Futility Redux: When May / Should / Must a Clinician Write a DNAR Order without Patient or Surrogate Consent?

University of Miami & Florida Bioethics Network • April 8, 2016

Thaddeus Mason Pope, J.D., Ph.D.
Mitchell Hamline School of Law

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

FILED
AHCA
AGENCY CLERK

2014 JUN -3 A 10:39

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

v. AHCA NO. 2014003053

ST. PETERSBURG NURSING HOME LLC d/b/a JACARANDA MANOR,

Respondent.

FINAL ORDER

Having reviewed the Administrative Complaint, and all other matters of record, the Agency for Health Care Administration finds and concludes as follows:

Lesson

DNAR

no CPR

Right to refuse

Sept. 1990

Browning

Florida

POLST

BUT . . .

Right to demand ?

Negative liberty ✓

Positive liberty ?

Our question

No DNAR

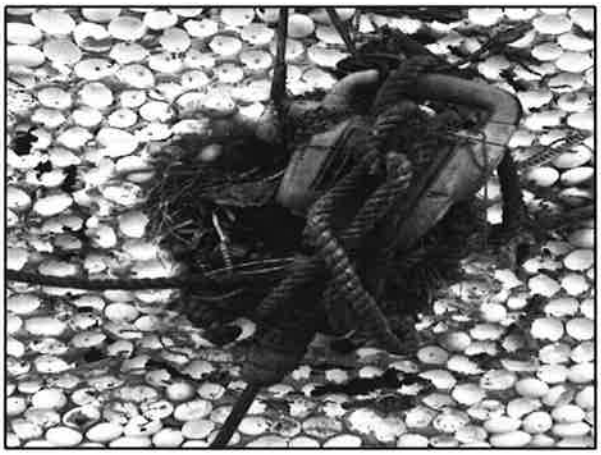
↓

CPR ?

No consent

↓

DNAR ?



Roadmap

Background

1. Consent
2. CPR is different
3. Medical futility
4. Prevalence

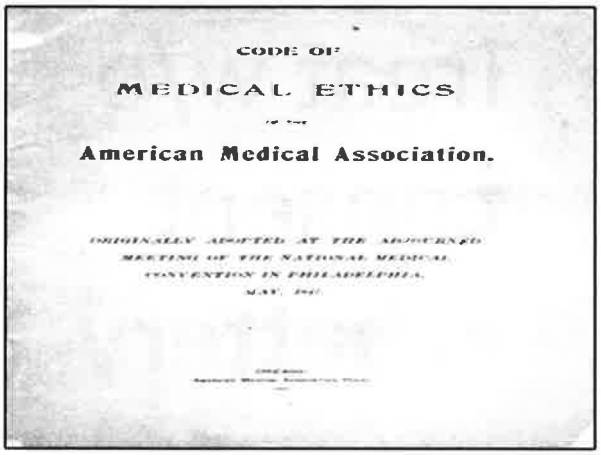
DNAR without consent

5. "Futile"
6. "Proscribed"
7. "PIT"
8. PIT traffic lights

Consent

1 of 8

1847


CODE OF

MEDICAL ETHICS

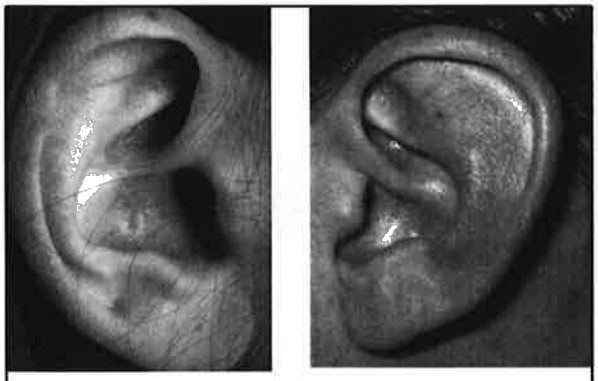
American Medical Association.

Do **NOT** consider patient's "own crude opinions"

1905

Clinicians need consent

Treat w/o consent is **battery**



Mohr v. Williams (Minn. 1905)

1914

Mary Schloendorff

Consent

But not "informed"

1972

Clinicians normally need **consent**

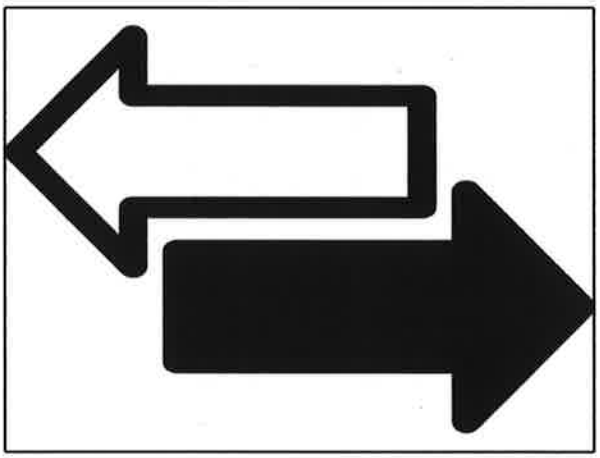
CPR is different

2 of 8

Normally need consent

But . . . consent to **what**

Consent to treatment



CPR is presumed

Consent **not** required for CPR

Consent required for **no CPR** (DNR)

What is a medical futility dispute

3 of 8

47

Surrogate will **not** consent when you think they should

Appropriate	Inappropriate

Proportionate	Disproportionate

Beneficial	Non-beneficial

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

Surrogate driven overtreatment

Clinician	Surrogate
CMO	LSMT

Clinician	Surrogate
DNAR	CPR

Prevalence

4 of 8

57

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

58

13%

ethics consults

MEMORIAL SLOAN-KETTERING CANCER CENTER

J. Oncology Practice (June 2013)

59

> 16%

ethics consults

HEC Forum
DOI 10.1007/s10730-015-9293-5

What Ethical Issues Really Arise In Practice at an Academic Medical Center? A Quantitative and Qualitative Analysis of Clinical Ethics Consultations from 2008 to 2013

Katherine Wasson[1,3] · Emily Anderson[1] ·

Original Investigation

The Frequency and Cost of Treatment Perceived to Be Futile in Critical Care **20%**

Thanh N. Huynh, MD, MSHS; Eric C. Kleerup, MD; Joshua F. Wiley, MA; Terrance D. Savitsky, MBA, MA, PhD; Diana Guse, MD; Bryan J. Garber, MD; Neil S. Wenger, MD, MPH

JAMA Intern Med. 2013;173(20):1887-1894. doi:10.1001/jamainternmed.2013.10261
Published online September 9, 2013.

