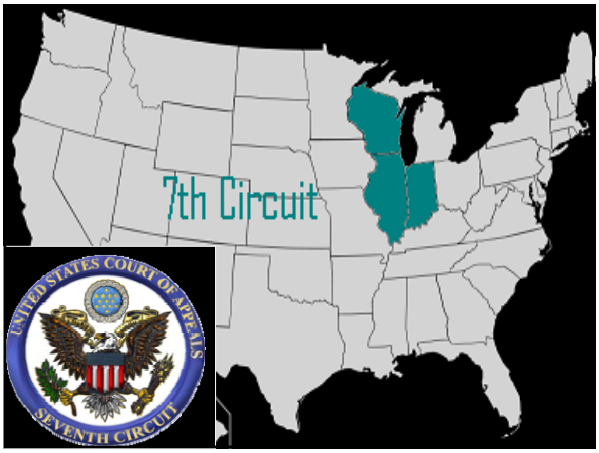
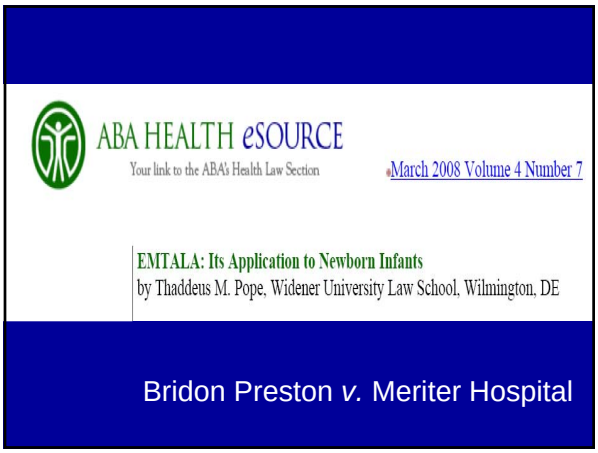
Unilateral Refusal of Treatment by Providers: Ethical & Legal Challenges

Thaddeus M. Pope, J.D., Ph.D.
Widener University Law School

Meriter Hospital Fall Ethics Conference
November 5, 2010





Bridon Preston *v.* Meriter Hospital

Roadmap (part 1)

- Definition & orientation
- Causes
- Typical resolution pathway

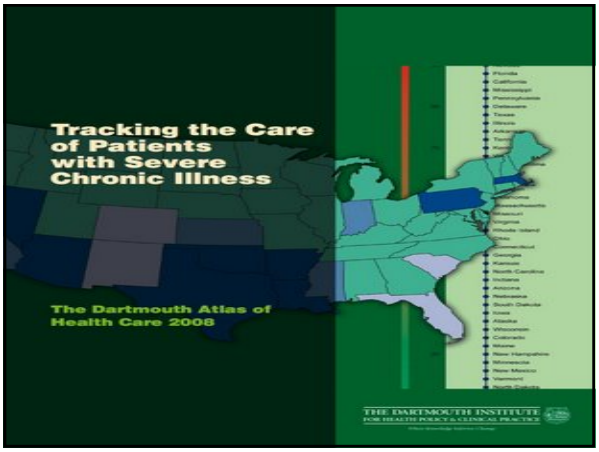
Today

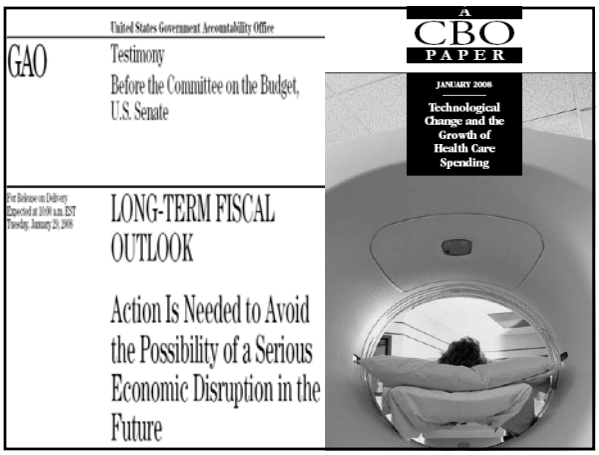
The Wisconsin Surgical Society
A Chapter of the American College of Surgeons

Past few weeks

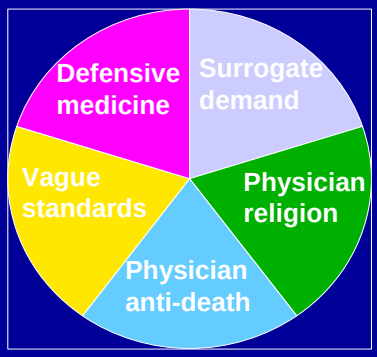
Children's Hospital and Health System
Children's Specialty Group
Medical College of Wisconsin
Critical Care Conference

What is a medical futility dispute?





Causes of non-beneficial medicine



- Patient
- Advance directive
- Proxy
- Agent
- Surrogate
- Conservator

"Continue to treat"

- Health care provider

"Treatment is inappropriate"

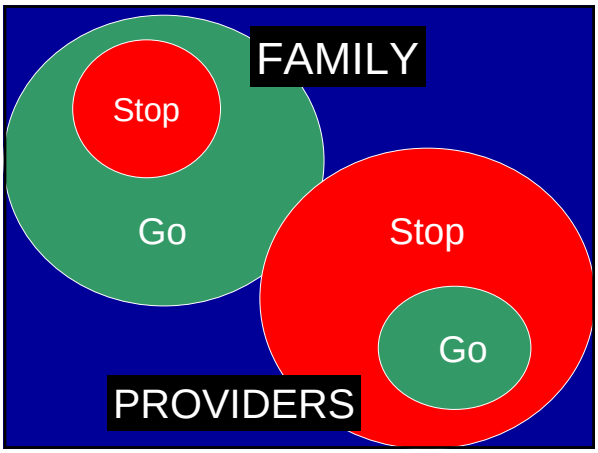


Table 4. Responses Regarding Demanding Care and Goals of Care for Those in a Persistent Vegetative State

Question and Responses[a]	Public, % (n=1006)	Professionals, % (n=774)	*P* Value
Do patients have the right to demand care that doctors think will not help?			
Yes	72.4	44.3	<.001
No	20.2	44.8	<.001

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Table 3. Preferences for Goals of Care and Limited Resources

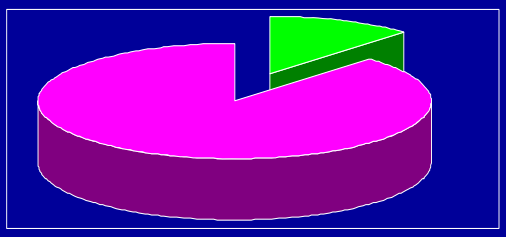
Question and Responses[a]	Public, % (n=1006)	Professionals, % (n=774)
If doctors believe there is no hope of recovery, which would you prefer?		
Life-sustaining treatments should be stopped and should focus on comfort	72.8	92.6
All efforts should continue indefinitely	20.6	2.5

Why do surrogates demand non-beneficial treatment?

