

Managing Patients or Families who demand Medically Futile Care

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Case Study

SH was a 91-year-old female intensive care unit patient with post-cardiopulmonary resuscitation anoxic encephalopathy superimposed on multi-system failure, seizure disorder and multiple decubitus ulcers. She was on a ventilator and was receiving artificial nutrition and hydration through a PEG tube surgically implanted into her stomach. The treatment team believed that SH could be kept alive for many months in the ICU but would not survive outside it. The team's opinion was that treatment was "futile," and they wished to switch SH to palliative care and withdraw life-sustaining treatment.

Case Study continued

Several meetings with the patient's eldest daughter, who held medical power of attorney, failed to change her request that the doctors "do everything" to keep her mother alive. Two other adult children of the patient privately told the attending physician that they agreed with the physician's recommendation to withdraw life-sustaining treatment, but were unwilling to publicly disagree with their older sibling.

- Must the treatment team maintain treatments they judge to be medically futile?

History of Medical Futility

- Hippocrates:
 - Three major goals of medicine: cure, relief of suffering and “refusal to treat those who are overmastered by their diseases, realizing that in such cases medicine is powerless”.
- Plato:
 - “to attempt futile treatment is to display an ignorance that is allied to madness.”

Early Twentieth Century

- Articulation of ethical principles
 - Beneficence; “do only good”.
 - Nonmaleficence: “do no harm”.
- Paternalistic approach to the practice of medicine
 - Issue of medical futility rarely arose.

Age of Patient Autonomy

In 1891 the U.S. Supreme Court held:

“no right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person.”

During 1970s and 1980s Another Shift Occurred.

- Families began asking that non-beneficial life-sustaining treatment be discontinued from patients unresponsive to medical interventions .
- The patients right to refuse or withdraw medical treatment was recognized by the Supreme Court:
 - Karen Ann Quinlan
 - Nancy Cruzan.

Today, a New Shift is Occurring

What should happen when the physician believes continuing the patient's treatment will not benefit or cure the patient and the patient or family disagrees with the physician's determination.

Competing Ethical Principles

- The principle of Patient Autonomy does not stand alone.
- Physicians also have a right of autonomy to exercise his/her ethical beliefs.
- Beneficence and Nonmaleficence requires that treatment be halted or withheld if it is the physician's judgment that curative treatment will not benefit the patient or may cause harm.

Definitions of Medical Futility

- No widely-accepted definition for the term “medical futility” exists.
- Physiologic futility: the desired outcome cannot be met.
- Imminent-Demise futility: in spite of intervention the patient will die in the near future.
- Quantitative futility: anything less than a 5% chance of success would be futile.
- Qualitative futility: the patient’s quality of life is so poor that continued treatment is not appropriate.

Examples of Medical Futility Definitions

- “A treatment evaluated by the health care team, the family, or both as being non-beneficial or harmful to a dying patient” .
- “Any treatment which fails to provide either cure, restoration or palliation to a patient” .

Definitions are Value-Laden

- Who should determine what treatment is futile when probability of success is low?
- When is the probability low enough to be “futile”?
- Who should determine the appropriate level of chance for success; the patient or the physician?
- Permitting physicians to make quality of life judgments for patients can lead to discrimination.

Determination of Futility Should be Made Jointly by the Physician, Patient and/or Surrogate

- Balance the effectiveness of treatment, benefit of the treatment to the patient, and the emotional, financial or social burden to the patient.
 - Effectiveness: objective determination made by the physician based on knowledge and expertise.
 - Benefit: subjective determination made by patient or surrogate by examining goals of treatment.
 - Burdens: are determined by both the physician and the patient looking at factual elements and subjective, personal aspects of treatment.

American Medical Association Council on Ethical and Judicial Affairs

AMA guidelines on medical futility:

- Process-based approach to futility disputes.
- If dispute is not resolved, attempt to transfer the patient to alternate providers.
- if no transfer can be arranged, halting futile treatment is ethically acceptable.