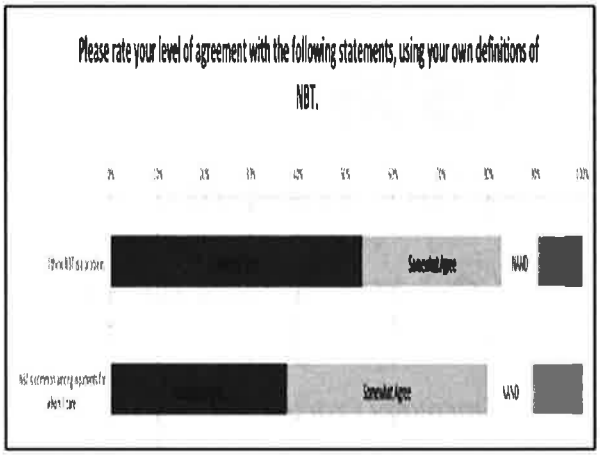
MGH 1811

2 CPR futility cases per month

Courtwright, 2015 J Crit Care 30(1):173–77

Feb. 2015

700 acute care clinicians



UNIVERSITY OF TORONTO

"top healthcare challenge"

6 BMC Med. Ethics (2005)

Big problem – moral distress, etc

Surrogate will **not** consent to DNAR recommendation

When may / should / must a clinician write a DNAR order <u>without</u> patient or surrogate consent?

67

It depends

3 types of CPR

- Futile
- Proscribed
- Potentially inappropriate

AMERICAN THORACIC SOC
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,

AMERICAN THORACIC SOCIETY · 1905 ·
ATS
We help the world breathe
PULMONARY · CRITICAL CARE · SLEEP

Society of Critical Care Medicine

The Intensive Care Professionals

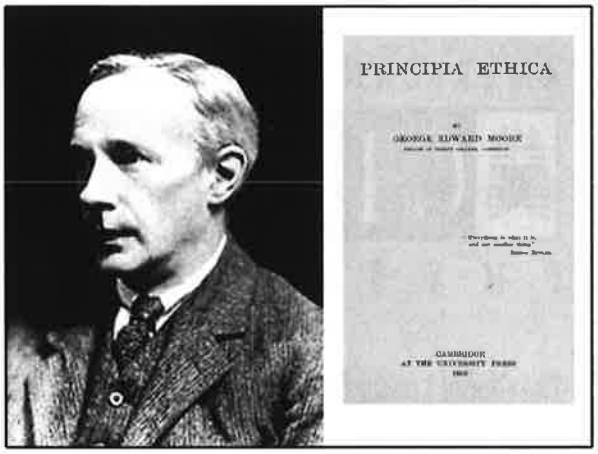
AMERICAN COLLEGE OF CHEST PHYSICIANS

The Global Leader in Clinical Chest Medicine

AACN

ESICM

EUROPEAN SOCIETY OF INTENSIVE CARE MEDICINE



"In Ethics . . . difficulties and disagreements. . . are mainly due to a very simple cause . ."

"the attempt to answer questions, without first discovering precisely **what question** it is you desire to answer."

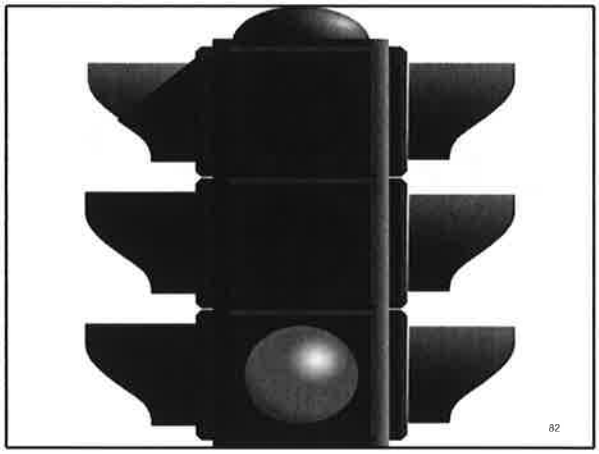
Futile

Proscribed

Potentially inappropriate

Futile

5 of 8



Interventions **cannot** accomplish physiological goals

Scientific impossibility

Example 1

Example 2

Example 3

Example 4

total brain failure = death

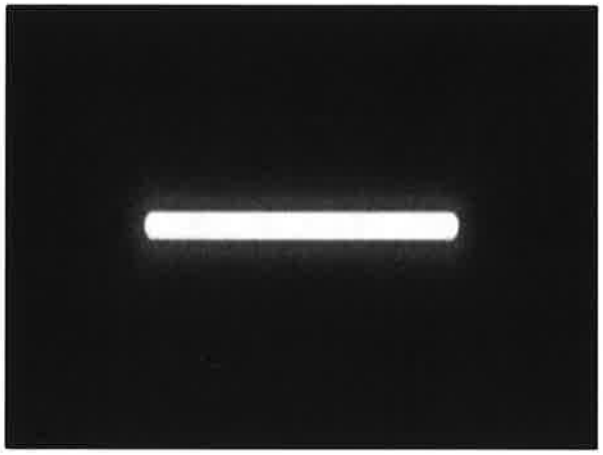
Dead → **No** duty to treat

Annals of Internal Medicine

American College of Physicians Ethics Manual
Sixth Edition
Lois Snyder, JD, for the American College of Physicians Ethics, Professionalism, and Human Rights Committee*

"After a patient . . . brain dead . . . medical support should be **discontinued**."

