1

Bridge to Nowhere

Can ECMO Be Withdrawn **over** Patient/Family Objections?

2

The Legal Dilemma

Who Has the Right to Decide?

3

4

clinician	surrogate
CMO	ECMO

5

have a conflict

6

what are your **options**

7

5 options

8

consensus

9

new surrogate

10

new hospital

11

if **none** of that works …

12

withdraw ECMO

without consent

13

14

patient with

capacity

15

consensus

16

most hospital policies

most society guidelines

17

17

negotiation

mediation

18

18

Code of Medical Ethics

of the American Medical Association

AMA American Medical Association

Council on Ethical and Judicial Affairs

Current Opinions with Annotations

19

4 of 7 steps

20

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

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

21

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

4. involve … **ethics committee**

22

why?

23

24

95%

25

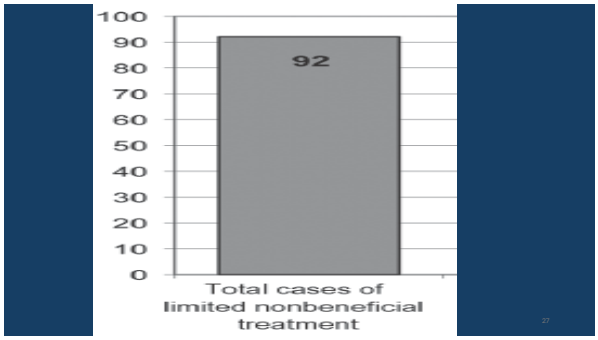
KAISER PERMANENTE

Nonbeneficial Treatment and Conflict Resolution: Building Consensus

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

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

26



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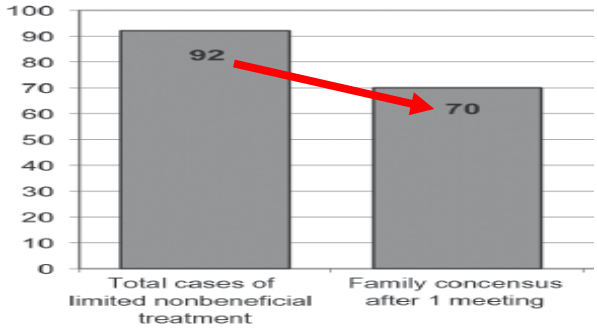

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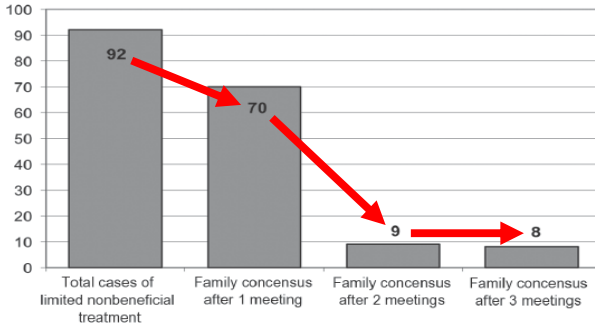

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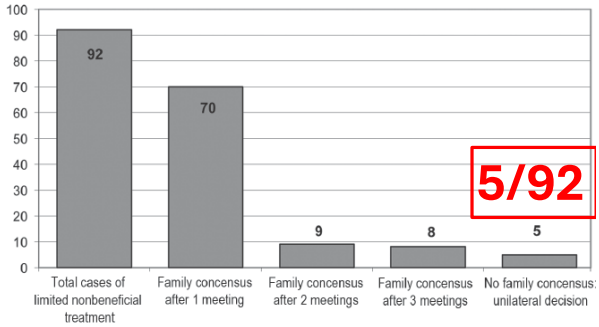


30

31

32

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.