Case Law for Medical Futility

When physicians and ethics committees recommended life support be withdrawn on futility grounds:

- Two courts held that families should determine when treatment should stop.
 - 1988 *Wanglie* case (PX-91-283(Minn 4th Dist. Ct, Hennepin Co, July 1, 1991)); 1994 *Baby K* case (In re Baby “K,” 832 F3d 590 (4th Cir), Cert denied, 513 US 825 (1994)).
- One court held that CPR not be provided to a dying patient even if requested by patient’s family.
 - *Gilgunn v Massachusetts General Hospital*; SUCV92-4820 (Mass Super Ct, Suffolk Co, April 21, 1995)

10 States' Laws Address Medical Futility

- Alaska, California, Delaware, Hawaii, Maine, Mississippi, New Jersey, New Mexico, Tennessee, Texas and Wyoming.
- All permit healthcare providers to refuse “medically ineffective” or “medically inappropriate” care.
- All require healthcare providers or facilities to notify the patient or surrogate when proposed treatment is determined to be futile.
- All require that life-sustaining treatment be continued until the patient can be transferred to another facility willing to comply with the patient's instructions.
- All require assistance in locating and transferring the patient to the other healthcare facility.

Texas Advance Directive Act (“TADA”) sec. 166.046 describes a medical futility process (“MFP”):

- A disagreement about the patient care between patient or surrogate and physician triggers the MFP;
- A physician’s refusal to honor a patient’s treatment decision must be reviewed by the facility’s ethics committee;
- The patient or family must be given written information about hospital’s ethics consultation process and an invitation to participate with at least 48 hours’ notice;
- Ethics committee must provide a written report of findings to the patient or family;
- If the dispute remains unresolved, the hospital, working with the family, must try to arrange a transfer to a provider willing to give the requested treatment;
- If after 10 days, no provider can be found, the futile treatment can be withheld or withdrawn;
- The patient or surrogate may ask a court to grant an extension of time only if the judge determines a willing provider will likely be found;
- If no extension is sought or granted, futile treatment may be unilaterally withdrawn by the treatment team with immunity from civil and criminal prosecution.

5 Legal Challenges to TADA

- Two cases: law suits were filed and restraining orders to delay withdrawal of life support were obtained.
 1. EMTALA was claimed; the judge denied restraining order extension; life support was removed and the patient died.
 2. Patient's mother sued to have TADA found unconstitutional; before the judge could render a ruling, the patient died.
- Two cases: 10 day period was extended to permit the successful transfer of the patient to another location.
- One case: family took no action; after 10 days patient was extubated and died shortly.

Oklahoma Futility Law

Medical futility only alluded to in:

- Do Not Resuscitate Act (63 OS 3131): attending physician may order DNR if in his/her medical judgment CPR would not prevent imminent death
 - no definition of “imminent death” is provided
- Hydration and Nutrition for Incompetent Patient’s act (63 OS 3080) : attending physician may order withdrawal or withholding of artificially administered hydration and nutrition (“AAHN”) if in his/her medical judgment patient’s death is immanent
 - but only if patient will die from underlying disease process and NOT from starvation or dehydration.

Oklahoma Advance Directive Act

63 OS 3101

- Requires healthcare providers to comply with a patient's advance directives or promptly take steps to transfer patient to another health care provider.
- If a provider's refuses to comply would likely result in the patient's death, the provider must comply pending a transfer to a provider willing to comply.
 - willful failure to arrange for the transfer is unprofessional conduct.
- Healthcare provider not obligated to comply if:
 - physically or legally unable to provide requested treatment, or
 - if by providing it, the same treatment would be denied to another patient.
- This requirement does not alter any legal obligation or lack of legal obligation to provide medical treatment to a patient who refuses or is unable to pay for it.

Benefits of Medical Futility Policy

- Effective conflict resolution tool.
- Permits all parties to compassionately arrive at consensus.
- Allows for appeal or patient transfer if consensus cannot be reached.
- Creates a fair process and greater consistency in handling medical futility cases.
- Opportunity for justice and due process for all the parties.
- More defensible than no process at all.

Risk of a Medical Futility Policy

1. No universally accepted definition of medical futility, permitting inconsistent results.
2. No opportunity for a meaningful hearing.
3. Inherent Conflict of Interest between the healthcare facility and its ethics committee.
4. Patient or family may suspect care is being withdrawn due to cost.
5. Oklahoma law provides no protection from civil or criminal liability.

Conclusion

- Many conflicts between healthcare providers and patients or families arise due to lack of communications resulting in loss of trust.
- Build trust by frequent communications and honest disclosures from the moment of admission.
- Invoke a Medical Futility Policy as last resort.