Biggest reason YOU HAVE seen for surrogate insistence

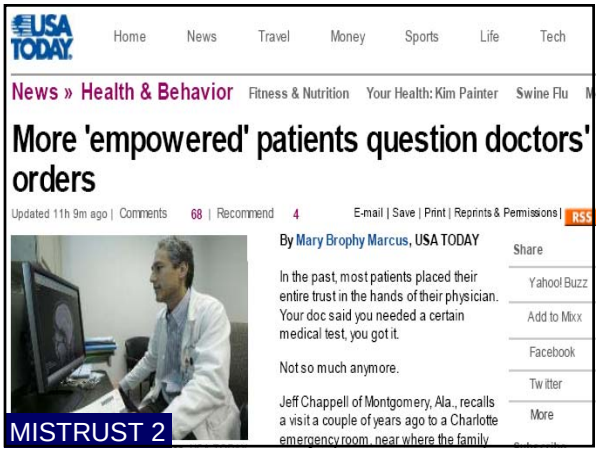
14% 1. Prognostic distrust
14% 2. Racial/Ethnic
14% 3. Religion/Miracles
14% 4. Guilt/Loyalty
14% 5. Family Dynamics
14% 6. Financial
14% 7. Other

Doubt prognostication



Zier, Critical Care Med. 2008

MISTRUST 1



MISTRUST 2

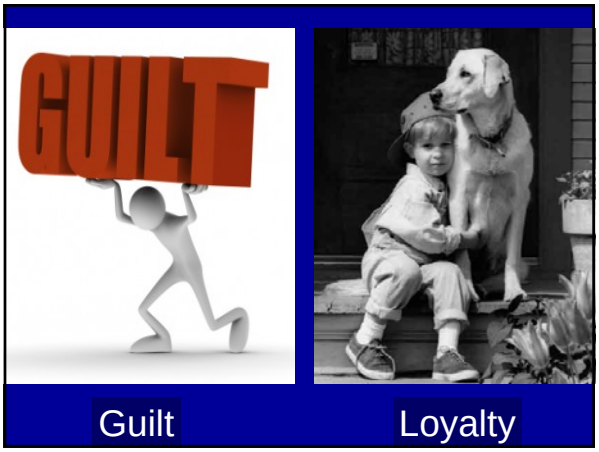
MISTRUST 3

MISTRUST 4

MISTRUST 5

MISTRUST 6

Family Dynamics



Guilt

Loyalty

No give up 1

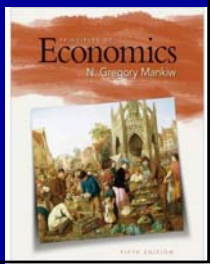
Rom Houben

No give up 2

No give up 3

Externalization

- Costs
- Guilt



Religion 1

Table 5. Responses Regarding Race, Culture, Ethnicity, and Religion

Question and Responses[a]	Public, % (n=1006)	Professionals, % (n=774)	*P* Value
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	<.001
No	35.5	61.1	<.001

Religion 2

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

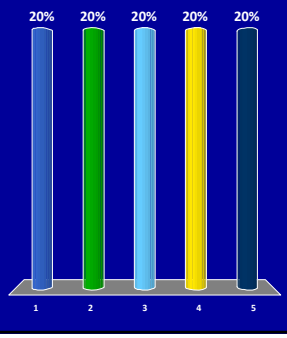
Zier et al., 2009 *Chest* 136(1):110-117

Religion 3

Why do providers resists surrogate requests?

Why do YOU resist surrogate demand for non-beneficial treatment

1. Professional integrity
2. Patient suffering
3. Stewardship/ resources
4. Distrust surrogate
5. Avoid staff moral distress

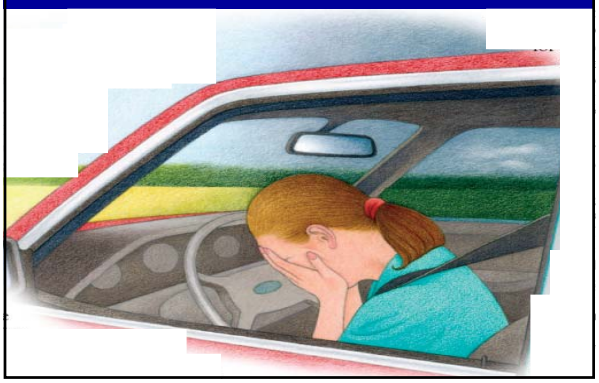


Avoid patient suffering

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

"abomination," "immoral," "tantamount to torture"

Moral distress



Category: futile care			
1.	Follow the family's wishes for the patient's care when I do not agree with them but do so because hospital administration fears a lawsuit	41 (93)	29 (66)
2.	Follow the family's wishes to continue life support even though it is not in the best interest of the patient	42 (95)	39 (89)
3.	Carry out a physician's order for unnecessary tests and treatment	43 (98)	32 (73)
5.	Initiate extensive life-saving actions when I think it only prolongs death	44 (100)	38 (86)
12.	Carry out the physician's orders for necessary tests and treatments for terminally ill patients	43 (97)	30 (68)
19.	Prepare an elderly man for surgery to have a gastrostomy tube put in, who is severely demented and a "No Code"	42 (95)	18 (41)

Intensive and Critical Care Nursing (2007) xxx, xxx–xxx
ELSEVIER
ORIGINAL ARTICLE
ICCN
www.elsevierhealth.com/journals/iccn

The relationship between moral distress and perception of futile care in the critical care unit☆

Melinda J. Mobley*, Mohamed Y. Rady**, Joseph L. Verheijde†, Bhavesh Patel*, Joel S. Larson*

Integrity of the profession

Distrust surrogate accuracy

Table 2. Predictive Accuracy of Surrogates Versus a Preliminary Population-Based Treatment Indicator

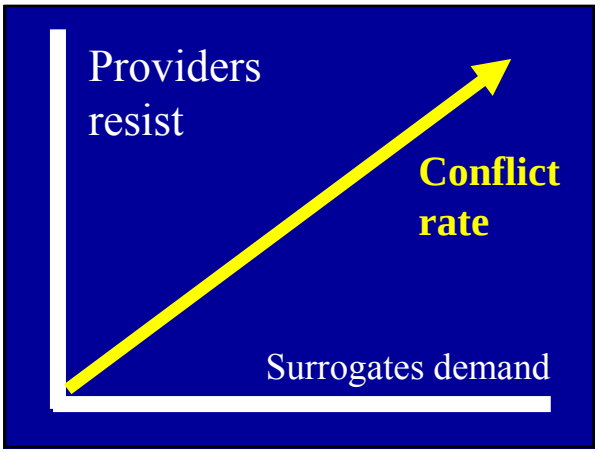
	Accuracy	(95% CI)
Overall[a]		
Surrogates	78.4%	(73, 84)
Treatment indicator	78.5%	(72, 85)