33

57% agree immediately

90% agree within 5 days

96% agree after more meetings

34

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

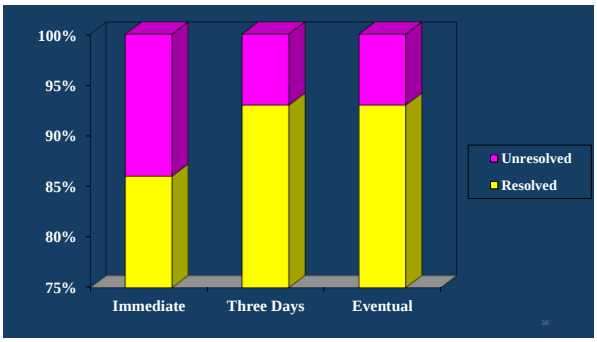
Robert L. Fine, MD, and Thomas Wm. Mayo, JD

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

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

35



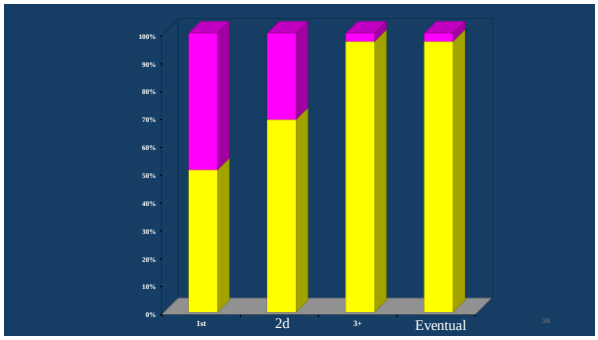
36

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

37

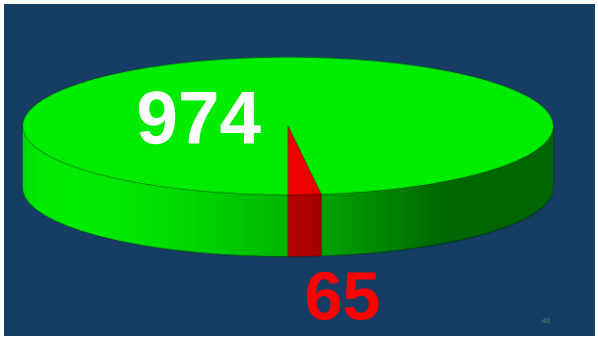


38

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)

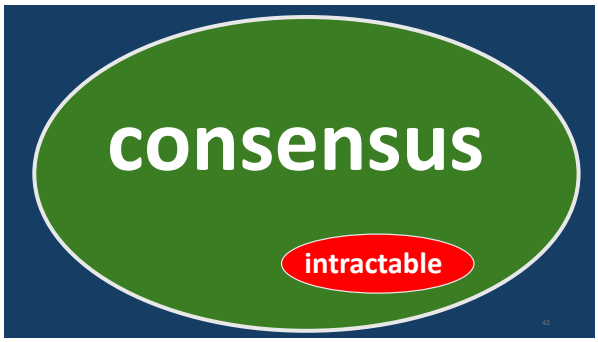
39



40

95%

41



42

but

43

43

tried reach consensus

44

44

intensive communication

mediation

45

45

still no consent

46

46

new surrogate

47

47

48

48

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

49

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

50

Cal. Prob. Code §§ 4684, 4714

51

but

52

53

~ 60% accurate

54

more

aggressive treatment

55

5

56

surrogate lacks **capacity**

57

surrogate has material **COI**

58

contradiction

59

AD →

← surrogate

60

known wishes →

← surrogate

61

if **no** AD or known wishes

62

best interest →

← surrogate

63

64

incongruent

patient wishes

or

patient best interests

65

SO…

66

sometimes surrogates should be **challenged**

67

sometimes surrogate should even be **replaced**

68

69

70

71

Genea Bristol

(St. Lucie County, FL May 2021)

72

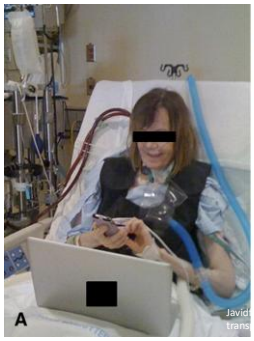
Steffen Rivenburg

(Montgomery County, Tenn. June 2017)

73

not always

74



Javidfar J, et al. Extracorporeal membrane oxygenation as a bridge to lung transplantation and recovery. J Thorac Cardiovasc Surg. 2012 Sep;144(3):716-21.

