Based Practice: Practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize healthcare.

3

The HealthPartners Institute for Education and Research designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credit(s)TM. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

This program has been designed to meet the Minnesota Board of Nursing criteria for 1.2 contact hours of required continuing education. It is the responsibility of each nurse to determine whether a continuing education activity meets the criteria established by the Minnesota Board of Nursing.

Other professional credits for continuing education (CEU) are available, per the standards of those professional organizations.

4

All evaluations, transcripts and CEUs are now being managed on myLearning. Your attendance at the Grand Rounds will be noted in myLearning by the end of today.

- This information is added from the sign-in sheets so please make sure your name is legible.
- For those attending by remote access --- please send your sign-in sheets to the person listed on the form.
- When you log into myLearning you will see your attendance noted in the Grand Rounds session and you will be able to:
  - View your learning activity details
  - Complete your evaluations
  - Claim CEU credit
  - Print transcripts and certificates for your records
  - Pre-register for upcoming Ethics Grand Rounds

There are a lot of pagers and cell phones in this room --- please keep them on silent. If you must leave and return, please do so as quietly as possible.
Bathrooms are available outside either exit door and telephones are available out the door to your right.

5

Objectives:

1. Understand current legal developments related to medical futility policies.
2. Learn how law and ethics interact around the topic of medical futility.
3. Appreciate how discussions of medical futility relate to clinical practices.

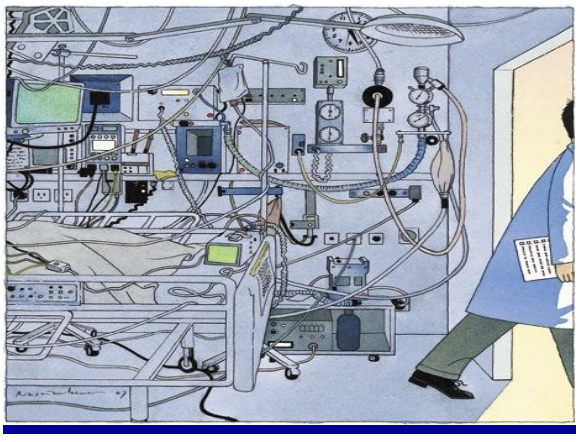
There will be time for questions at the end of the presentation.

6

Surrogate driven over-treatment

10

Clinician	Surrogate
CMO	LSMT



1136 patients

11% futile”

8% “probably futile”

JAMA Intern Med. 2013;173(20):1887-1894

14

69 ICUs with correct patient codes completed ICU questionnaire

1447 Clinicians returned clinician questionnaire

29 Clinicians excluded (answers missing for perceived inappropriateness of care rate)

1418 Clinicians completed questionnaire

329 Reported ≥1 patient was receiving inappropriate care

JAMA. 2011;306(24):2694-2703

Clinician driven over-treatment

16

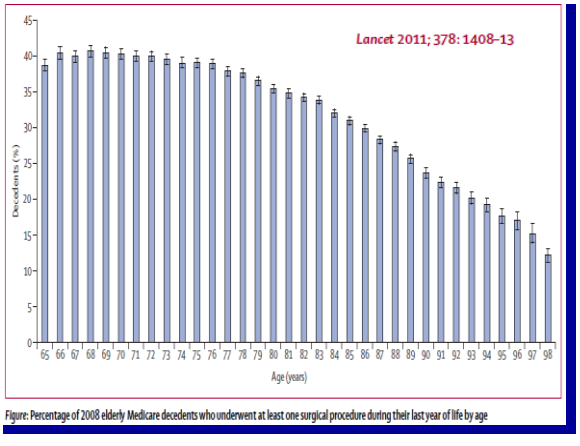
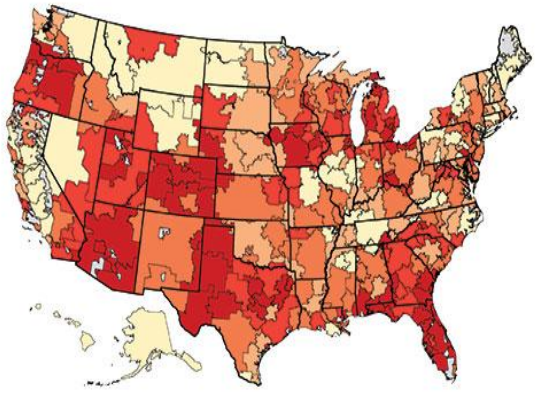
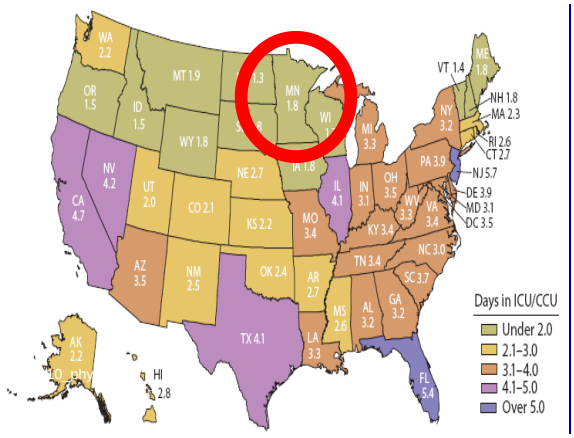


Figure: Percentage of 2008 elderly Medicare decedents who underwent at least one surgical procedure during their last year of life by age





1. Causes
2. Prevention
3. Consensus

4. Intractable
5. ATS policy

Causes

24

Table 3. Preferences for Goals of Care and Limited Resources

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**

26

Surrogate demand

27

Cognitive

28

Iatrogenic

- Inadequate communication
- Uncoordinated, conflicting
- Undue pressure

30

Mistrust

31

USA TODAY Home News Travel Money Sports Life Tech

News » Health & Behavior Fitness & Nutrition Your Health: Kim Painter Swine Flu M

More 'empowered' patients question doctors' orders

Updated 11h 9m ago | Comments 68 | Recommend 4 E-mail | Save | Print | Reprints & Permissions | RSS

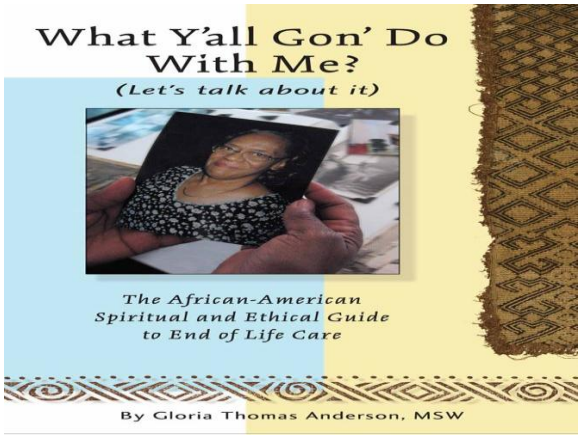
By Mary Brophy Marcus, USA TODAY

In the past, most patients placed their entire trust in the hands of their physician. Your doc said you needed a certain medical test, you got it.

Not so much anymore.