Stewardship

Growth in rate of conflict

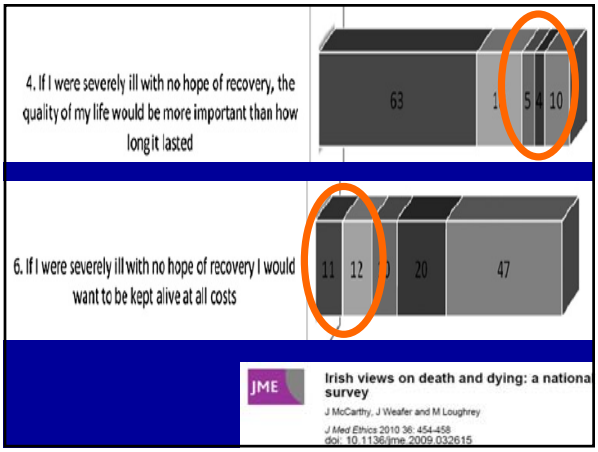
Population or percent, sex, and age	2000	2010	2020	2030	2040	2050
PERCENT OF TOTAL						
TOTAL						
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0
0-4	6.8	6.9	6.8	6.7	6.7	6.7
5-19	21.7	20.0	19.6	19.5	19.2	19.3
20-44	36.9	33.8	32.3	31.6	31.0	31.2
45-64	22.1	26.2	24.9	22.6	22.6	22.2
65-84	10.9	11.0	14.1	17.0	16.5	15.7
85+	1.5	2.0	2.2	2.6	3.9	5.0

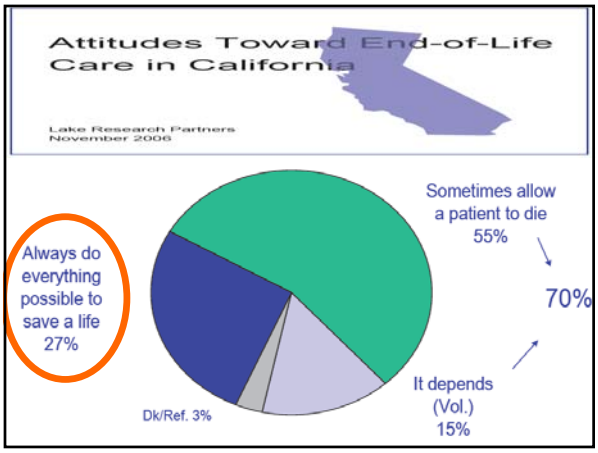
Source: U.S. Census Bureau, 2004, "U.S. Interim Projections by Age, Sex, Race, and Hispanic Origin," <http://www.census.gov/ipc/www/usinterimproj/>



TREND: DO EVERYTHING TO SAVE LIFE, OR SOMETIMES LET PATIENT DIE?

	----------May 1990----------			---------November 2005---------		
	Do everything to save life	Sometimes let a patient die	It depends / DK / Ref	Do everything to save life	Sometimes let a patient die	DK/ Ref
	%	%	%	%	%	%
	15	73	12=100	22	70	8=100





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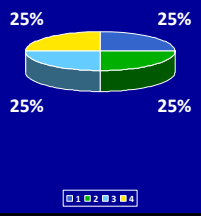
- More palliative care
- More EOL training
- Provider rights
- Financial incentives

Typical dispute resolution pathway

How are futility disputes usually resolved?

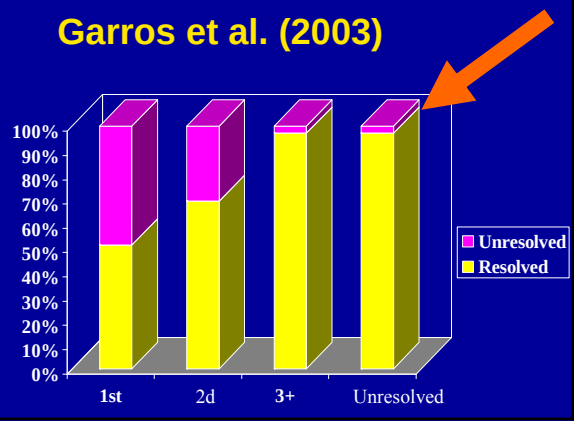
1. Surrogate eventually agrees with HCP
2. HCP accedes to surrogate demands
3. Patient dies
4. Patient transferred

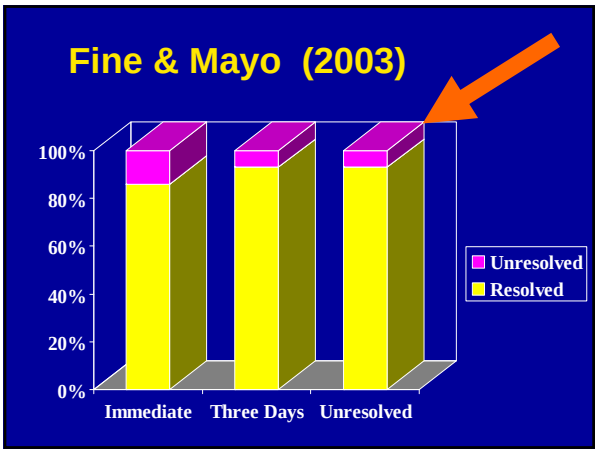


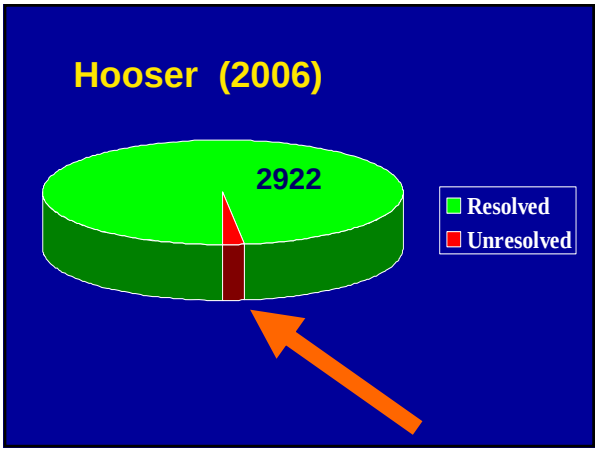
Prendergast (1998)

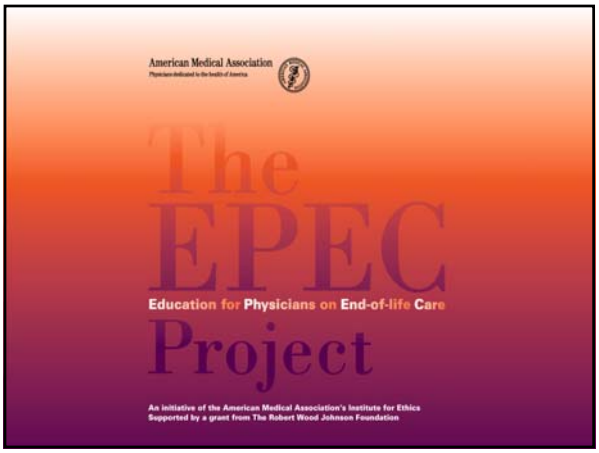
- 57% surrogates immediately agree
- 90% agree within 5 days
- 4% continue to insist on LSMT

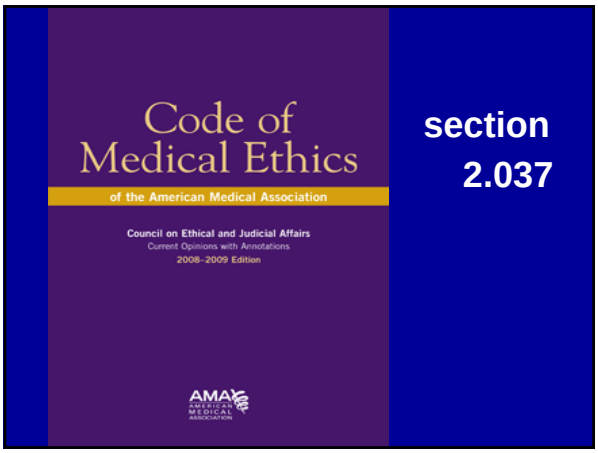
Garros et al. (2003)