75

Consent and Capacity Board Commission du consentement et de la capacité

Ontario

no

15-0538-01
15-0538-02

IN THE MATTER OF
The *Health Care Consent Act, 1996*
S.O. 1996 c.2,
as amended

AND IN THE MATTER OF
SS
A PATIENT AT THE HOSPITAL FOR SICK CHILDREN
TORONTO, ONTARIO

76

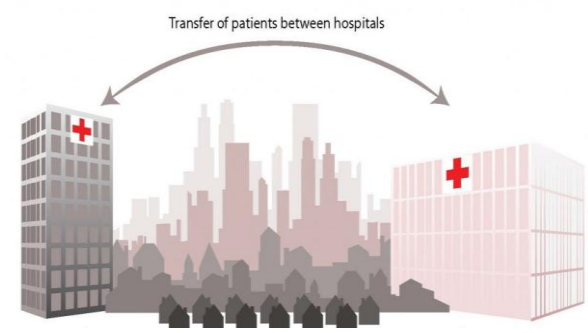
no consensus

no new surrogate

77

new hospital

78



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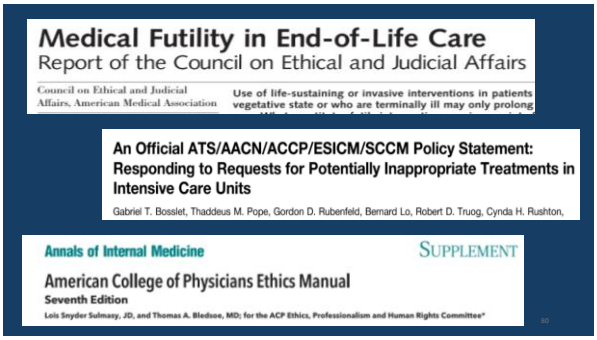


80

rare

81

81

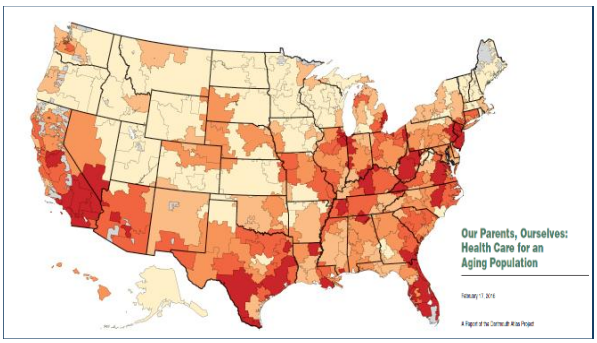
but

possible

82

82

83



84

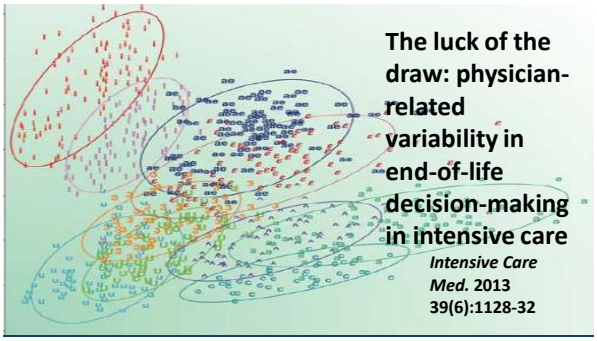
ICU days last 6 mo.

85

physician

variability

86



The luck of the draw: physician-related variability in end-of-life decision-making in intensive care

Intensive Care Med. 2013 39(6):1128-32

87

hospital

variability

88

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

89

[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;

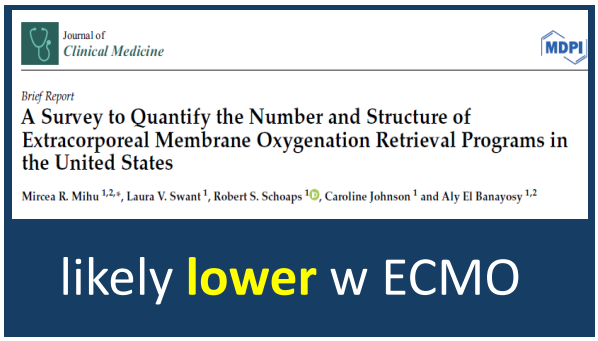
90

can find &
make transfers

91

that's based
on experience
with trad. **LST**

92



likely **lower** w ECMO

93

but

94

no consent
no new surrogate
no transfer

95

withdraw ECMO w/o consent

96

97

Intensive Care Med (2019) 45:364–366
https://doi.org/10.1007/s00134-018-05510-z

UNDERSTANDING THE DISEASE

Determination of brain death under extracorporeal life support

Thomas Bein[1*], Thomas Müller[2] and Giuseppe Citerio[3]