Jeff Chappell of Montgomery, Ala., recalls a visit a couple of years ago to a Charlotte emergency room, near where the family

Share
Yahoo! Buzz
Add to Mixx
Facebook
Twitter
More

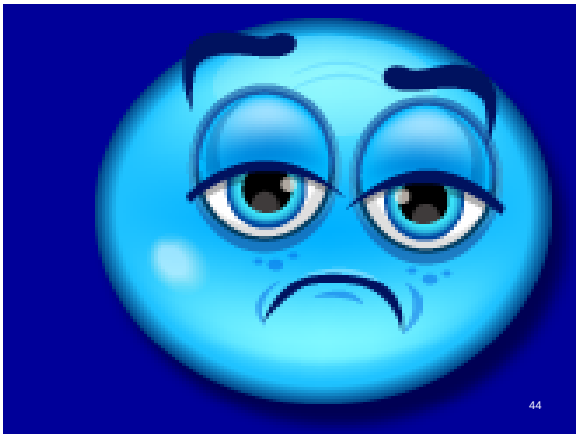


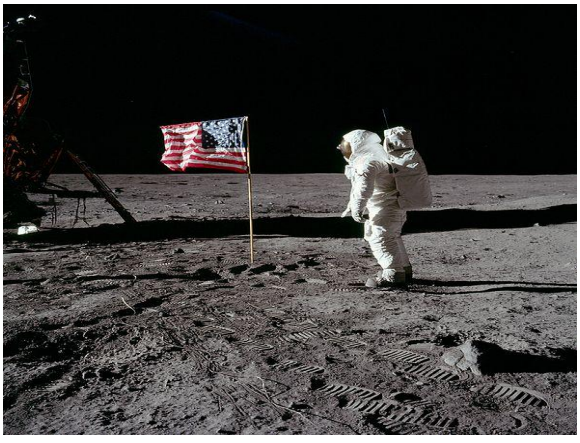
Emotional Barriers

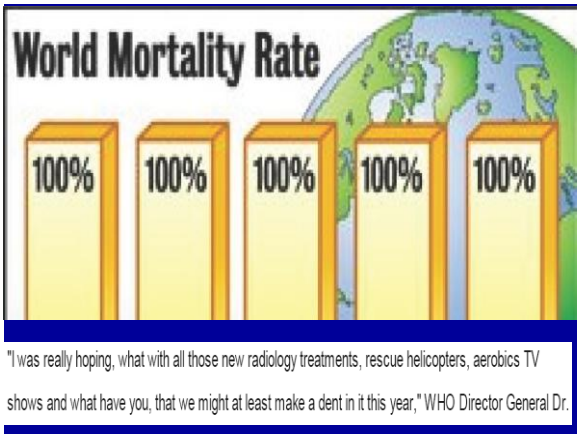
38

Psychological Barriers

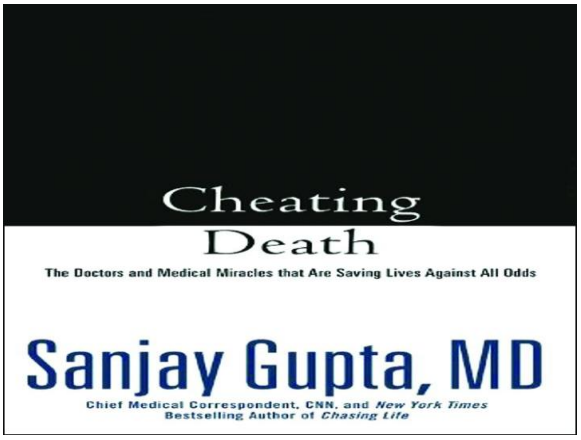
42

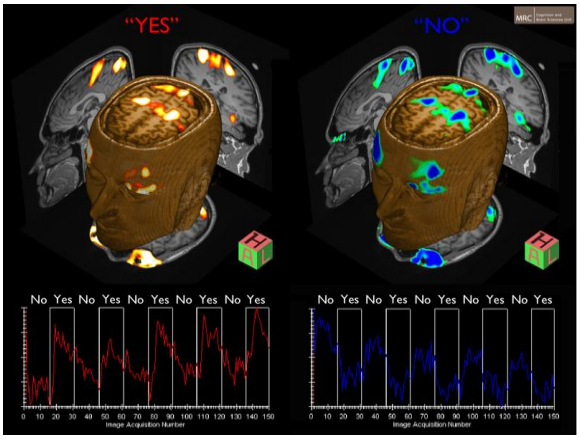

44




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, . . .


Cheating
Death
The Doctors and Medical Miracles that Are Saving Lives Against All Odds
Sanjay Gupta, MD
Chief Medical Correspondent, CNN, and New York Times
Bestselling Author of Chasing Life


"YES"
"NO"
No Yes No Yes No Yes No Yes No Yes
No Yes No Yes No Yes No Yes No Yes


Ceci n'est pas une pipe.


autonomy

Religion

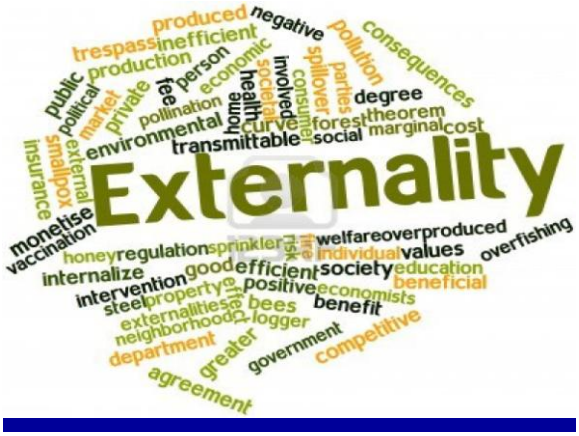
54

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

"**religious grounds** were more likely to request continued life support in the face of a very poor prognosis"

Zier et al., 2009 *Chest* 136(1):110-117

57



PewResearchCenter

NUMBERS, FACTS AND TRENDS SHAPING THE WORLD

NOV. 21, 2013

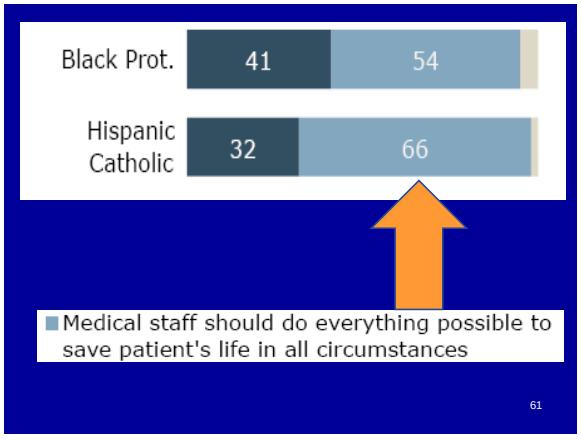
Views on End-of-Life Medical Treatments

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

Views About End-of-Life Treatment Over Time

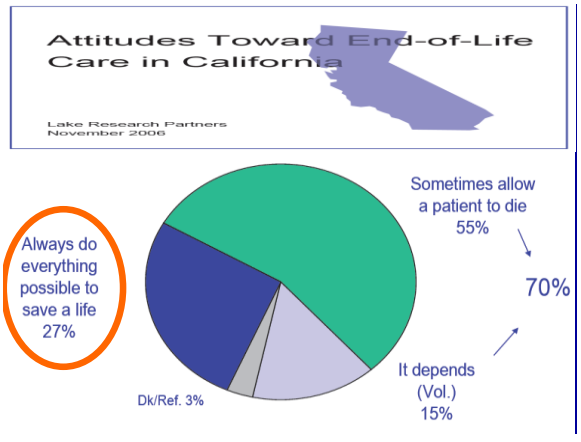
% of U.S. adults

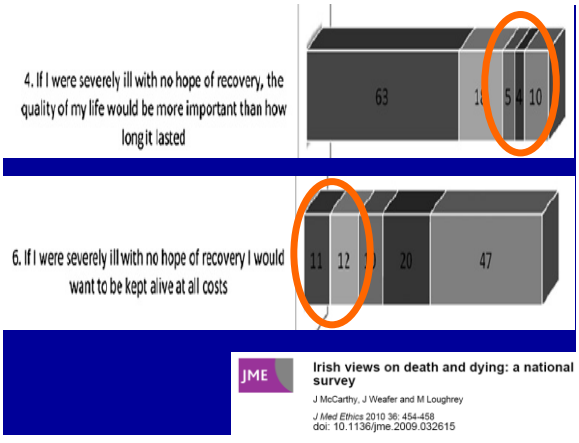
	1990	2005	2013	Diff. 90-13
Which comes closer to your view?				
There are circumstances in which a patient should be allowed to die	73	70	66	-7
Doctors and nurses should do everything possible to save the life of a patient in all circumstances	15	22	31	+16
Don't know	12	8	9	-9
	100	100	100	



20%: "More important to prolong life."