Aden Hailu



"Futile"

Value free objective

But . . .

futile for **what** outcome

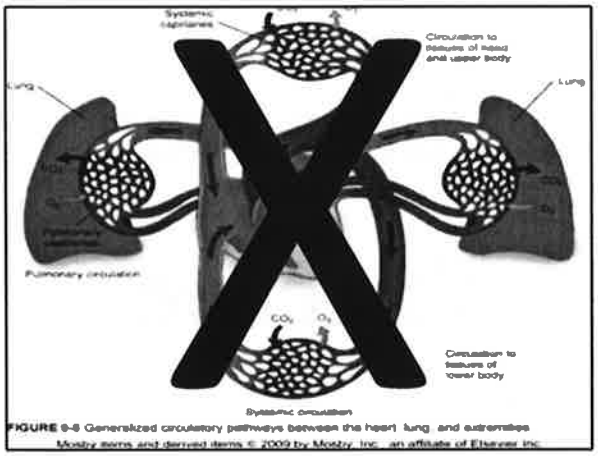
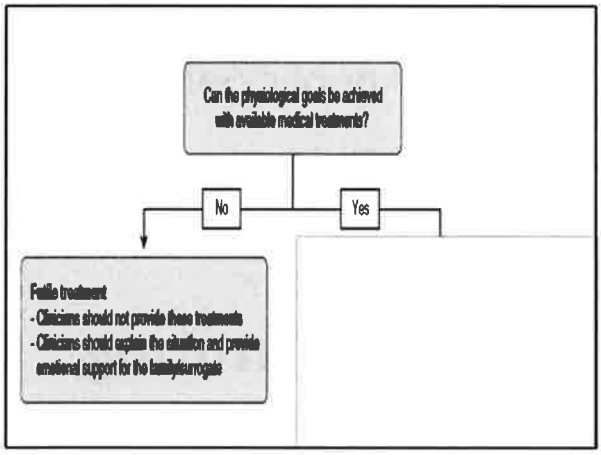


FIGURE 9-8 Generalized circulatory pathways between the heart, lung, and extremities.