Fine & Mayo (2003)
100%
80%
60%
40%
20%
0%
Immediate
Three Days
Unresolved
Unresolved
Resolved


Hooser (2006)
2922
Resolved
Unresolved

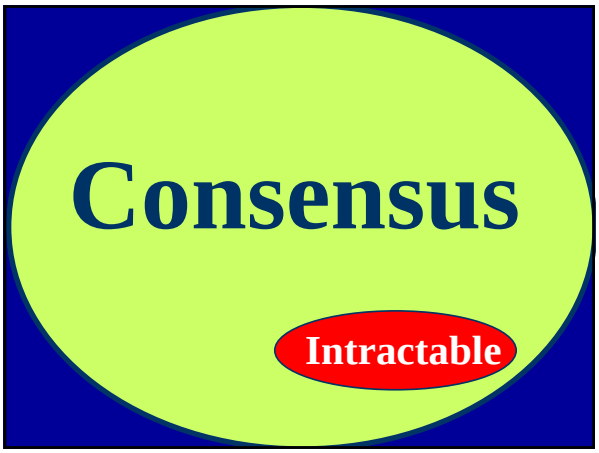

American Medical Association
The
EPEC
Education for Physicians on End-of-life Care
Project
An initiative of the American Medical Association's Institute for Ethics
Supported by a grant from The Robert Wood Johnson Foundation



section 2.037

1. Earnest attempts . . . **deliberate over and negotiate** prior understandings . . .
2. **Joint decision-making** should occur . . . maximum extent possible.
3. Attempts . . . **negotiate** . . . **reach resolution** . . ., **with the assistance of consultants** as appropriate.
4. Involvement of . . . **ethics committee** . . . if . . . irresolvable.

5. . . . .
6. If the process supports the physician's position and the patient/proxy remains un-persuaded, **transfer**. . . .
7. If transfer is not possible, the **intervention need not be offered**.



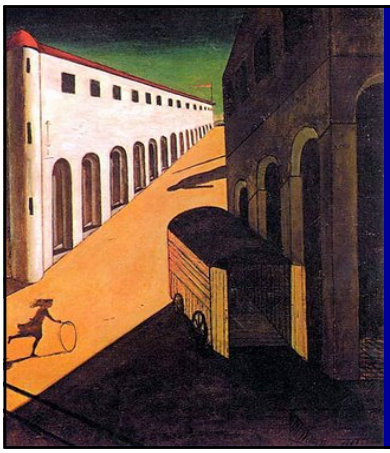
Roadmap (part 2)

Intractable conflict

Court cases

4 legislative approaches

Intractable conflict



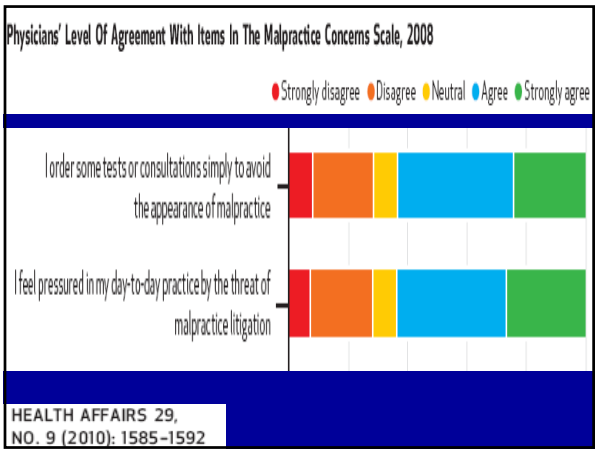
Mediation occurs in the "shadow" of the law

Bad law

Mass. Med. Society (Nov. 2008)

DOCTOR SURVEY

Action	% ordered for defensive reasons
Hospital admissions	13.0%
Lab tests	17.9%
X-rays	21.9%
Ultrasound studies	24.0%
MRI studies	27.4%
CT scans	27.6%
Specialty referrals	28.4%



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

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

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

Author: H Hugh Vincent, MD; William Andereck, MD

Introduced by: District 8 Delegation

Endorsed by: District 8 Delegation

Reference Committee **E**

October 4-6, 2008

This resolution constitutes a proposal for consideration by the California Medical Association House of Delegates and does not represent official CMA policy.

WHEREAS, it is still common for physicians who feel non-beneficial or futile treatments are being provided or considered to feel threatened by legal action by the patient's family or other surrogates, and thus continue to provide such care against their best medical judgment; and

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 medical care	9.3	0
Concern that the surrogate(s) might sue	8.4	1.1

Court Cases

Damages

Injunctions

Damages

Exposure to civil liability

- State HCDA (incl. fees)
- Battery
- Medical malpractice
- IIED / NIED
- Informed consent
- EMTALA

Criminal liability

- *e.g.* homicide

L**icensure** discipline

What is the legal risk from unilateral w/h or w/d

25% 1. High
25% 2. Medium
25% 3. Low, yet material
25% 4. Low and immaterial

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

Burks v. St. Joseph's Hosp., No. 95-CV-002639 (Milwaukee Cir. Ct. 1996), 596 N.W.2d 391 (Wis. 1999).

Providers typically only lose on claims for IIED

- Secretive
- Insensitive
- Outrageous

Luce is confirming the trend of **un**successful lawsuits against providers

Risk > 0

- Barber (Cal. 1983)
- Manning (Idaho 1992)
- Rideout (Pa. 1995)
- Bland (Tex. 1995)
- Wendland (Iowa 1998)
- Causey (La. 1998)

Grossly overstated risks

But **some** real exposure

"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).

"The only fear a doctor need have in denying heroic measures to a patient is the **fear of liability** for negligence . . . where qualified practitioners would have thought intervention warranted."

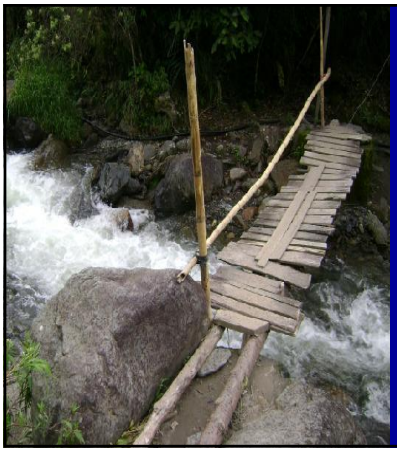
Child & Fam. Svcs. v. Lavallee (Man. App. 1997).