National Journal (Mar. 2011)
Archives Surgery (Aug. 2008)



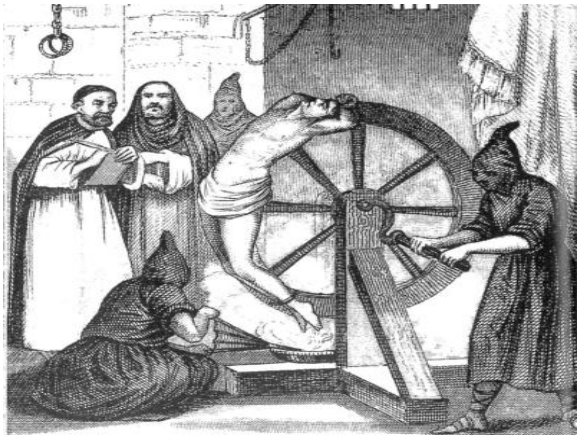


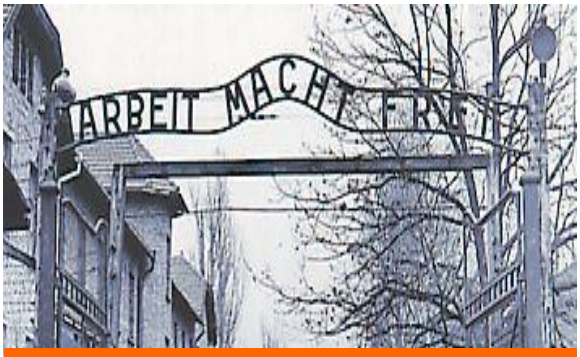
Clinicians resist

65

Avoid patient suffering

66





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

"I do not see much difference between what we are doing . . . and . . . **atrocities** . . . in **Bosnia**."

69

Moral distress

70

Absenteeism

Retention

Quality

72

Integrity of profession

73

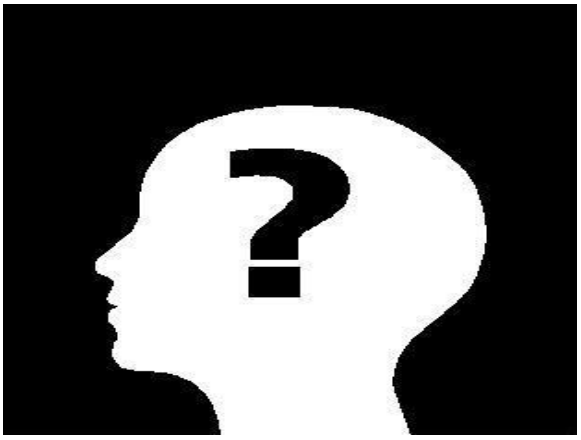
Stewardship

76

Limited ICU beds
ER boarding
Antibiotic resistance

Distrust surrogate

78



Prevention

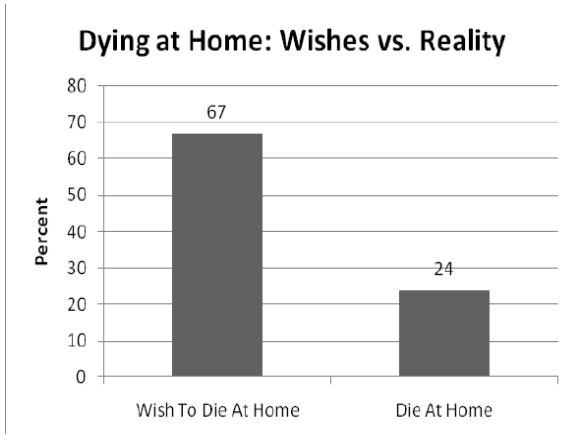
80

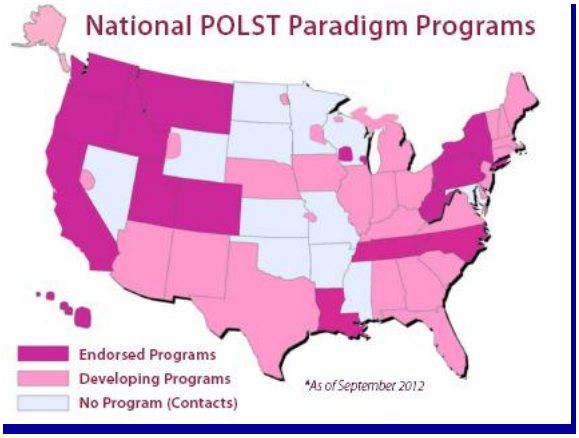
71%: "More important to enhance the **quality** of life for seriously ill patients, even if it means a **shorter life.**"

National Journal (Mar. 2011)

82

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





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. IBERA 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

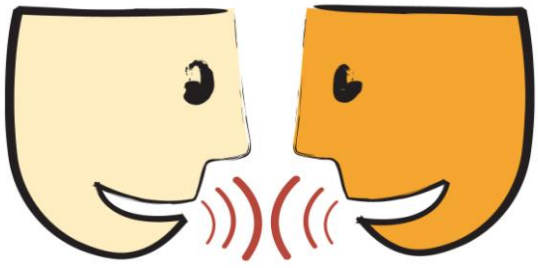
A BILL

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".



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

90

Choosing Wisely®

An initiative of the ABIM Foundation

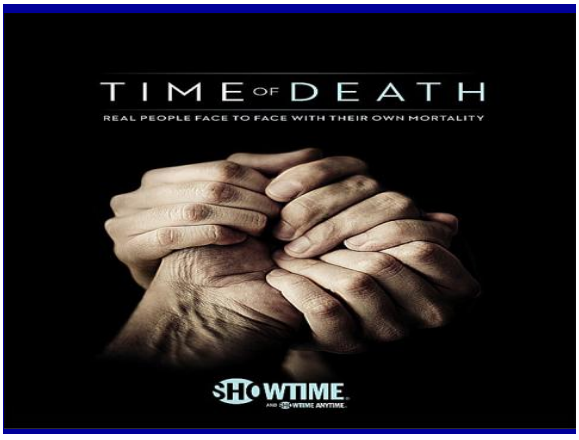
IPDAS

International Patient Decision Aid Standards Collaboration

Honoring Choices® MINNESOTA

An initiative of the Twin Cities Medical Society.

93



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"

96

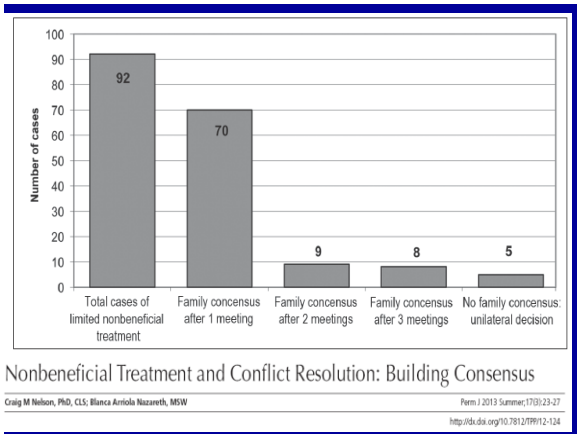
Informal Resolution

97

Consensus

Intractable

99



Prendergast (1998)

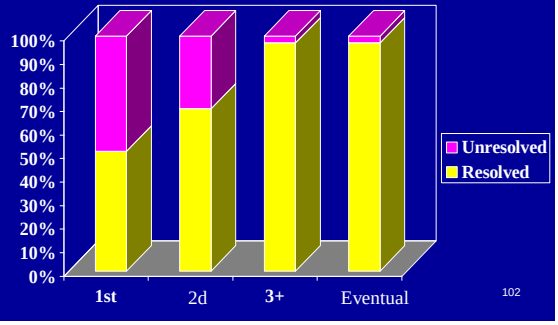
57% agree immediately

90% agree within 5 days

96% agree after more meetings

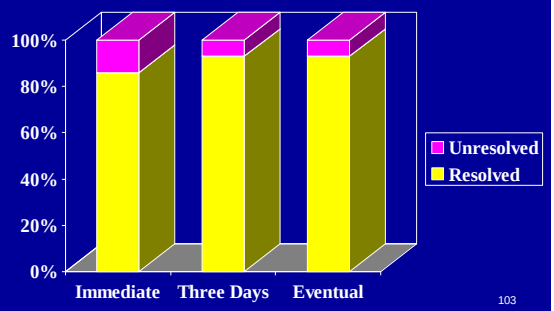
101

Garros et al. (2003)