May & should refuse



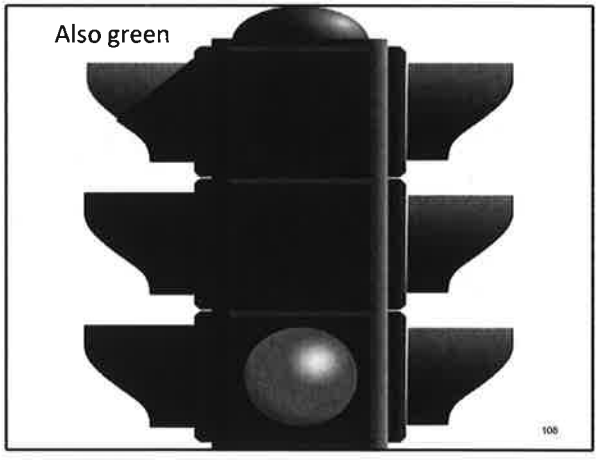
Futile

Proscribed

Potentially inappropriate

Proscribed

6 of 8



Treatments that **may accomplish** effect desired by the patient

Laws or public policies

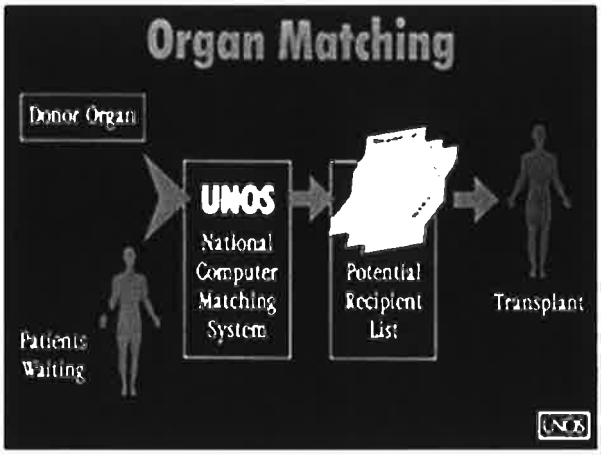
Prohibit

or

Permit limiting

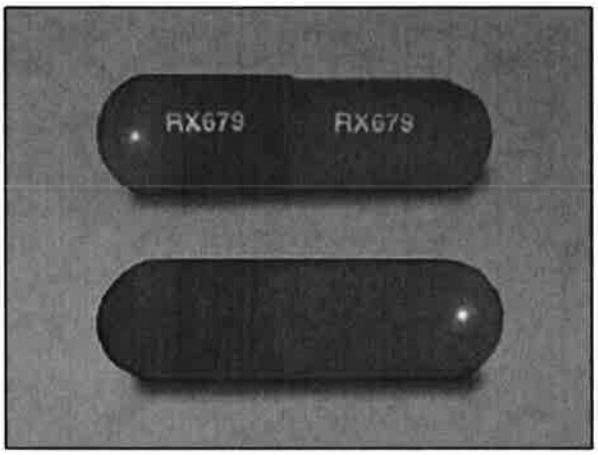
Prohibited provision

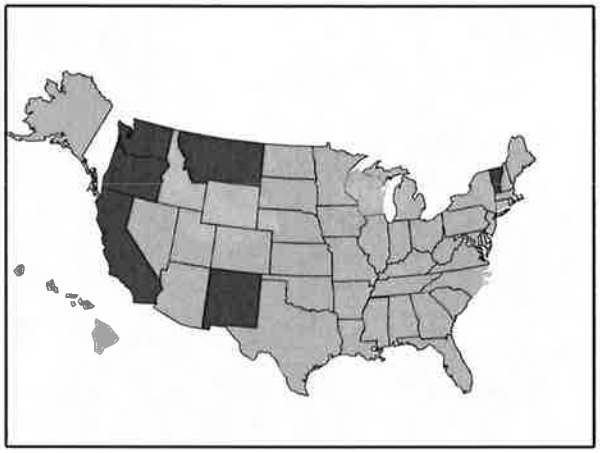
Example 1



Example 2

Example 3



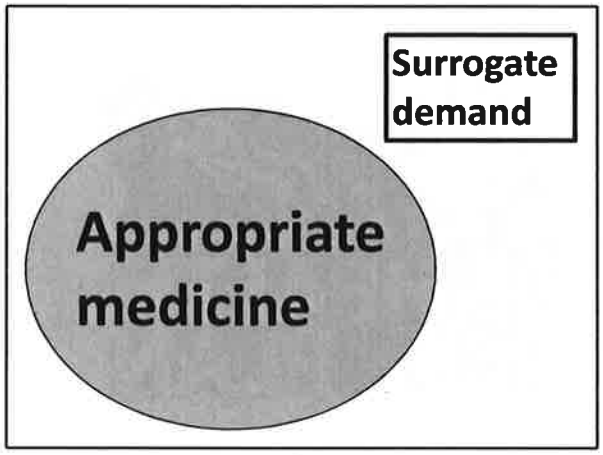


Proscribed

Prohibited

Permitting limiting

Permitted limiting



Example 1

Trisomy 18

22-week gestation

ECMO

Example 2

Also disaster plans

Example 3

Physician Orders for Life-Sustaining Treatment (POLST)-Florida

A Check One

CARDIOPULMONARY RESUSCITATION (CPR): Patient is unresponsive, pulseless, and not breathing.

☐ Attempt Resuscitation/CPR

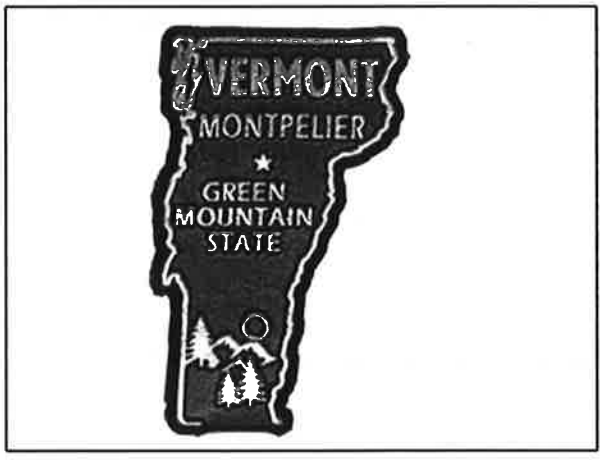
☐ Do Not Attempt Resuscitation/DNR

When not in cardiopulmonary arrest, follow orders in B and C.

PATIENT

Print Patient/Resident or Surrogate/Proxy Name | Relationship (write 'self' if patient)

Patient or Surrogate Signature (mandatory) | Date



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)

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

Not ATS "futility"

Might restore CP function

"imminent death"

3 days

http://healthvermont.gov/regs/ad/dnr_colst_instructions.pdf

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.

I hereby certify that these orders are based on:

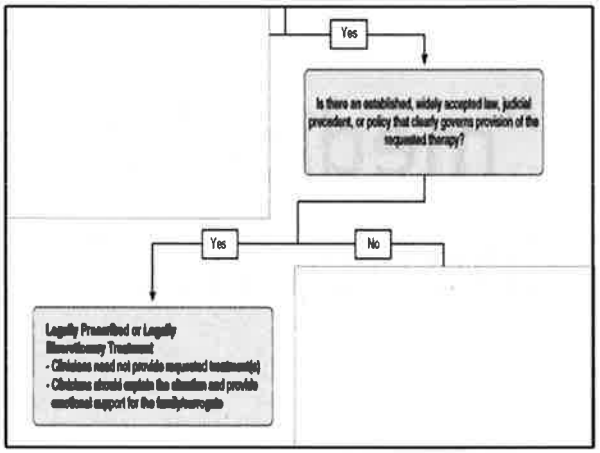
_____ instructions in the patient's advance directive; or
_____ other legal authority in accordance with all provisions of the Health Care Decisions Act. All supporting documentation must be contained in the patient's medical records.

"medically ineffective"

"[not] prevent the **impending death**"

imminent = impending

May & should refuse



Futile

Proscribed

Potentially inappropriate

Potentially Inappropriate

7 of 8

Some chance of accomplishing the effect sought by the patient or surrogate

Not "futile" because might "work"

E.g. dialysis for permanently unconscious patient

E.g. vent for patient w/ widely metastatic cancer

We call them "futility disputes"

. . . BUT . . .

Disputed treatment **might** keep patient alive.

But . . . is that chance or that outcome **worthwhile**

Not a medical judgment

Value judgment

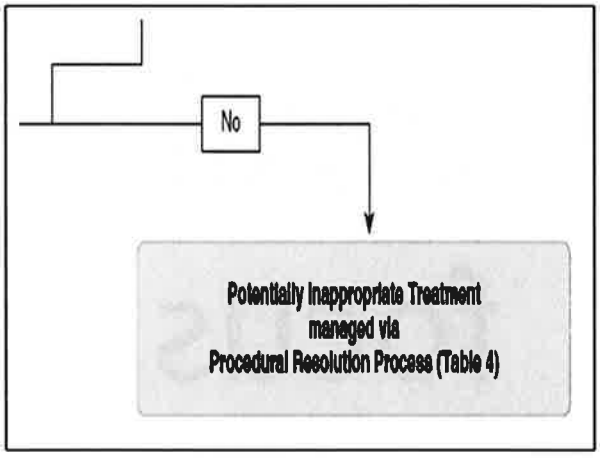


Table 4. Recommended Steps for Resolution of Conflict Regarding Potentially Inappropriate Treatments

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.