But the process itself can be punishment

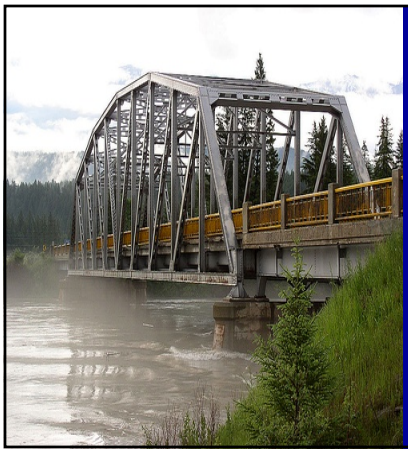
Even prevailing parties pay transaction costs

Liability averse

Litigation averse too



Providing good, clinically appropriate medicine



Acceding to surrogate demands

Easier to accede to surrogate demands

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

But not happy about it

Injunctions

Courts frequently grant **temporary** injunctions to preserve status quo

But patients often **die** before adjudication of merits

Ruben Betancourt

vs.

Trinitas Hospital

- 73yo male
- PVS
- COPD
- End-stage renal disease
- Hypertensive cardiovascular disease

- Stage 4 decubitus ulcers
- Osteo-myeletitus
- Diabetes
- Parchment-like skin

- "The only organ that's functioning really is his heart."
- "It all seems to be ineffective. It's not getting us anywhere."
- "We're allowing the man to lay in bed and really deteriorate."

Intramural process

No consensus

Unilateral withdrawal

- DNR order written
- Dialysis port removed

January 21, 2009

Jacqueline files complaint

January 23, 2009

Court issues TRO

February 10, 2009

Court extends TRO

January – February 2009

Evidentiary hearings

Medical expert witnesses

Family witnesses

March 4, 2009

Permanent injunction on the merits

August 2009

Appeal: NJHA, MSNJ, NJP, GNYHA

August 13, 2010

Appellate court refuses to reverse


The Star-Ledger

Bin Laden calls for battle in Sudan

INDIA'S WAR IN THE WOODS

Repeatedly flooded properties targeted

Report on UMDNJ exposes thousands in misspent funds


THE WALL STREET JOURNAL.

What's News

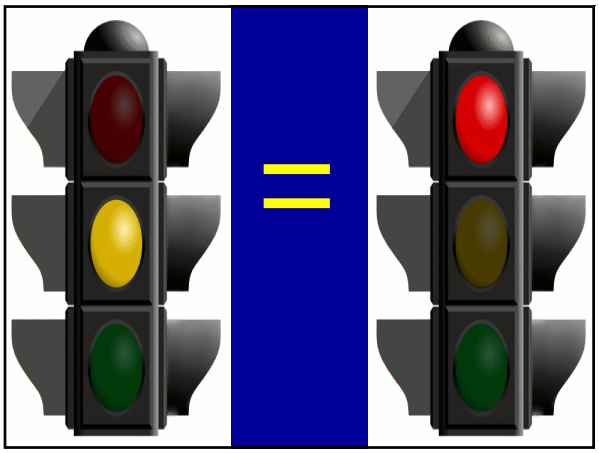
Fed's Surprise Rate Cut Sparks Rally

Easier to ask for forgiveness, than to ask for permission

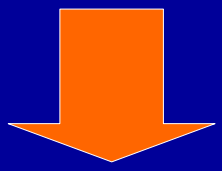
"The Court cannot require a medical advisor to act . . . contradictory to . . . bona fide clinical judgment"

Rotaru v. Vancouver Gen. Hosp., 2008 BCSC 318 (Mar. 13, 2008)

4 Statutory Approaches



Typical response to "bad law" claims



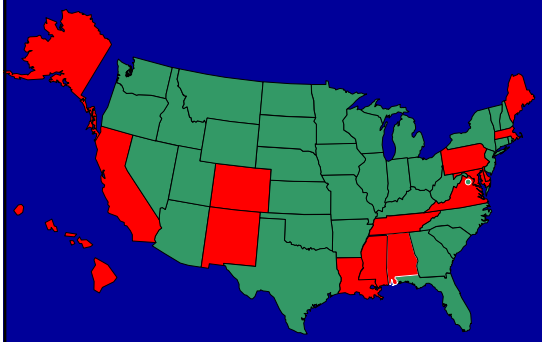
Safe harbor immunity

1. UHCDA model
2. Ontario model
3. Texas model
4. Conscientious objection

UHCDA model

Statutory approach 1 of 4

New Mexico (1995)
Maine (1995)
Delaware (1996)
Alabama (1997)
Mississippi (1998)
California (1999)
Hawaii (1999)
Tennessee (2004)
Alaska (2004)
Wyoming (2005)



Tenn. Code 68-11-1808(e)

"A health care provider . . . may decline to comply with . . . health care decision that requires **medically inappropriate** health care or health care contrary to **generally accepted health care standards** . . ."

Tenn. Code 68-11-1808(f)

(3) . . . make all reasonable efforts to assist in the transfer . . .

(4) If a transfer cannot be effected, the health care provider . . . **shall not be compelled to comply.**

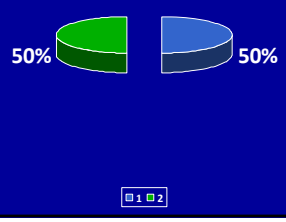
16 Del. Code 2508(g)

A health-care provider . . . that declines to comply . . . shall . . .

Provide continuing care, including continuing life sustaining care, . . . **until a transfer can be effected**

Are there "generally accepted healthcare standards"