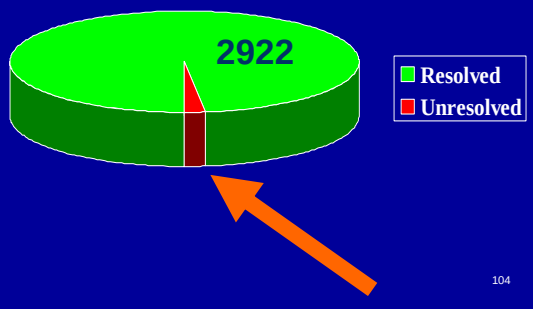
102

Fine & Mayo (2003)

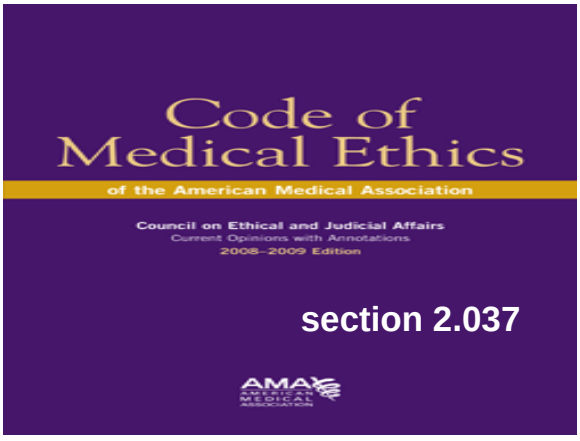


103

Hooser (2006)



104



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

106

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

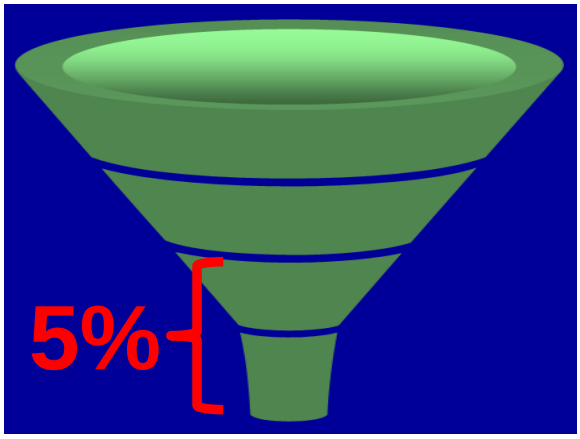
107

Regions Hospital

Subject	Attachments
Decision-making and Dispute Resolution for Medical Interventions Considered to be Harmful, Non-beneficial or Futile	☐ Yes ☒ No
Key words Medical futility	Number RH-RI-PC-10-28

95%

109



Transfer

111

Rare, but possible

112

Intractable Conflict

113

1. Covert
2. Cave-in
3. New surrogate
4. Unilateral stop

Covert

115

Without legal support to w/d or w/h openly and transparently, some do it covertly.

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)

Cave-in

119

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."**

120

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

121

Legal Risk

124

"It is **not** settled law that, in the event of disagreement . . . **the physician** has the final say."

Golubchuk v. Salvation Army Grace Gen. Hosp., 2008 MBQB 49 (Feb. 13, 2008).

Civil liability

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

126

Licensure discipline

Criminal liability

e.g. homicide

127

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

128

Providers typically lose only **IIED** claims

Secretive

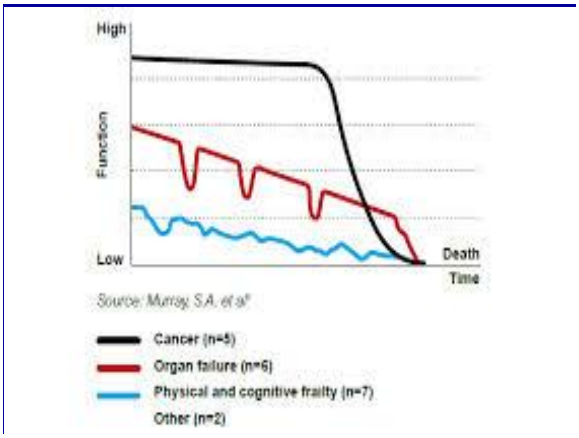
Insensitive

Outrageous

129

$250,000

132



ALLIANCE DEFENSE FUND

Defending Our First Liberty

135

Risk > 0

136

Liability averse

Litigation averse

137

Process = punishment

Even prevailing parties pay **transaction costs**

- Time
- Emotional energy

138

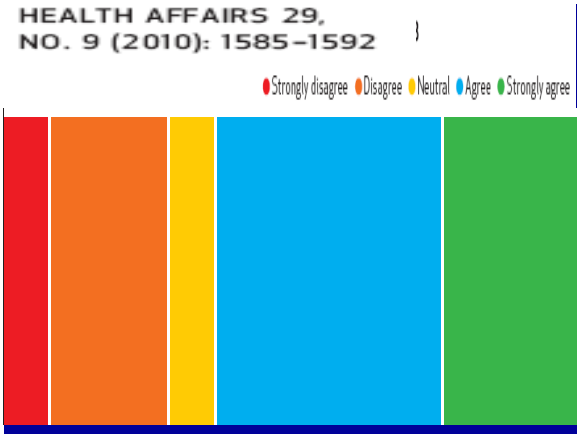
Easier to cave-in

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

139

Defensive Medicine

140



J Am Geriatr Soc 58:533–538, 2010.

Factor	Extremely or Very Important	Most Important of All Factors Listed
Patient's prognosis	98.5	12.0
What was best for the patient overall	98.1	33.2
Respecting the patient as a person	96.6	5.4
Patient's pain and suffering	94.6	12.5
What the patient would have wanted you to do	81.8	29.4
Providing the standard of care	81.5	2.2
Respecting the wishes of the family or surrogate(s)	80.9	3.3
Following the law	68.6	1.1
The burden on the family	44.8	0
Religious beliefs of the patient	35.3	0
Religious beliefs of the family or surrogate(s)	28.6	0
Cost to society of caring for the patient	14.2	0
Physician's religious beliefs	10.7	0
Concerns about paying for [illegible]	9.3	0
Concern that the surrogate(s) might sue	8.4	1.1

Get a new Surrogate

143

Substituted judgment

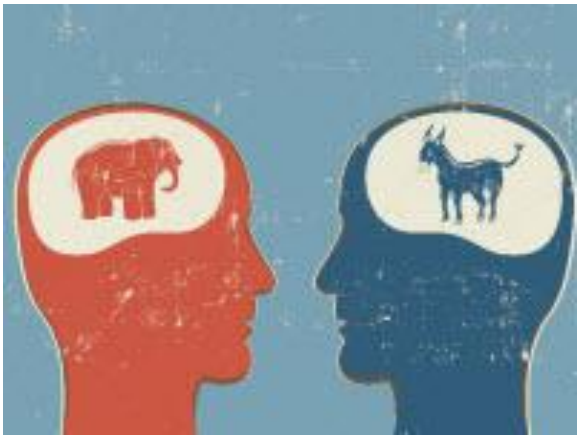
Best interests

145

Minn. Stat. 145C.07(3)