"potentially"

Legal focus

Try again for consent

PDA
Mediation
Transfer
New surrogate

1

162

PDA

163

Using effective decision aids

Robust evidence shows PDAs are highly effective

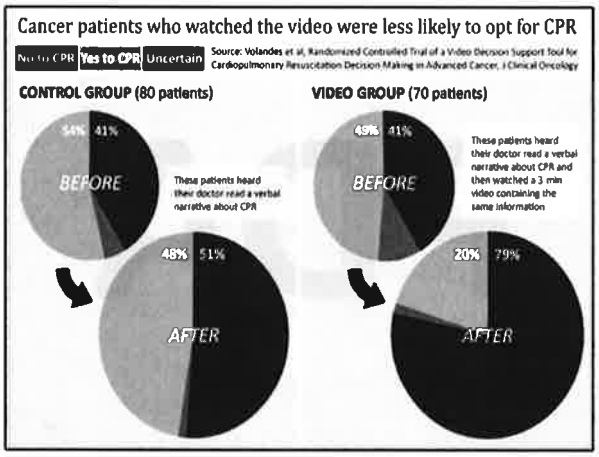
THE COCHRANE COLLABORATION®

Shared Decision Making in ICUs: An American College of Critical Care Medicine and American Thoracic Society Policy Statement

Alexander A. Kon, MD, FCCM[1]; Judy E. Davidson, DNP, RN, FCCM[2]; Wynne Morrison, MD, MBE, FCCM[3]; Marion Danis, MD, FCCM[4]; Douglas B. White, MD, MAS[5]

DOI: 10.1097/CCM.0000000000001388

Critical Care Medicine



Informed surrogates are **less** aggressive

2

170

Negotiation

Mediation

171

95%

172

Prendergast (1998)

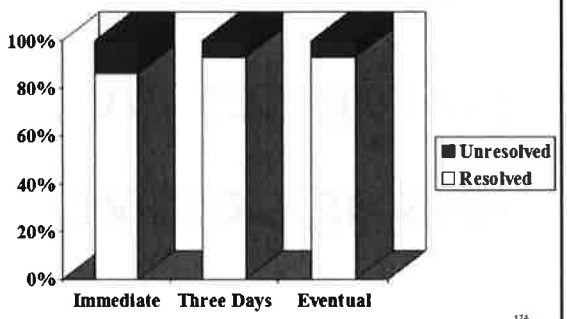
57% agree immediately

90% agree within 5 days

96% agree after more meetings

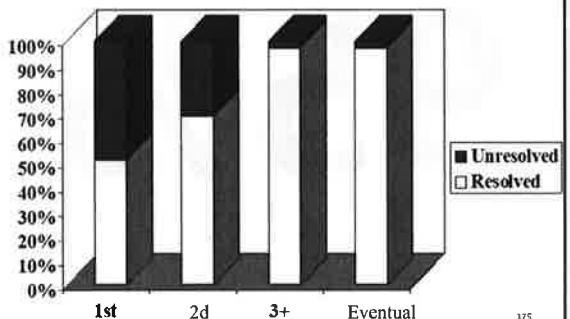
173

Fine & Mayo (2003)



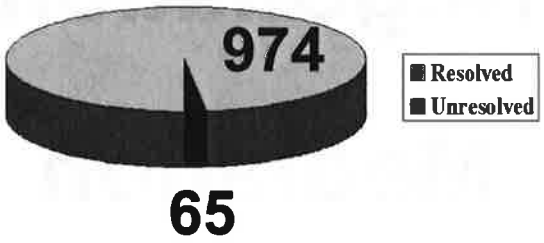
174

Garros et al. (2003)



175

Hooser (2006)



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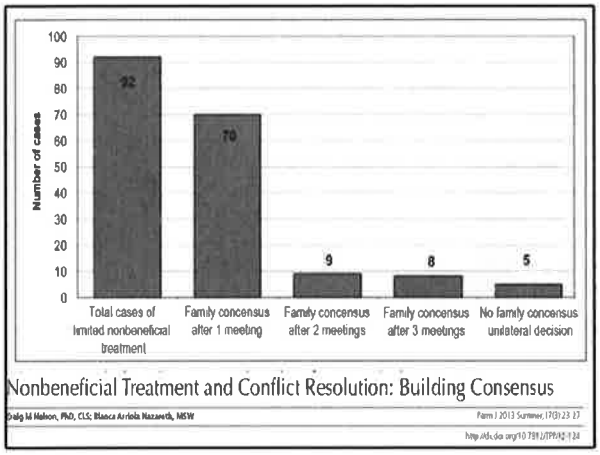


