MEDICAL FUTILITY IN TEXAS: MYTHS AND MISCONCEPTIONS

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Myths and Misconceptions

1. M & M #1: Texas has a “medical futility law”

It’s a section, it’s a chapter, it’s a law!

- Texas Advance Directives Act (“TADA”: chapter 166, Health & Safety Code)
  - Medical Power of Attorney (subchapter D)
  - OOH-DNR (subchapter C)
  - Living will (“directive to physician”) and surrogate (subchapter B)
    - terminal or irreversible condition AND
    - lacks decision making capacity
    - dispute-resolution provision (§ 166.046)

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2. M & M #2: § 166.046 addresses only disputes about life-sustaining treatment

Right-to-die disputes

Refusal of treatment

“Classic right-to-die” dispute

Demand for treatment

“Reverse right-to-die” (futility) dispute

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3. M & M #3: § 166.046 addresses only disagreements over surrogate *demands* for treatment deemed by the attending physician to be futile

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3. M & M #3: § 166.046 addresses only disagreements over surrogate *demands* for treatment
4. M & M #4: § 166.046 doesn’t define “futile treatment”

§ 166.046

- “Futile treatment” not in TADA
- § 166.046(e): “If the patient or the person responsible for the health care decisions of the patient is requesting life-sustaining treatment that the attending physician has decided and the review process has affirmed is **inappropriate treatment**, the patient shall be given available life-sustaining treatment pending transfer under Subsection (d).”

§ 166.046

COUNCIL REPORT

JAMA, 1999;281:937-941

Medical Futility in End-of-Life Care

Report of the Council on Ethical and Judicial Affairs

Council on Ethical and Judicial Affairs, American Medical Association

Use of life-sustaining or invasive interventions in patients in a persistent vegetative state or who are terminally ill may only prolong the dying process. What constitutes futile intervention remains a point of controversy in the medical literature and in clinical practice. In clinical practice, controversy arises when the patient or proxy and the physician have discrepant values or goals of care. Since definitions of futile care are value laden, universal consensus on futile care is unlikely to be achieved. Rather, the American Medical Association Council on Ethical and Judicial Affairs recommends a process-based approach to futility determinations. The process includes at least 4 steps aimed at deliberation and resolution including all involved parties, 2 steps aimed at securing alternatives in the case of irreconcilable differences, and a final step aimed at closure when all alternatives

IN THE COURSE OF CARING FOR A critically ill patient it may become apparent that further intervention will only prolong the final stages of the dying process. At this point, further intervention is often described as futile. There has been controversy in the literature and in clinical practice regarding what constitutes futile intervention.

§ 166.046's process-based approach

- "Requires" ethics consultation when impasse exists as to life-sustaining treatment ("classic" and "reverse")
- Authorizes life-sustaining treatment to be withheld if elaborate due-process standards are satisfied

§ 166.046's process-based approach

- Surrogate decision maker entitled to:
  - at least 48 hours' prior notice of meeting
  - attend meeting
  - written overview of process

§ 166.046's process-based approach

- Surrogate decision maker entitled to receive:
  - state agency list of providers willing to accept transfer of patients AND others who are willing to assist in finding providers who will accept transfer
  - written explanation of committee outcome (copy in medical record)

§ 166.046's process-based approach

- If ethics committee agrees with attending physician:
  - disputed treatment must be continued pending an attempt to transfer
  - after 10 days, hospital not obligated to continue LST

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5. Other states don’t have futility statutes like ours

AMA Ethics Opinion 2.035 (06/1994)

“Physicians are not ethically obligated to deliver care that, in their best professional judgment, will not have a reasonable chance of benefiting their patients. Patients should not be given treatments simply because they demand them. . . .”

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8. M & M #8: Futility provision is overutilized

Other outcomes under § 166.046

- Patient died during 10-day waiting period
- Patient transferred
- Patient discharged to home
- Surrogate withdrew request for treatment
- Ethics committee did not agree with physician

Why so few cases under § 166.046?