Duty to act in good faith

146



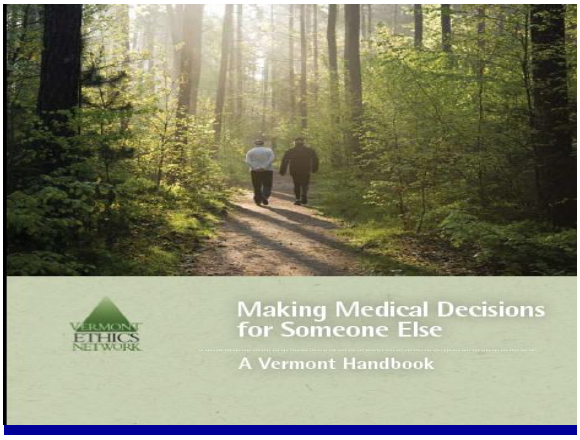
~ 60%

accuracy

More aggressive treatment

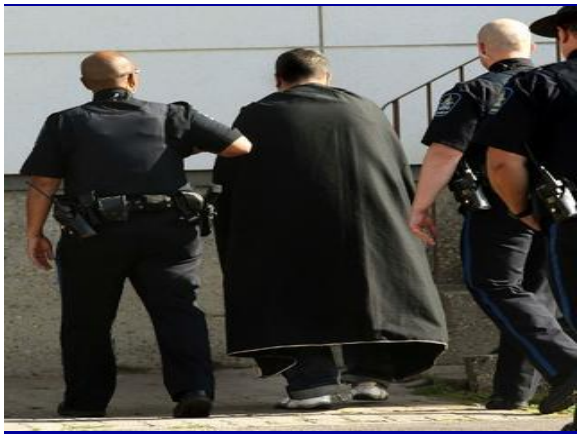
149

Improve Surrogate Accuracy


Making Medical Decisions
for Someone Else
A Vermont Handbook


You're
Fired!


Baby M
Children's
Hospital



Surrogate	Advance directive
GO	STOP

157

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

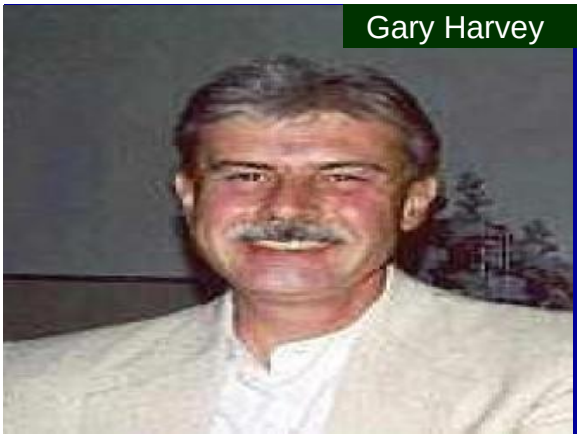
Order Appointing Emergency Guardian

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

163



"failed to follow medical advice"

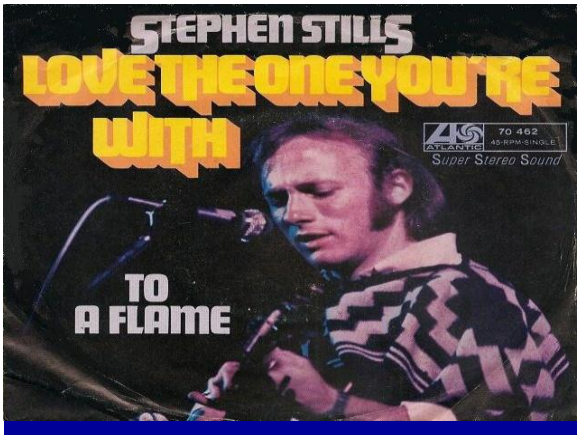
"failed to use good judgment"

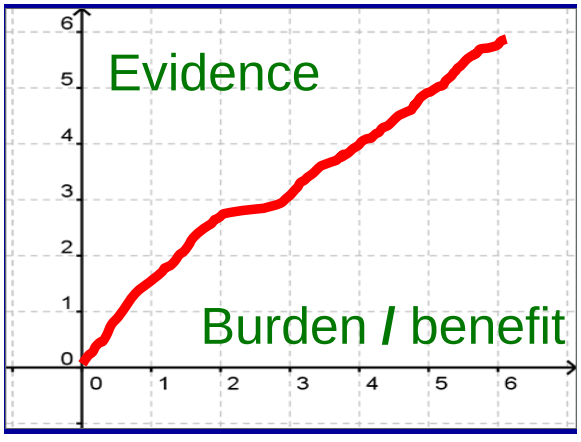
Your own personal issues are "impacting your decisions"

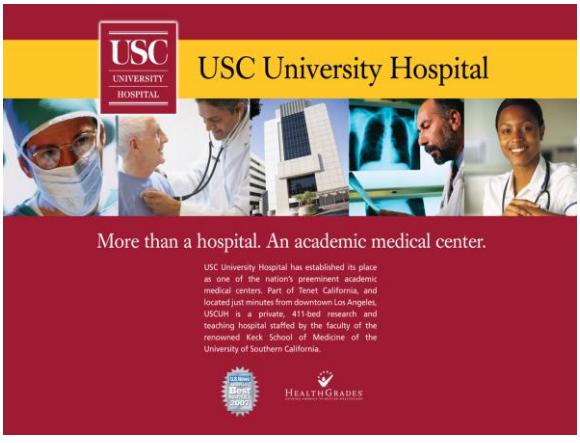
"Refocus your assessment"

AMA Code Ethics 2.20

Though the surrogate's decision . . . should **almost always** be accepted . . . situations . . . may require . . . institutional or judicial review . . .





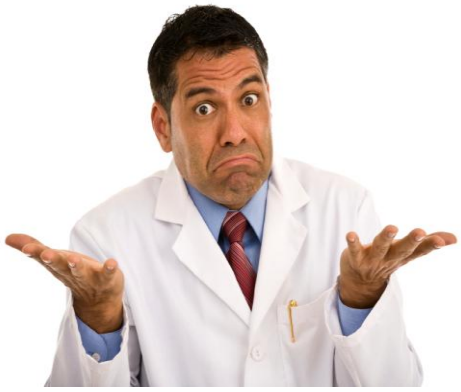


BUT

173

1

Providers cannot show deviation



2

Surrogates get benefit of doubt

In re Helga Wanglie

(May 1991)