Nonbeneficial Treatment and Conflict Resolution: Building Consensus

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

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

http://dx.doi.org/10.7191/JTPHQ.124

5%

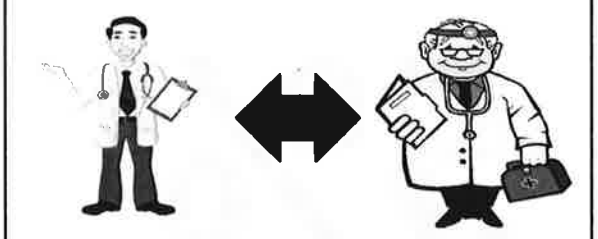
178

3

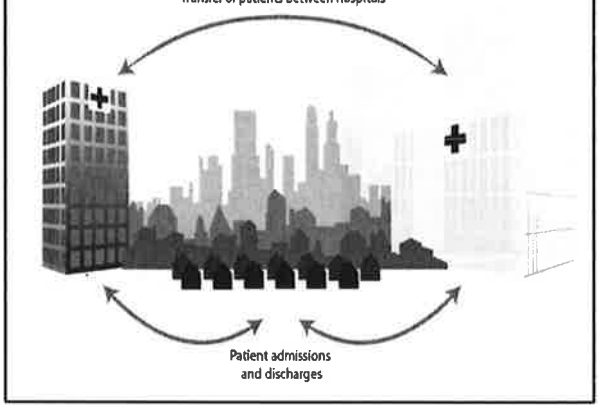
179

Transfer

180



New provider



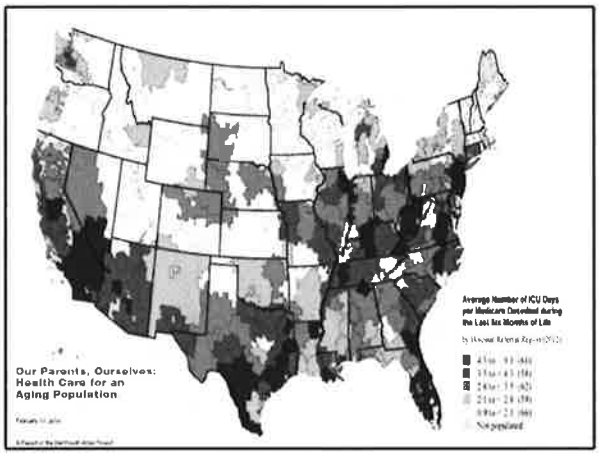
Rare

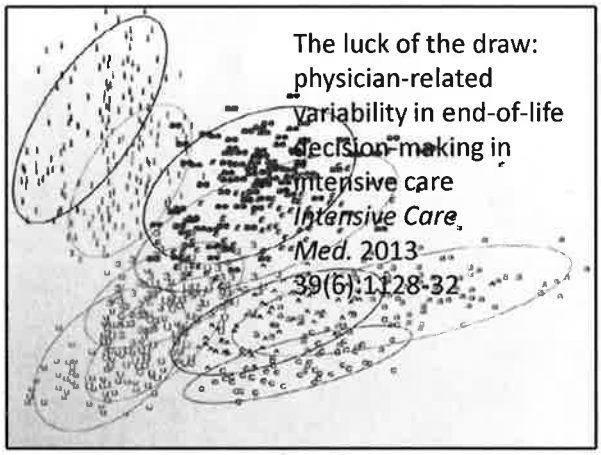
183

but

possible

184





4

187

Replace Surrogate

188

Substituted judgment

Best interests

190

~ 60% accuracy

More

aggressive treatment

192

Code of Medical Ethics

of the American Medical Association

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

AMA

Making Medical Decisions for Someone Else

A Vermont Handbook

Fla. Stat. 765.105

"the health care facility, or the attending physician, . . . may seek expedited judicial intervention . . . **surrogate . . . not in accord** with the patient's known desires . . . failed to discharge duties . . . "

Still no consent?

197

Not futile

Not proscribed

198

No surrogate consent

No "new" surrogate

No transfer

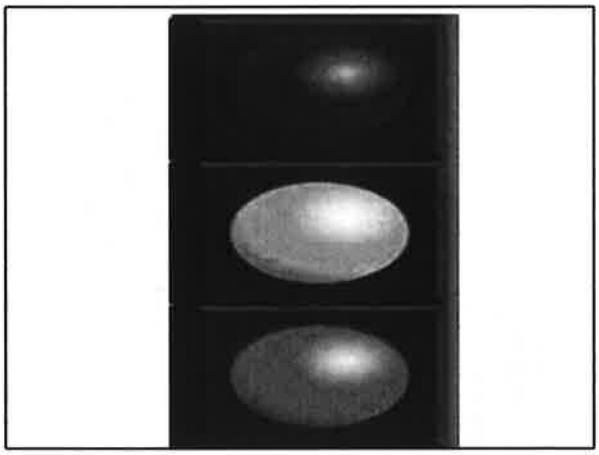
199

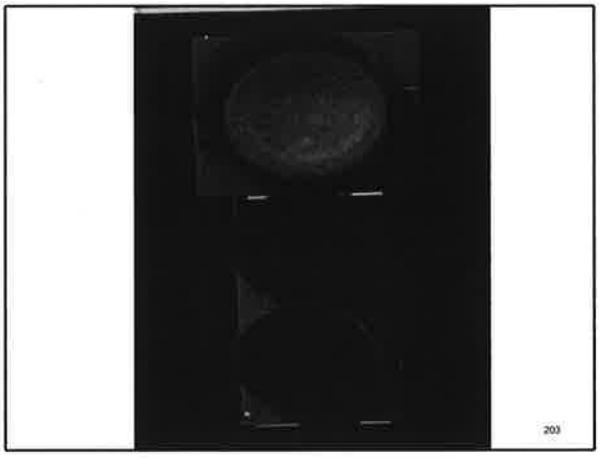
May you write DNAR?

200

Traffic Lights

201

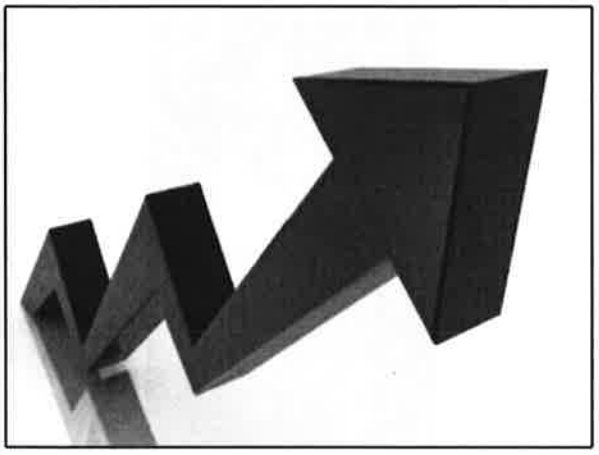


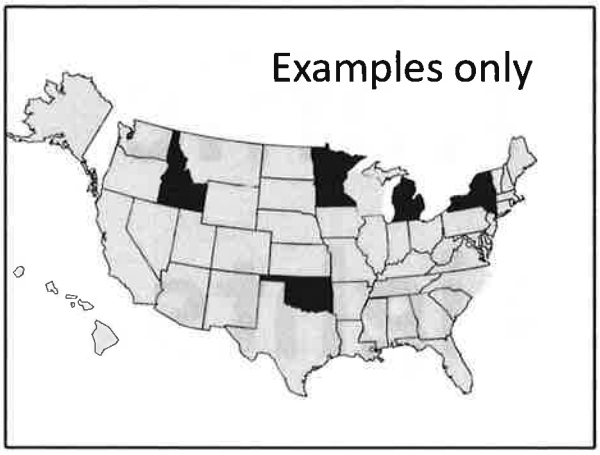


203

Consent **always**

204





Nondiscrimination in Treatment Act

November 2013

"health care provider **shall not deny** . . . life-preserving health care . . . directed by the patient or [surrogate]"