98

CMA California Medical Association

Views & Reviews

Really, most SINCERELY dead

Policy and procedure in the diagnosis of death by neurologic criteria

D.M. Shaner, MD; R.D. Orr, MD; T. Drought, PhD, RN; R.B. Miller, MD; and M. Siegel, MD

"once death … diagnosed … **discontinue** support"

99

Guidelines for Physicians: Forgoing Life-Sustaining Treatment for Adult Patients

Joint Committee on Biomedical Ethics
of the
Los Angeles County Medical Association
and
Los Angeles County Bar Association

Approved by the Los Angeles County Medical Association February 15, 2006
Approved by the Los Angeles County Bar Association March 22, 2006

"all medical interventions should be **withdrawn**"

100

consent **not** required

101

102

103

Summer Medford v. UCLA

104

alive patients

105

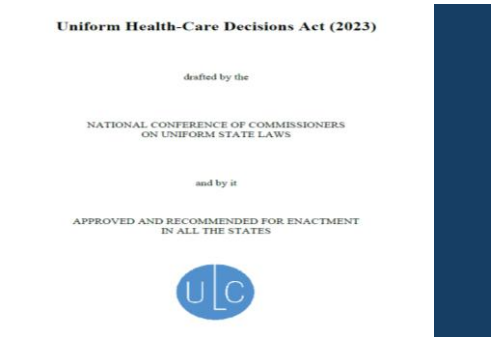
106

big state

here **now**

modeled UHCDA

107



Uniform Health-Care Decisions Act (2023)

drafted by the

NATIONAL CONFERENCE OF COMMISSIONERS ON UNIFORM STATE LAWS

and by it

APPROVED AND RECOMMENDED FOR ENACTMENT IN ALL THE STATES

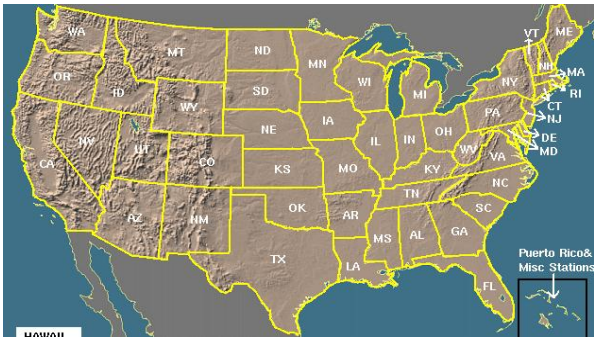
ULC

108

followed in many **other** states

109

110



111

112

normally, clinicians must **follow** patient & surrogate decisions

113

114

"provider … **shall … comply** with a … decision … made by a person then authorized"

115

but

116

EXCEPTION TO THE RULES

117

118

"provider … **may decline to comply** with … decision that … requires"

119

either

120

"**medically ineffective** health care"

121

or

122

"health care **contrary** to generally accepted health care **standards**"

123

plus

124

legal immunity

125

126

"**not subject** to civil **or** criminal liability **or** to discipline for unprofessional conduct"

127

128

may stop ECMO **without** consent

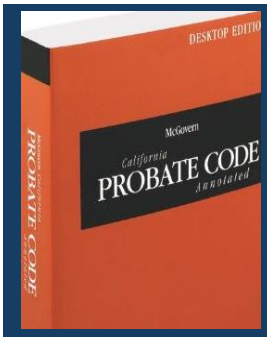
129

contrary to GAHCS

130

medically ineffective

131



what do these words **mean**

132

contrary to GAHCS

133

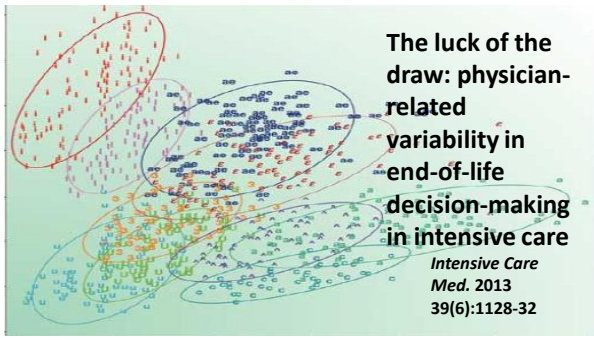
GAHCS S

134

standard of care S

135

136



The luck of the draw: physician-related variability in end-of-life decision-making in intensive care