178

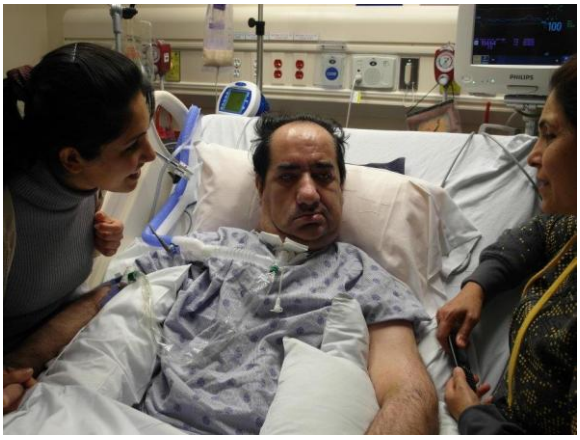
3

Surrogates are faithful

Ontario

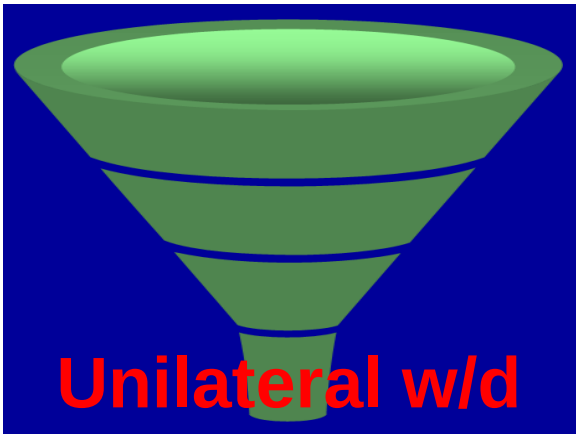
Consent and Capacity Board

181

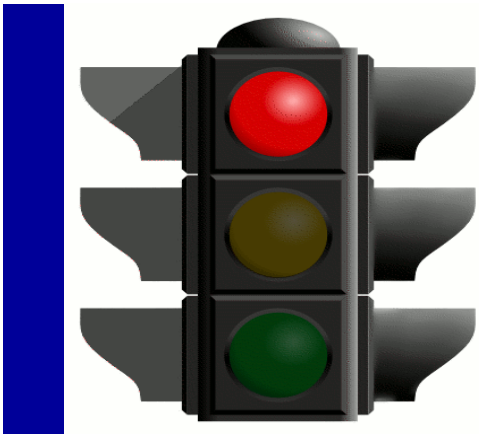


Stop without consent

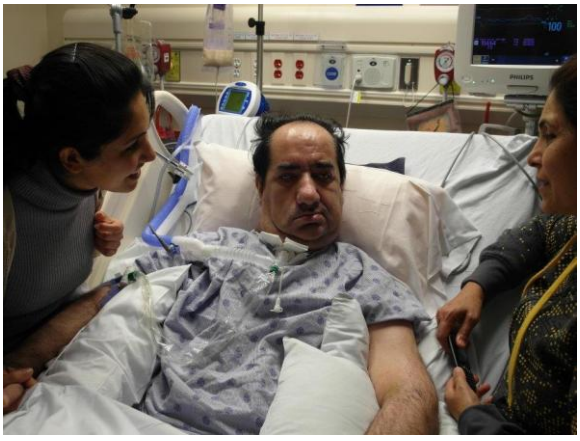
185



187



188



Ontario

Consent and Capacity Board

190

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

193

Discrimination in Denial of Life Preserving Treatment Act

194

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

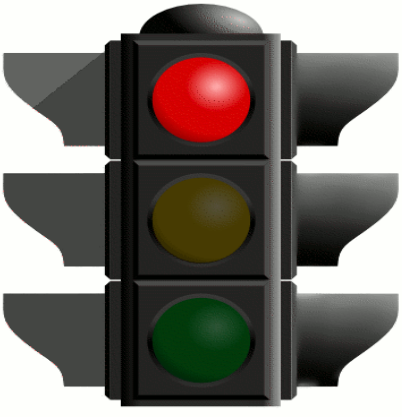
195

H.B. 1403 (2013)

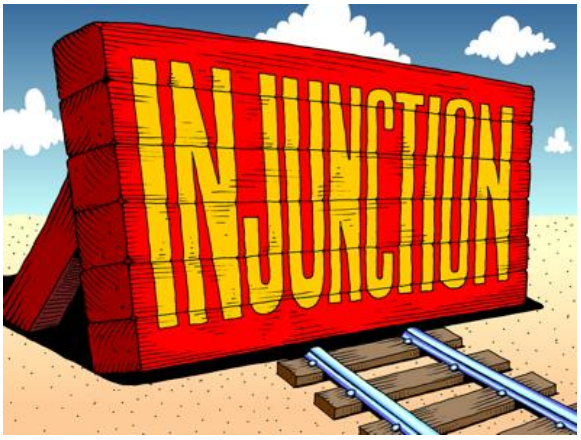
196

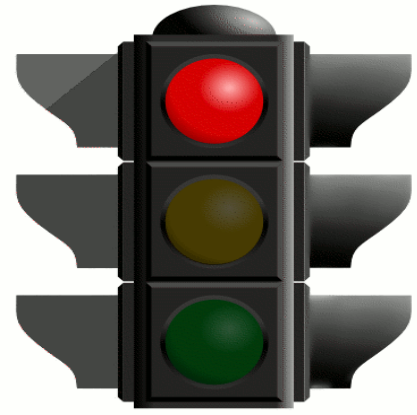
SB 172, HB 309 (2012)

197



198





200

CHAPTER 145C

HEALTH CARE DIRECTIVES

145C.01	DEFINITIONS.	145C.09	REVOCATION OF HEALTH CARE DIRECTIVE.
145C.02	HEALTH CARE DIRECTIVE.	145C.10	PRESUMPTIONS.
145C.03	REQUIREMENTS.	145C.11	IMMUNITIES.
145C.04	EXECUTED IN ANOTHER STATE.	145C.12	PROHIBITED PRACTICES.
145C.05	SUGGESTED FORM; PROVISIONS THAT MAY BE INCLUDED.	145C.13	PENALTIES.
		145C.14	CERTAIN PRACTICES NOT CONDONED.
145C.06	WHEN EFFECTIVE.	145C.15	DUTY TO PROVIDE LIFE-SUSTAINING HEALTH CARE.
145C.07	AUTHORITY AND DUTIES OF HEALTH CARE AGENT.	145C.16	SUGGESTED FORM.
145C.08	AUTHORITY TO REVIEW MEDICAL RECORDS.		

Minn. Stat. 145C.15

203

"A health care provider who is **unwilling** to provide directed health care . . . that, in reasonable medical judgment, has a significant possibility of sustaining the life of the [patient] . . . **shall** take all reasonable steps to ensure provision of the directed health care **until** the [patient] is transferred."

204

Jackie Schweitzer

Minnesota Citizens Concerned for Life

205

Expressio unius est exclusio alterius

206

Minn. Stat. 145C.11

207

"administers health care necessary **to keep the principal alive**, despite . . . agent . . ., is not subject to criminal prosecution, civil liability, or professional disciplinary action . . ."

208

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

Not **red**

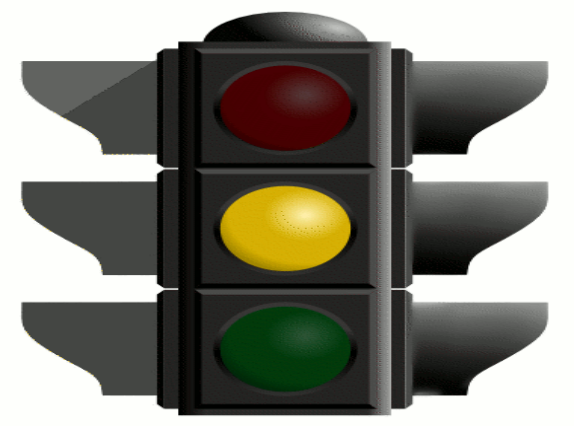
210

Not
green
either

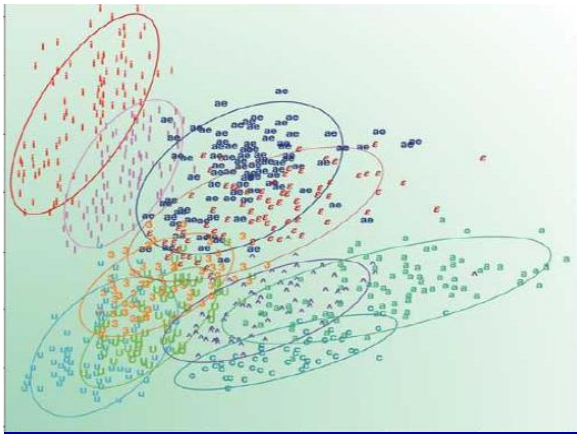
211

Yellow

212



"generally accepted health care standards"



136 No congruence in patients
93 Indicated by 1 nurse
38 Indicated by 1 physician
5 Missing data (clinicians professional role unknown)

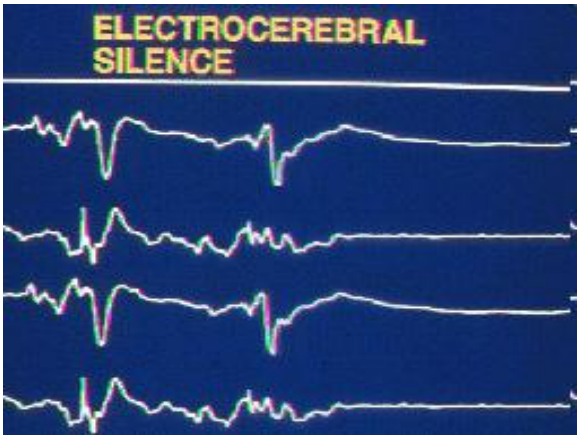
71 Patients identified by multiple clinicians
42 Identified by 2 clinicians
14 Identified by 3 clinicians
15 Identified by >3 clinicians