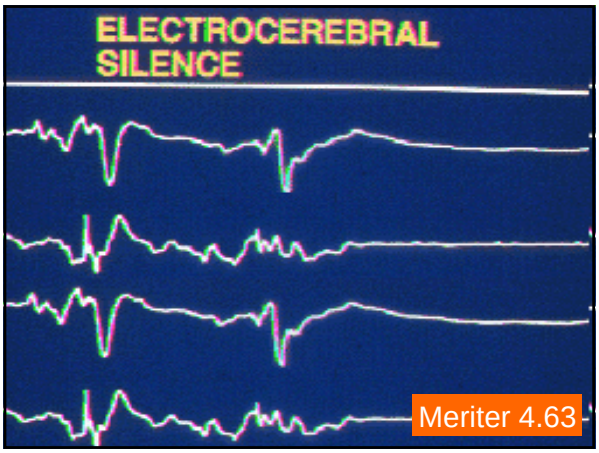
1. Yes
2. No

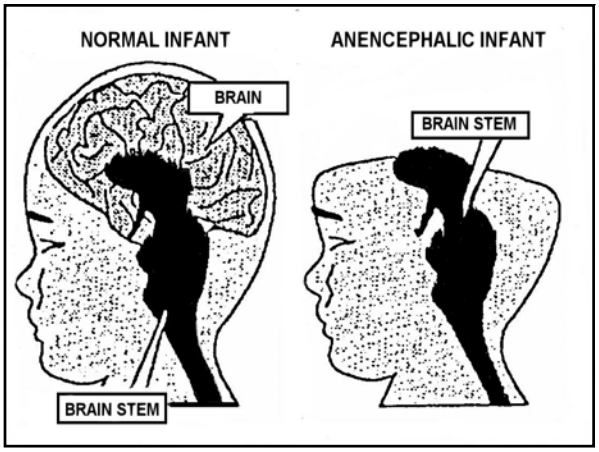


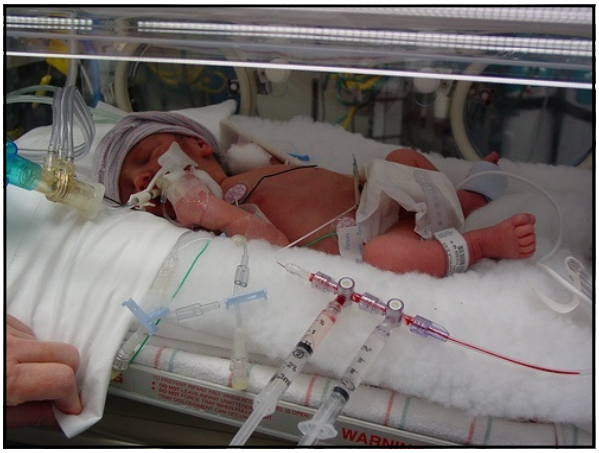
“Bad” safe harbor language

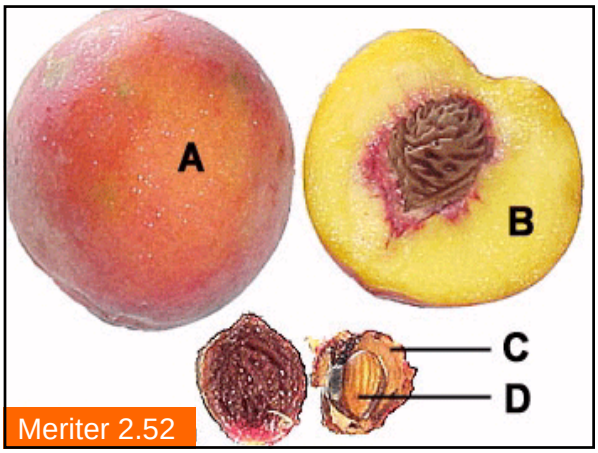
“generally accepted health care standards”

“significant benefit”

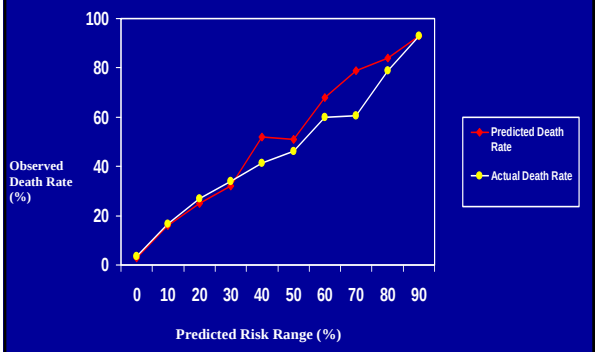

ELECTROCEREBRAL
SILENCE
Meriter 4.63


NORMAL INFANT
ANENCEPHALIC INFANT
BRAIN
BRAIN STEM
BRAIN STEM





APACHE Scores and Mortality



Wide variation in what considered futile

- Some: only when 0%
- Others: as high as 13%

Lantos, Am J Med 1989

What threshold

Uncertainty in extrapolating from populations to individuals

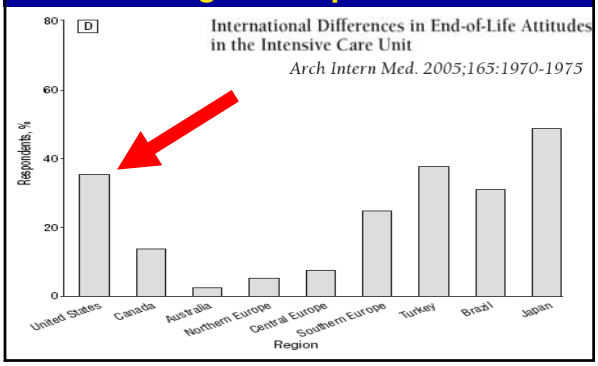
"The essence of futility is overwhelming improbability in the face of possibility"

Bernat 2008

Qualitative Futility

- Benefit burden
- QOL
- Cost per QALY

Treatment for septic shock in vegetative patient



Goals of Medicine

- Cure disease
- Alleviate pain & suffering
- Restore function
- Prevent disease
- Prolong corporeal existence

?

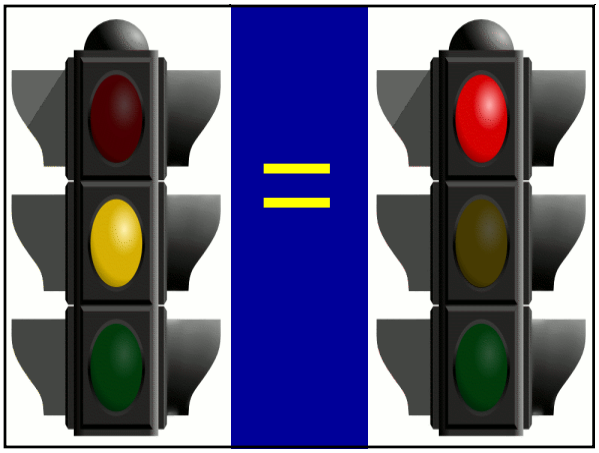
Not just ambiguity

Providers continue to create the "wrong" standard of care

Dan Merenstein
291 *JAMA* 15 (1994)

Result of Ambiguity

- Few futility policies
- Rare "full" implementation



Surrogate selection model

Statutory approach 2 of 4

A proxy shall act in accordance

1. “directive . . . decisions”
2. “the maker’s . . . wishes”
3. “maker’s best interests”

Wis. Stat. 155.20(5)

The health care agent **shall act** in good faith **consistently** with the desires of the principal . . . with any valid declaration . . . in the best interests of the principal

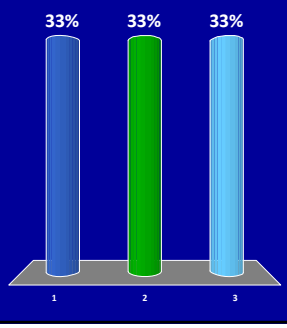
Wis. Stat. 155.60(4)

The **court may . . .**

"direct the . . . agent to act in accordance . . . [or] rescind all powers"

Have you ever replaced a surrogate?

1. Yes
2. No
3. No, but saw it done

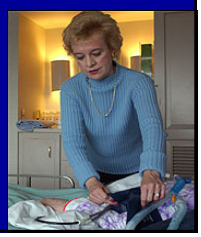


Helga Wanglie

(Minn. 1991)

Surrogate with material COI

Surrogate decision inconsistent with P preferences



Bernstein v. Superior Court of Ventura County (Feb. 2, 2009).

Court to Barbara Howe:

Your own personal issues are "impacting your decisions"

"Refocus your assessment"

Ontario

Ontario Capacity and Consent Board

Limitations of surrogate replacement

Problem 1

Surrogates can often demonstrate congruity

Problem 2

Providers lack evidence to demonstrate deviation

If cannot replace the surrogate, then (in those rare cases) just provide the treatment

We **still need** dispute resolution mechanisms for those intractable cases in which surrogates are "irreplaceable"

Texas model

Statutory approach 3 of 4

You can stop LSMT for **any reason** if your **own** hospital's ethics committee agrees

Tex. H&S Code 166.046

- 48hr notice
- Ethics committee meeting
- Written decision
- 10 days
- No judicial review

Tex. H&S Code 166.045

A physician . . . is not civilly or criminally liable or subject to review or disciplinary action . . . if the person has complied with the **procedures** outlined in Section 166.046

TX safe harbor

- Measurable procedures
- Safe harbor protection certain

TN safe harbor

- Vague substantive standards
- Safe harbor protection uncertain

Emilio Gonzalez

April 14, 2006

~~Christina~~ Ms. Gonzales
407 Neches St.
Lockhart, Texas 78644

SETON MEDICAL CENTER
A member of the

Dear Ms. Gonzales;

We, the physicians and other members of the healthcare team, appreciate you taking your time to attend the patient care conferences regarding your son.