- House staff “coached” through treatment discussions
- Intensive focus on consensus-building with staff and family
- Emphasis on pastoral care role – emotional and spiritual support
- Effective palliative care service

Why so few cases under § 166.046?

- Family may experience TADA process as *fait accompli*
- Ethics consultation “roundtable” discussion may be intimidating and coercive
- Families find responsibilities for end-of-life care burdensome and therefore are more willing to capitulate to others’ wishes

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9. Ethics committee is predisposed to agree with hospital/physician

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8. M & M #8: Futility provision is overutilized
9. Ethics committee is predisposed to agree with hospital/physician
10. Family can stymie process by not showing up

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12. There is no consensus as to meaning of "medical futility"
13. Talk about "medical futility" is almost always about something other than "true" medical futility
14. § 166.046 is flawed because it fails to provide for judicial review before life-sustaining treatment is withheld or withdrawn

Myths and Misconceptions

15. Futility is applicable to patients who are dead

Special Communication

A Definition of Irreversible Coma

Report of the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death

Our primary purpose is to define irreversible coma as a new criterion for death. There are two reasons why there is need for a definition: (1) Improvements in resuscitative and supportive measures have led to increased efforts to save those who are desperately injured. Sometimes these efforts have only partial success so that the result is an individual whose heart continues to beat but whose brain is irreversibly damaged. The burden is great on patients who suffer permanent loss of intellect, on their families, on the hospitals, and on those in need of hospital beds already occupied by these comatose patients. (2) Obsolete criteria for the definition of death can lead to controversy in obtaining organs for transplantation.

Irreversible coma has many causes, but *we are concerned here only with those comatose individuals who have no discernible central nervous system activity*. If the characteristics can be defined in satisfactory terms, translatable into action—and we believe this is possible—then several problems will either disappear or will become more readily soluble.

More than medical problems are present. There are moral, ethical, religious, and legal issues. Adequate definition here will prepare the way for better insight into all of these matters as well as for better law than is currently applicable.

The Ad Hoc Committee includes Henry K. Beecher, MD, chairman; Raymond D. Adams, MD; A. Clifford Barger, MD; William J. Curran, LLM, SMHyg; Derek Denny-Brown, MD; Dana L. Farnsworth, MD; Jordi Folch-Pi, MD; Everett I. Mendelsohn, PhD; John P. Merrill, MD; Joseph Murray, MD; Ralph Potter, ThD; Robert Schwab, MD; and William Sweet, MD.

Reprint requests to Massachusetts General Hospital, Boston 02114 (Dr. Henry K. Beecher).

Characteristics of Irreversible Coma

An organ, brain or other, that no longer functions and has no possibility of functioning again is for all practical purposes dead. Our first problem is to determine the characteristics of a *permanently* nonfunctioning brain.

A patient in this state appears to be in deep coma. The condition can be satisfactorily diagnosed by points 1, 2, and 3 to follow. The electroencephalogram (point 4) provides confirmatory data, and when available it should be utilized. In situations where for one reason or another electroencephalographic monitoring is not available, the absence of cerebral function has to be determined by purely clinical signs, to be described, or by absence of circulation as judged by standstill of blood in the retinal vessels, or by absence of cardiac activity.

1. *Unreceptivity and Unresponsitivity.*—There is a total unawareness to externally applied stimuli and inner need and complete unresponsiveness—our definition of irreversible coma. Even the most intensely painful stimuli evoke no vocal or other response, not even a groan, withdrawal of a limb, or quickening of respiration.

2. *No Movements or Breathing.*—Observations covering a period of at least one hour by physicians is adequate to satisfy the criteria of no spontaneous muscular movements or spontaneous respiration or response to stimuli such as pain, touch, sound, or light. After the patient is on a mechanical respirator, the total absence of spontaneous breathing may be established by turning off the respirator for three minutes and observing whether there is any effort on the part of the subject to breathe