Medical Treatment Laws Information Act

November 2014

Information for Patients and Their Families

Your Medical Treatment Rights Under Oklahoma Law

No Discrimination Based on Mental Status or Disability:

Medical treatment, care, nutrition or hydration may not be withheld or withdrawn from an incompetent patient because of the mental disability or mental status of the patient.

Required by Section 3080.5(B) of Title 63 of the Oklahoma Statutes)

What Are Your Rights If A Health Care Provider Denies Life-Preserving Health Care?

- If a patient or person authorized to make health care decisions for the patient directs life-preserving treatment that the health care provider gives to other patients, your health care provider may not deny it.

Report suspected violations of any of the laws summarized in this brochure listed above, or attempts to violate any such laws, to the state Licensing Board of the profession(s) of all health care providers involved in the violation.

Oklahoma Board of Medical Licensure and Supervision

www.okmedicalboard.org

405- 962-1400

1-800-381-4519 (Toll free outside the 405 area code)

Oklahoma Health Care Providers' Responsibilities and Rights Under Certain Medical Treatment Laws

I hereby certify that I have read this brochure in its entirety and that I understand my legal duties pursuant to the laws described in it

Printed name _____

Licensing entity _____

Employer _____ Date _____

Signature _____

Please complete all information requested above the signature line

Once complete give to your employer to be placed in your personnel file for a maximum of four (4) calendar years

Review & sign once per year

SB 172, HB 309 (2012)

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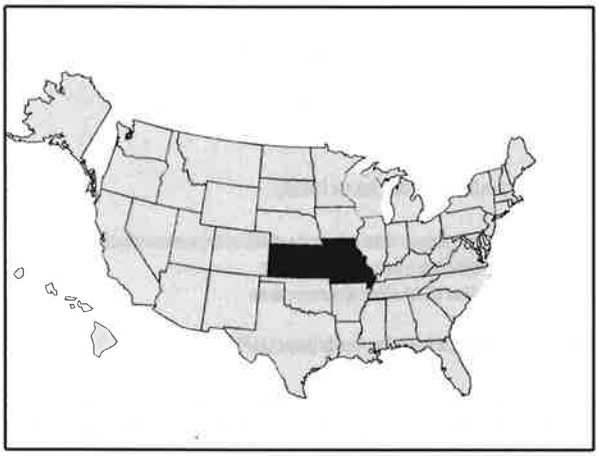
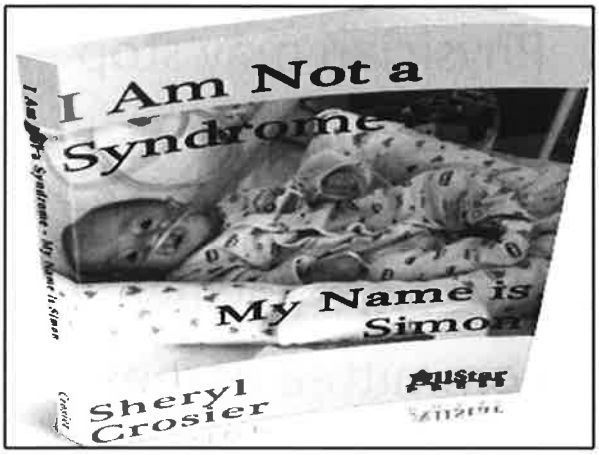
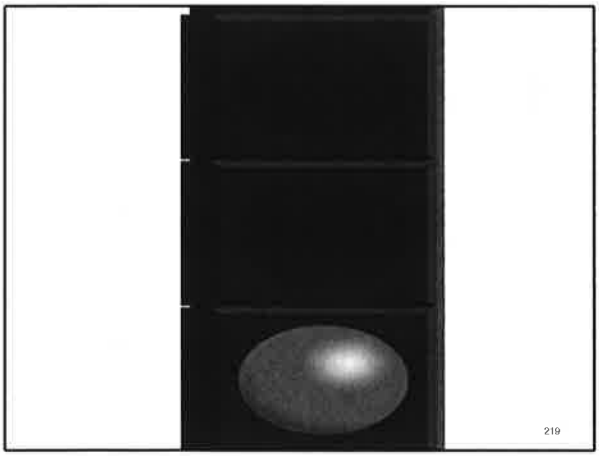




~~Slow code~~

~~Show code~~

Short code



Physician may stop LST **without** consent for **any reason**, if review committee agrees