At the last conference, your son's physician discussed his brain condition and the poor prognosis for any further neurological improvement. As you know, the physicians involved in the care of your son believe that his condition is irreversible and that to continue certain treatments will serve to prolong his suffering without the possibility of cure. We understand that you do not agree with this position and want the hospital to continue to provide all current treatments for your son.

When disagreements of this nature arise, Texas law allows hospitals to call the hospital ethics committee meeting to review whether certain treatments are medically appropriate. A meeting has been called for the Seton Family of Hospitals Pediatric Ethics Committee to consider Emilio Gonzales's care. This meeting will be held on February 16, 2007 at 09:00 a.m. in the 3rd floor boardroom at Brackenridge Hospital of Austin. The physicians providing care for your son, as well as the ethics committee members will attend the meeting. Under Texas law you have the right to attend and participate in this meeting. While that is not legally required, we strongly encourage you to be present for this discussion. You will be given the opportunity to ask questions regarding your son's care and to provide input into the committee's decision-making process.

Step 2: HEC Meeting

Step 3: HEC Decision

The Ethics Committee further recommends that

- **The treatment plan for the patient be modified to allow only comfort measures (such as hydration, pain control and other interventions designed to decrease the patient's suffering).**
- **New complications that develop should not be treated, except with additional palliative measures, as appropriate.**
- **The patient's code status be changed to a DNR.**
- **Appropriate spiritual and pastoral care resources should be provided to Emilio's mother and family members.**

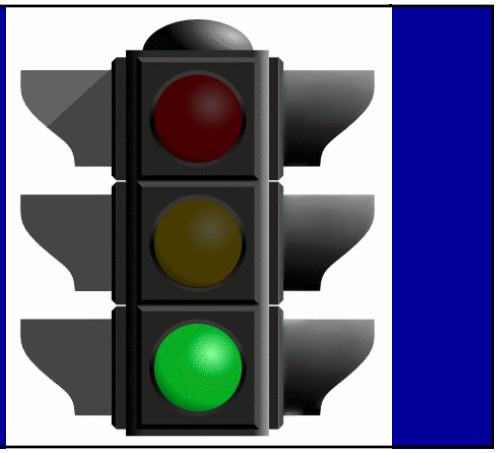
In summary, the consulted members of the Ethics Committee concur with the recommendation by the Attending Physician and patient care team to withdraw aggressive care measures, including use of the ventilator, and to allow palliative care only. The Attending Physician, with the help of the Children's Hospital of Austin, will continue to assist the patient's family in trying to find a physician and facility willing to provide the requested treatment. The family may wish to contact providers of their choice to get help in arranging a transfer.

Step 4: Attempt transfer

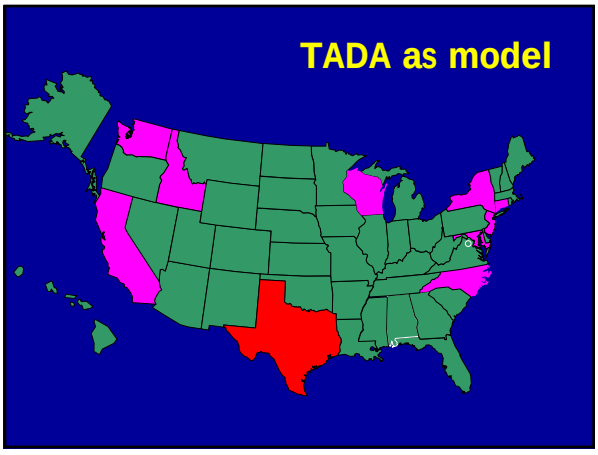
Step 5: Unilateral Withdrawal

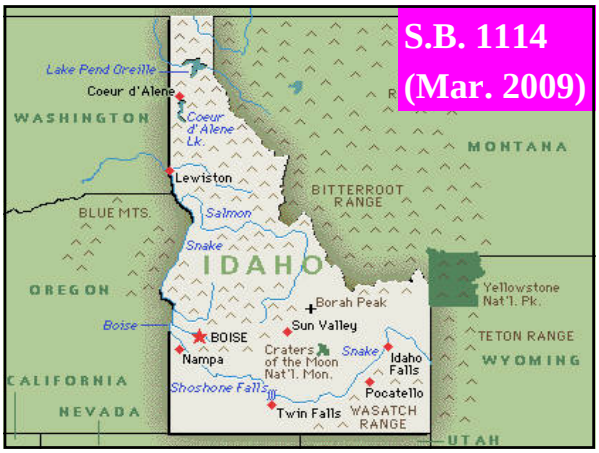
No transfer → Withdraw 11th day

Texas: the good



Ontario	Texas
Fast	Fast
Judicial review	No judicial review
Independent	Not independent
Rules & procedures	No rules
Only for bad proxies (not Golubchuk)	For **all** disputes





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

Author: H Hugh Vincent, MD; William Andereck, MD

Introduced by: District 8 Delegation

Endorsed by: District 8 Delegation

Reference Committee **E**

October 4-6, 2008

This resolution constitutes a proposal for consideration by the California Medical Association House of Delegates and does not represent official CMA policy.

Resolution 506-09 **TITLE:** END-OF-LIFE CARE AND FUTILE TREATMENT

Author: Larry A. Bedard, MD

Introduced by: Larry A. Bedard, MD

Endorsed by:

Reference Committee **E**

October 17-19, 2009

This resolution constitutes a proposal for consideration by the California Medical Association

WASHINGTON STATE MEDICAL ASSOCIATION
HOUSE OF DELEGATES

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

WASHINGTON STATE MEDICAL ASSOCIATION
HOUSE OF DELEGATES

Resolution: A-2
(A-10)

Subject:	WSMA Opinion on Medical Futility in End-of-Life Care
Introduced by:	Shane Macaulay, MD, Delegate WSMA Board of Trustees
Referred to:	Reference Committee A

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

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.

Texas: the bad and the ugly

Few **substantive** criteria for identifying inappropriate EOL treatment

Without substantive criteria, we must resort to **procedural criteria**

Intractable value conflict

Pure process

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

Is the TADA process fair?

Procedural defects recognized

Tex. S.B. 439 (2007)

Tom Mayo, Ga. St. U. L. Rev. (2009)

Due Process

- Notice (48hrs)
- Opportunity to present
- Opportunity to confront
- Assistance of counsel
- Independent, neutral decision-maker
- Statement of decision with reasons
- Judicial review

No time to evaluate all these aspects of due process

Basically, providers should give patients what they give themselves

- *E.g.* Peer review
- *E.g.* Licensure actions

Who Makes the Decision?