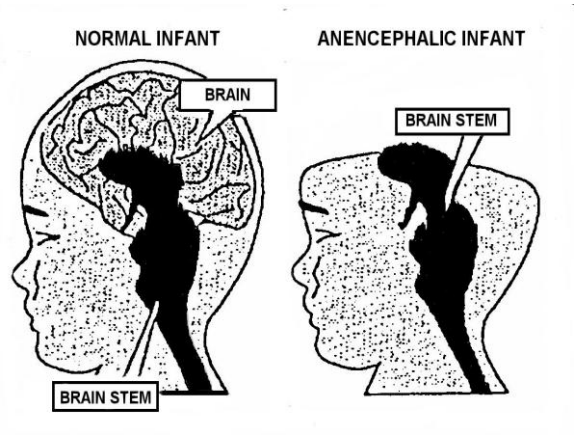
45 Indicated by ≥1 nurse and ≥1 physician
18 Indicated by nurses only
5 Indicated by physicians only
3 Missing data (≥1 professional role unknown)

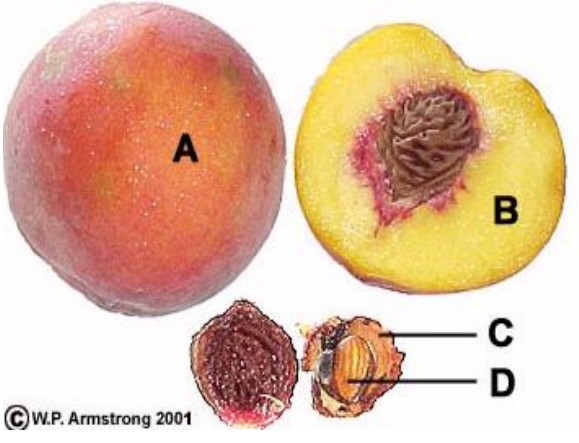
JAMA. 2011;306(24):2694-2703

0% → 13%

Lantos, Am J Med 1989



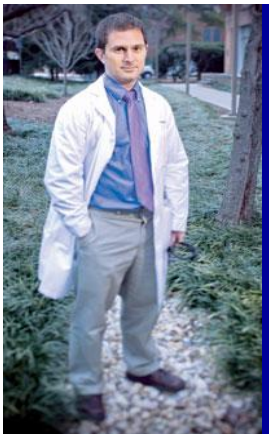




Safe harbor attributes

- Clear
- Precise
- Concrete
- Certain

224



Not just ambiguity

Providers continue to create the "wrong" standard of care

Dan Merenstein
291 *JAMA* 15 (1994)

AMA
AMERICAN MEDICAL ASSOCIATION

"**general, if unofficial, consensus** among most intensivists that surrogate requests . . . be granted even when patients are irreversibly ill and will not survive"

229

CPR

Dialysis

Mechanical ventilation

CANH

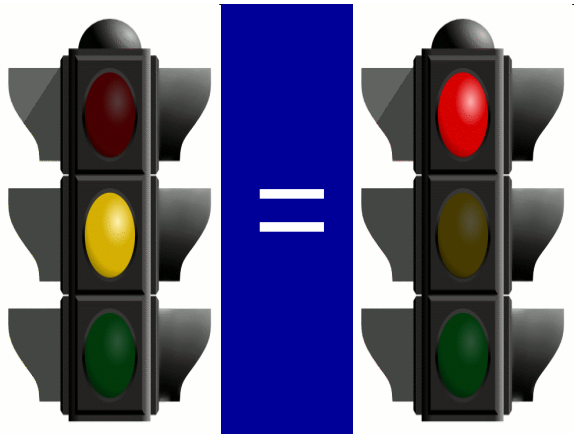
ECMO

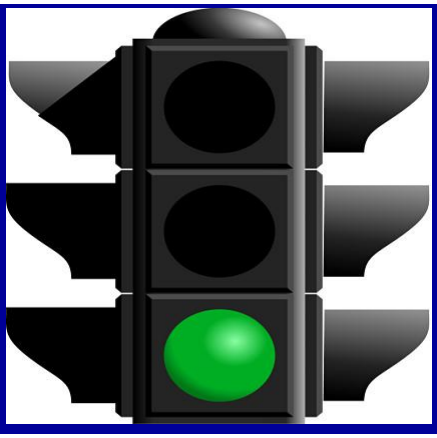
ELAD

230

RPA

Renal Physicians Association



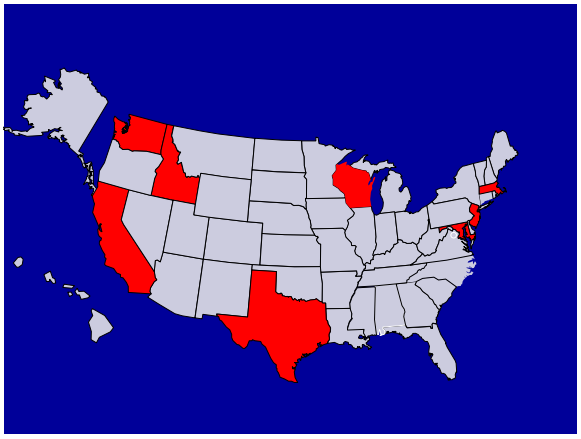


You may stop LSMT for **any reason**

so long as your HEC agrees

Tex. H&S 166.046

1. 48hr notice
2. HEC meeting
3. Written decision
4. 10 days to transfer
5. Unilateral WH/WD



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

E

Reference Committee

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

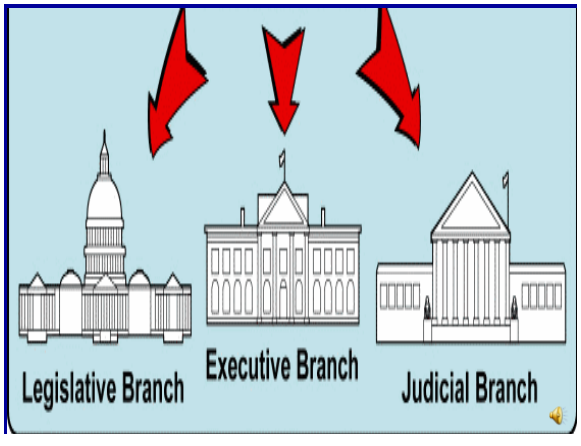
RESOLUTION 1 - 2004
(read about the *action* taken on this resolution)

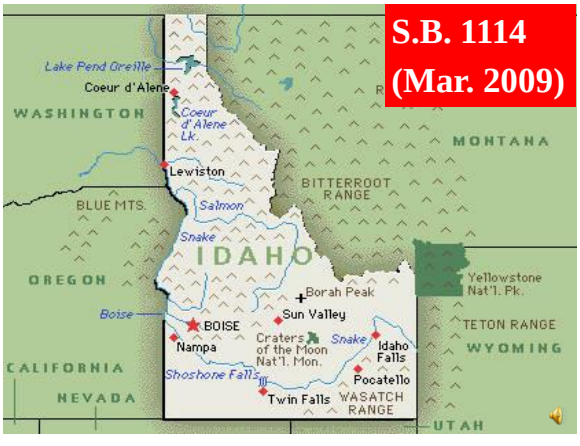
WI

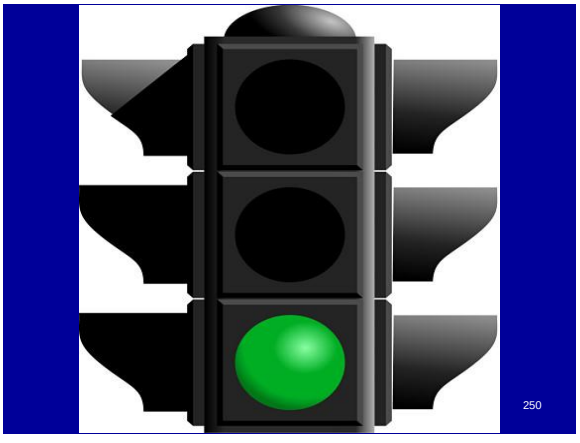
Subject: Futility of Care

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.