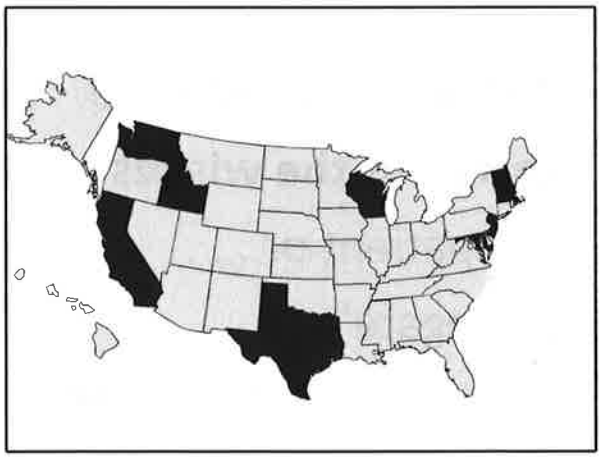
Give the surrogate

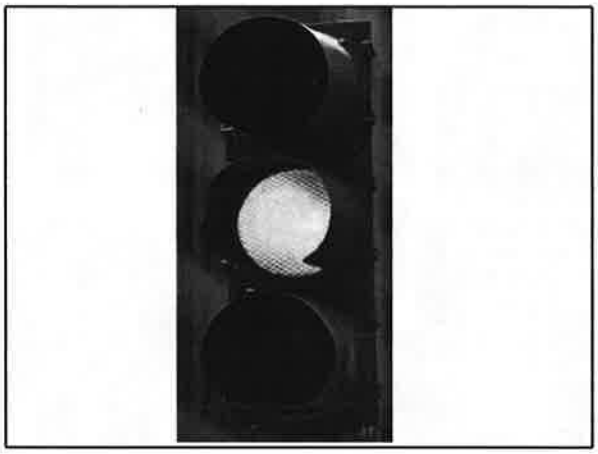
48hr notice RC

Written decision RC

10 days to transfer

Write DNAR without consent





"health care provider . . . that **refuses to comply** . . . make reasonable efforts to **transfer**"

Fla. Stat. 765.1105

Want to refuse

↓

Try to transfer

"not been transferred, **carry out the wishes** of the patient or . . . surrogate"

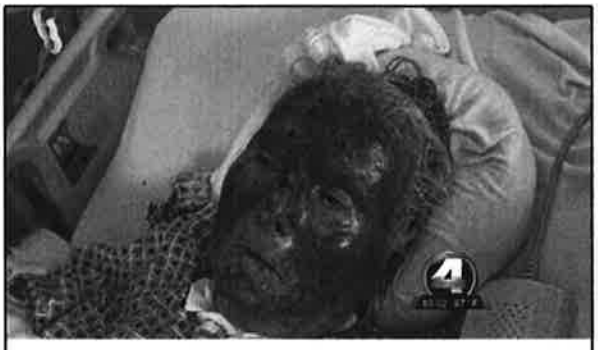
Fla. Stat. 765.1105

No transfer

↓

Must comply

But . . .



Confidential Party v. Confidential Party, No. 14MH165 (Lee County Circuit Court, Mar. 2014)

"unwilling to carry out . . . because of **moral or ethical beliefs**"

How to proceed

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Overt & Open

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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)

IIED

NIED

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Secretive

Insensitive

Outrageous

243

Consultation expected

Distress foreseeable

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GRAND JURY & CONFERENCE ROOM


Wendland v. Sparks (Iowa 1998)


Janet Tracey
©PA

Transparent enough

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Seek assent

Not consent

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Open ended question

Announce plan:
"We are going to…"

Silence = assent

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Standard of Care

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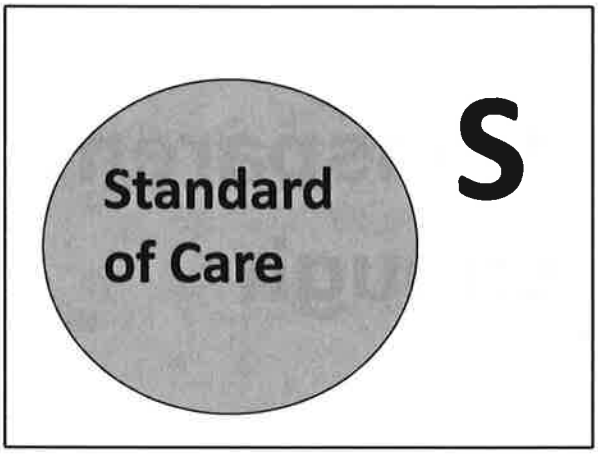

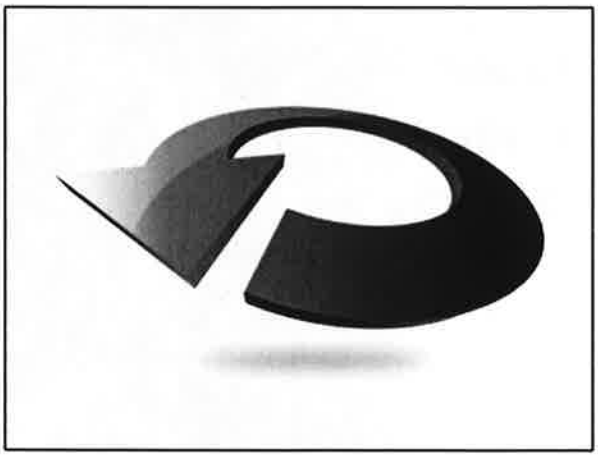

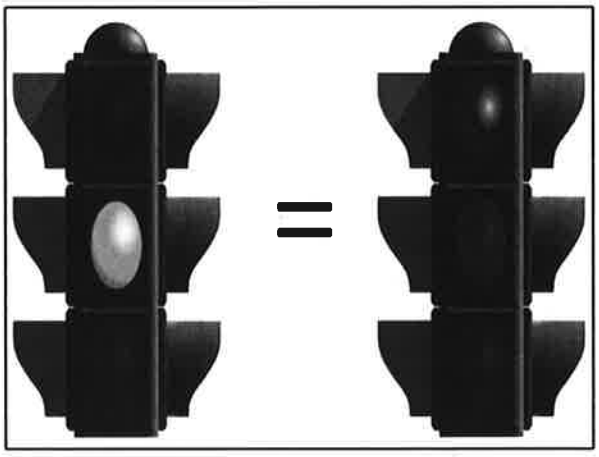

Thank you

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Since July 2007, I have been blogging, almost daily, to **medicalfutility.blogspot.com**.

This blog reports and discusses legislative, judicial, regulatory, medical, and other developments concerning end-of-life medical treatment conflicts. The blog has received **over one million** direct visits. Plus, it is distributed through RSS, email, Twitter, and re-publishers like Westlaw, Bioethics.net, Wellsphere, and Medpedia.

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