Intramural institutional ethics committee

But the HEC is controlled by the hospital

TADA recognizes need for some "independent" check

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

But the current mechanism is **not** sufficient

TADA is **silent** on HEC composition

No community member requirement, like IRB

Lack of transfer is **not** external review

COI

More documented

More targeted

Conflict of interest ($$$)

- Ruben Betancourt (NJ)
- Brianna Rideout (PA)
- James Bland (TX)
- Kalilah Roberson-Reese (TX)

Conflict of interest (other)

Statement of Decision

- Provide rationale
- Factual basis
- Considered, supported

But decisions are of variable quality

Issues that were identified and considered:

Seton Family of Hospitals

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

MEMORIAL HERMANN
Memorial City

Dear Mrs. Ella Davis and Family:

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

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

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

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

Sincerely,

Harold Kurlander, MD
Review Committee Chair

Robert Herman, MD
Review Committee Facilitator

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

Date JANUARY 21, 2009 Time 7 00 PM

Patient Name MAURICE DAVIS Medical Record # 38646326-8320

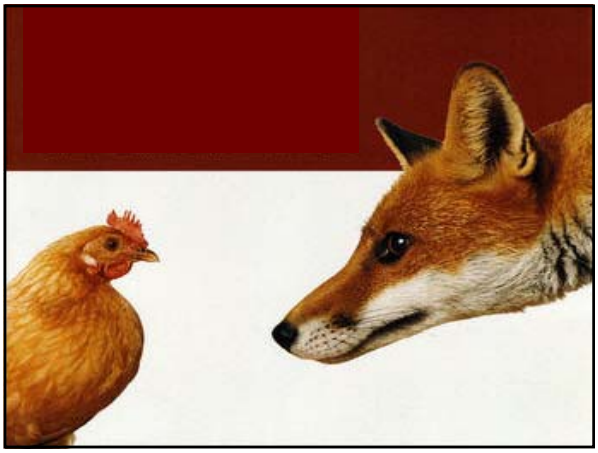
Background:
MULTIPLE CVA'S, MULTISYSTEM FAILURE, SEPSIS, UNRESPONSIVE

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

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

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

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



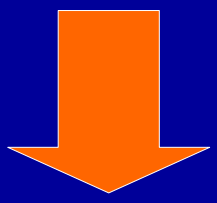
Is TADA fair?

20%	1. Very fair
20%	2. Somewhat
20%	3. Neutral
20%	4. Somewhat unfair
20%	5. Very unfair

Conscientious Objection

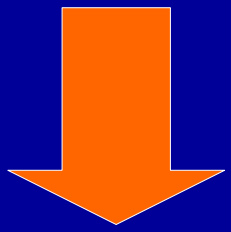
Statutory approach 4 of 4

No treatment relationship



May refuse to treat
for **any** reason

Existing treatment relationship



Must continue to treat

Termination: normally

- Sufficient notice to find alternative
- Medical Board may require ~30 days

Termination: life-and-death

"free to refuse . . . **upon** providing reasonable assurances that basic treatment and care will continue"

Couch (N.J.A.D. 2000).

Del. Code 2508(e)

". . . provider may decline to comply . . . for reasons of **conscience**."

Del. Code 2510(a)(5)

. . . provider . . . not subject to civil or criminal liability or to discipline . . . for . . . [d]eclining to comply . because . . . conscience . .

Del. Code 2508(g)

[If] decline to comply . . .

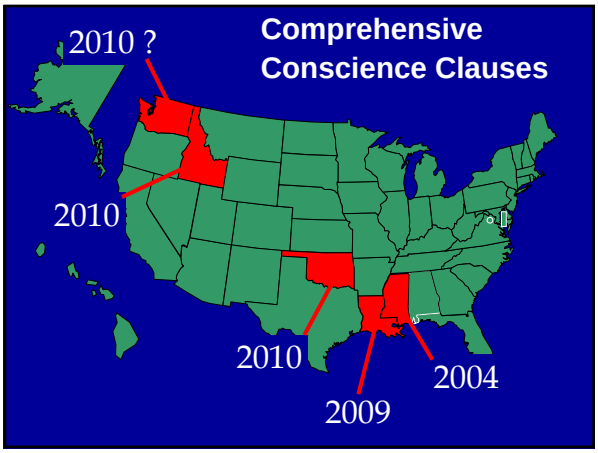
(2) Provide continuing care, including continuing life sustaining care, . . . **until a transfer can be effected**

Want to refuse → Try transfer

No transfer → Must comply

Cal. Probate Code 4736

(c) Provide continuing care . . . until a transfer can be accomplished **OR** until it appears that a transfer cannot be accomplished.



Idaho Code 18-611

No health care professional . . . shall be civilly, criminally or administratively liable for . . . declining to provide health care services that violate his or her conscience

. . . in a **life-threatening situation** . . . professional shall provide treatment and care **until** an alternate health care professional capable of treating the emergency is found.

Miss. Code 41-107-5

A health care provider has the right not to participate, . . . violates his or her conscience. . . .

No emergency exception
No duty to refer

Looking Forward

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

TABLE 5

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)

Avoid intractable conflict

Better ACP

– Most patients do not want overly aggressive treatment

More ethics resources

– Because they work

Better communication

Clinical Practice Guidelines

CPG linked to **new** safe harbors

CPGs make **existing** safe harbors effective

111TH CONGRESS
1ST SESSION

S. 391

The New York Times
The Opinion Pages

CONTRIBUTING COLUMNIST
Malpractice Methodology
By PETER ORSZAG
Published: October 20, 2010

THE NANNY STATE

Total bliss is just one more regulation away.

GUIDANCE FOR ESTABLISHING

CRISIS STANDARDS OF CARE

FOR USE IN

DISASTER SITUATIONS

A Letter Report

INSTITUTE OF MEDICINE

- Multi-institutional ethics committee
- Medical society
- Specialized agency
  - Malpractice panel
  - Licensure board

Ontario

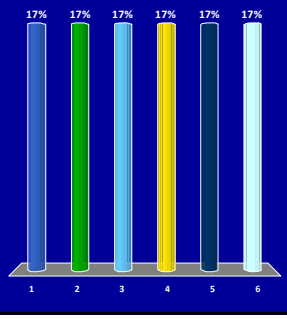
Iowa

CITY OF FORT WAYNE INDIANA

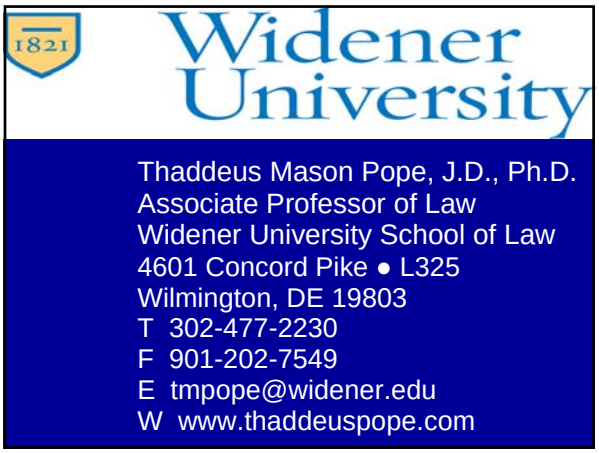
Statement on futility and goal conflict in end-of-life care in ICUs revising the 1991 policy statement

Solution with most promise?

1. Better ACP
2. Better communication
3. CPGs
4. TADA
5. Surrogate selection
6. Reimbursement incentives



Thank you


1821
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