Treat
'til
transfer

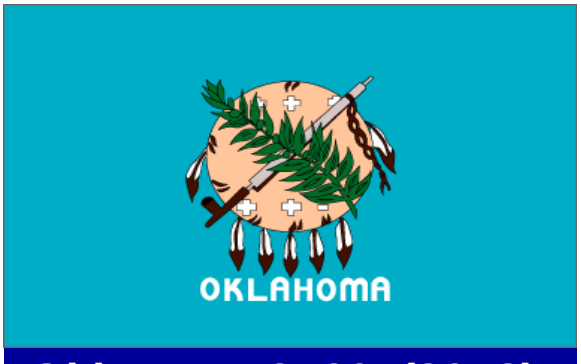
252

Miss. Code § 41-107-3 253

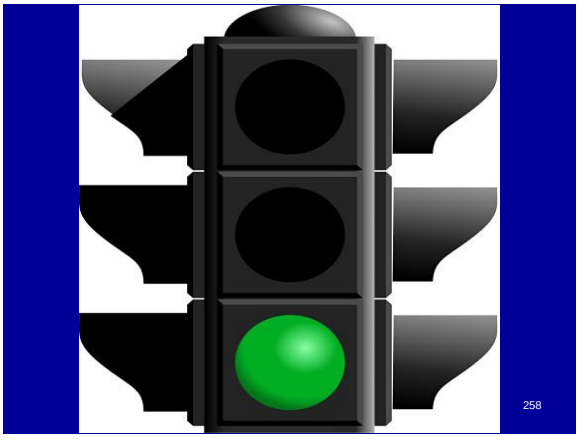
L.B. 564 (2013) 41

Mich. S.B. 136 (2013) 42

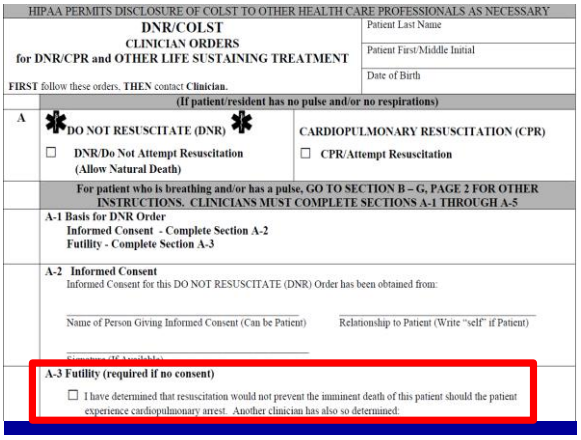
H.B. 279 (2013) (over veto) 40



Okla. H.B. 2460 (2012) 257



258



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

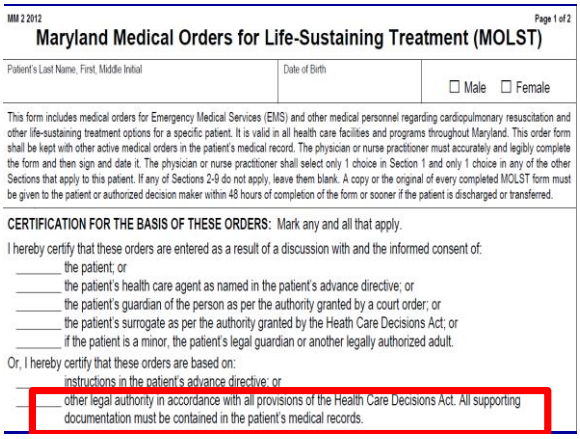
A-2 Informed Consent
Informed Consent for this DO NOT RESUSCITATE (DNR) Order has been obtained from:

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.

New ATS Policy

261

AMERICAN THORACIC SOCIETY · 1905 ·

ATS

We help the world breathe

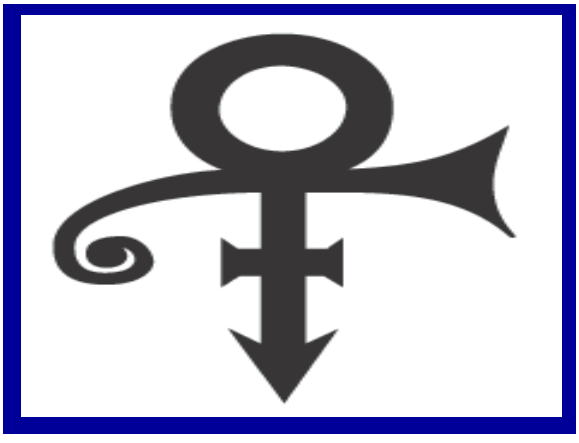
PULMONARY · CRITICAL CARE · SLEEP

Society of Critical Care Medicine

The Intensive Care Professionals

AMERICAN COLLEGE OF CHEST PHYSICIANS

The Global Leader in Clinical Chest Medicine



1. Futile
2. Inappropriate
3. Provisionally inappropriate

269

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

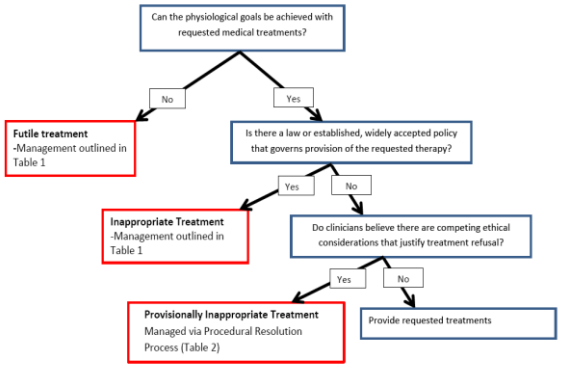


Table 2- Model policy highlighting procedural steps for resolution of conflict regarding life-sustaining treatments

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.

Time pressured decisions

Consensus among clinicians present

Case review to extent possible

275

Thaddeus Mason Pope
Director, Health Law Institute
Hamline University School of Law
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

277

References

278

Dispute Resolution Mechanisms for Intractable Medical Futility Disputes, 58 N.Y.L. SCH. L. REV. (forthcoming 2013) .

Pope TM & White DB, *Patient Rights, in* OXFORD TEXTBOOK OF CRITICAL CARE (2d ed., Webb et al., eds., forthcoming 2013).

Pope TM & White DB, *Physician Power, in* OXFORD HANDBOOK OF DEATH AND DYING (Robert Arnold & Stuart Younger eds., forthcoming 2013).

279

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).

280

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).

281

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).

282

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).

283

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).

284

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).

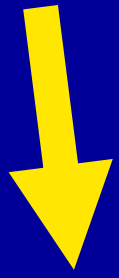
Philosopher's Corner: Medical Futility, 15 MID-ATLANTIC ETHICS COMM. NEWSL, Fall 2007, at 6-7

285

Problems with Texas

286

No substantive criteria



Pure procedural justice

287

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

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

Neutral independent decision maker

Appellate review

290

1-5 members	48%
5-10 members	34%

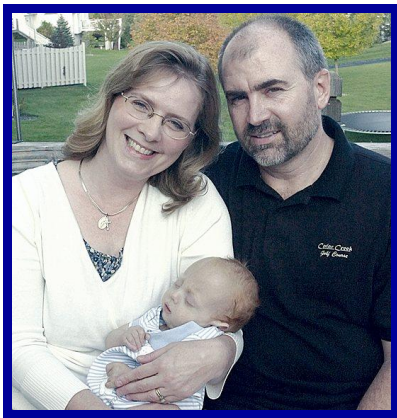
Mostly physicians, administrators, nurses

No community member requirement, like IRB

< 10% TX HECs have community member

Other MN Law

294



Mary Kellett

295

H.F. 1656
S.F. 908

Sen. Nienow

296

FROEDTERT MEM LUTHERAN HSPTL	**9200 W WISCONSIN AVE MILWAUKEE, WI 53226**	**Feb. 2, 2012**

VIOLATION: *PATIENT RIGHTS*

Tag No: A0115

Based on review of policies and procedures, patients' medical records, and staff interviews the hospital failed to notify 1 of 1 patient of the hospital's Medical Futility Policy prior to implementing the policy. This failure does not promote and protect patients' rights, and potentially affects all patients admitted to the hospital.

Findings include:

The hospital changed patient #1's Full Code status to Do Not Resuscitate without the consent of patient #1's HCPOA (health care power of attorney). (A131)