Intensive Care Med. 2013 39(6):1128-32

137

	Y	N	?
Should surrogate consent be required to discontinue VA-ECMO?	32	40	27
Should physicians have the right to discontinue over surrogate objection?	57	11	32

A survey of physician attitudes toward decision-making authority for initiating and withdrawing VA-ECMO: Results and ethical implications for shared decision-making, : J Clin Ethics. 2016 Winter;27(4):281–289

138

for updates

Empirical Ethics

CLINICAL ETHICS

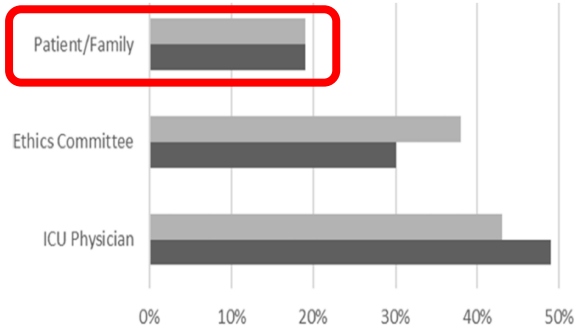
Clinical Ethics
2022, Vol. 17(2) 144–151

DOI: 10.1177/14777509211001560
journals.sagepub.com/home/cet
SAGE

Opinions among pediatric critical care physicians regarding the ethics of withdrawal of ventricular assist devices and extracorporeal membrane oxygenation

Antonia A Melas[1], Leanna L Huard[1], Rong Guo[2] and

139



140

GAHCS

141

medically ineffective

142

143

"not offer any significant benefit"

144

"not offer any significant benefit"

145

3 situations

146

imminent death
irreversible coma
never leave ICU

147

imminent death

148

patient will die in **hours/days** even with ECMO

149

irreversible coma

150

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

151

never leave ICU

152

no realistic chance of returning patient to survival **outside acute care** setting

153

ECMO w/o bridge

=

medically ineffective

154

155

may unilaterally withdraw ECMO

156

157

but

158

even **without**
safe harbor
legal immunity

159

low risk

160

few cases
brought

161

almost **none** even
want to sue

162

163

even if surrogate wants to sue, attorneys **decline**

164

unlikely to win
immunity
judicial deference

165

damages **too low**
< $300,000

166

few cases brought

167

in rare instances cases filed,
providers win

168

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

CALIFORNIA MEDICAL ASSOCIATION

169

"**no successful legal suits** against physicians and institutions who … appropriately invoked such policies"

170

"**appropriately** invoked such policies"

171

providers lose only **one type** lawsuit re unilateral WD

172

infliction of emotional distress

173

secretive

insensitive

outrageous

174

not liable for withdrawing but for

how

175

176

177

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,

178

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.

179

interdisciplinary institutional committee

180

patient with capacity

181

182

183

common basis for judging non-bridge ECMO inappropriate

184

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

185

Society of Critical Care Medicine

The Intensive Care Professionals

186

SAN DIEGO COUNTY MEDICAL SOCIETY

187

but

188

FEDERAL REGISTER

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

189

effective

July 8, 2024

190

"discrimination is particularly salient in the context of **medical futility**"

191

discriminatory

"deny … treatment … cannot end dependence on intensive … care"

192

SO…

193

may not withdraw ECMO based on judgment

"life ICU is not worth living"

194

may **still** withdraw over objections

195

different rationale

196

stewardship

distributive justice

197

198

199

Alvin Maharaj

[2023] NZHC 2128
(August 2023)

200

conclusion

201

201

clinician

CMO

surrogate

ECMO

202

203

try to **prevent**

w/ better communication
w/ documentation Pt wishes

204

try to reach **consensus**

with more family meetings
with EC, palliative, chaplaincy …

205

no consensus?

206

try **transfer** to another facility

207

try to **replace** surrogate

208

use your fair multidisciplinary review process

209

withdraw ECMO **without** consent

210

211

Thaddeus Mason Pope, JD, PhD, HEC-C
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E Thaddeus.Pope@mitchellhamline.edu
W www.thaddeuspope.com
B medicalfutility.blogspot.com

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