Legal Aspects of Medical/End-of-Life Decision-Making

Date Jan 28, 2016
Objectives

- Define essential background issues
  - Capacity for medical decision-making
  - Ethics of withholding/withdrawing
- Discuss Ohio laws pertaining to:
  - Terminal condition/Permanent Unconscious State
  - Advance directives
  - Code status
  - Surrogate decision-makers
  - Medical futility
- Apply the above to some challenging cases
Capacity for Medical Decision-Making

- Care providers must be satisfied that patient is able to:
  - Receive information
  - Evaluate, deliberate, and mentally manipulate information, and
  - Communicate a treatment preference

- Look for understanding, logic, and consistency

- Often time-specific and task-specific

Ethics of Withholding vs. Withdrawing

- Withdrawal feels more “active”

- Now more accepted that these are equivalent

- Some say preferable to withdraw, rather than withhold
  - proves treatment has not had desired effect
Ohio Legal Definition: Terminal condition

- an irreversible, incurable, and untreatable condition caused by disease, illness, or injury from which, to a reasonable degree of medical certainty by the attending physician and one other physician who has examined the patient, both:

  1. There can be no recovery
  2. Death is likely to occur within a relatively short time if life-sustaining treatment is not administered

http://codes.ohio.gov/orc/2133 [April 24, 2013.]
Ohio Legal Definition: Permanently Unconscious State

- a state of permanent unconsciousness that, to a reasonable degree of medical certainty by the attending physician and one other physician who has examined the patient, is characterized by both:
  
  - (1) *Irreversible* unawareness of one's being and environment
  
  - (2) Total loss of cerebral cortical functioning, resulting in the patient having no capacity to experience pain or suffering

http://codes.ohio.gov/orc/2133 [April 24 2013.]
Ohio Law and Advance Directives

- Living Will: document expressing wishes about life-sustaining treatments ("life support," nutrition and hydration) and organ donation

  - Effective only* when patient is not able to express wishes and is either permanently unconscious or terminally ill (cannot use to enact DNR unless one of these exists)

  - DPOA-HC cannot go against Living Will (when Living Will is enacted)

  *Enactment is limited during pregnancy

Ohio Law and Decision-Maker Hierarchy

1. Guardian
2. Patient
3. DPOA-HC
4. Spouse (even if separated)
5. Adult Children (age >18) (majority decision of those available within ‘reasonable period of time’)
6. Parents
7. Adult Siblings (age >18) (majority as with children)
8. Nearest blood/adoptive relative

http://codes.ohio.gov/orc/2133 [April 24 2013.]
Ohio Law and Advance Directives

- Durable Power of Attorney for Health Care: patient-designated surrogate to make decisions on patient’s behalf when patient is unable to do so
  - Designee cannot be patient’s attending physician (or employee of facility or staff caring for patient)

- Form available free online from multiple sites
- Requires EITHER notary or 2 witnesses’ signatures
  - Witnesses cannot be the DPOA-HC, related to patient (blood/marriage/adoption), patient’s attending physician, or nursing home administrator

Ohio Law: Limitations to POA-HC Authority

- POA cannot withdraw life-sustaining treatment from a pregnant patient if doing so would terminate the pregnancy unless:
  - there is substantial risk to patient’s life, or
  - two physicians determine that the fetus would not be born alive

Ohio Law: Limitations to POA-HC Authority

- POA cannot withdraw consent for treatment given by patient before becoming unable to communicate unless:
  - physical conditions have changed, and/or
  - treatment is no longer of benefit or has not been proven effective

Ohio Law and Code Status

Ohio’s Portable DNR Order (follows patient and applies wherever they are – hospital, ECF, home)

http://www.odh.ohio.gov/pdf/forms/dnrfm.pdf [April 24, 2013.]
Ohio Law and Code Status

- **DNR Comfort Care-Arrest**: “do not resuscitate* in case of cardiac or respiratory arrest.”
  - Within an institution, sometimes accompanied by Do Not Intubate (under any circumstances; no official forms to support/document; not portable)

- **DNR Comfort Care Only**: comfort measures only, starting when the order is signed
  - Colloquially, some debate as to what this includes
    - (e.g., antibiotics for COPD exacerbation in DNR-CC patient, vs. just steroids)

*Ideally, “attempt resuscitation”

http://www.odh.ohio.gov/pdf/forms/dnrfm.pdf [April 24, 2013.]
Ohio Law & Code Status: DNRCC Protocol

Allows:
• Suction the airway
• Administer oxygen
• Position for comfort
• Splint or immobilize
• Control bleeding
• Provide pain* medication
• Provide emotional support
• Contact other appropriate health care providers

Does Not Allow:
• Administer chest compressions
• Insert artificial air way
• Administer resuscitative drugs
• Defibrillate or cardiovert
• Provide respiratory assistance (other than that listed above)
• Initiate resuscitative IV
• Initiate cardiac monitoring

*ideally should specifically mention/allow other comfort meds as well

http://www.odh.ohio.gov/pdf/forms/dnrfm.pdf [April 24, 2013.]
Ohio Law and Medical Liability

- Physicians who make these determinations “in good faith,” to a reasonable degree of medical certainty, and in accordance with reasonable medical standards, are not subject to:
  - criminal prosecution
  - damages in tort or other civil action
  - professional disciplinary action

http://codes.ohio.gov/orc/2133 [April 24 2013.]
Cases
How would you counsel the following regarding her life-expectancy?

- 58 y.o. female; 176 pack year smoking history. No longer smoking
- BMI = 30.1
- Severe Obstruction with FEV1 = 31% predicted
- Dyspneic getting dressed
- Exercise capacity - 1004 feet on 6 minute walk
What is the patient’s expected 4 year survival?

A. 80%
B. 60%
C. 40%
D. 20%
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<tbody>
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<td><strong>BMI (kg/m²)</strong></td>
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<td>36-49</td>
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Approximate 4 year survival based on total score:

- 0-2 points: 80%
- 3-4 points: 70%
- 5-6 points: 60%
- 7-10 points: 20%
BODE score

- Quartile 1: 0-2
- Quartile 2: 3-4
- Quartile 3: 5-6
- Quartile 4: 7-10

ATS Staging

FEV1 % pred.

- Stage I: > 50%
- Stage II: 36-50%
- Stage III: < 35%
The progression of COPD is heterogeneous: change in FEV1 over time is highly variable.

**Figure 1.** Distribution of Estimated Annual Rates of Change in Forced Expiratory Volume in 1 Second (FEV1) over a 3-Year Period in Patients with Chronic Obstructive Pulmonary Disease.

Empirical Bayes estimates of the change in FEV1 were calculated for each patient with the use of the random-coefficient model and are summarized in the form of a histogram. Each bar represents a change in FEV1 of 20 ml per year.

Vestbo, NEJM 2011
Case

Patient with widely metastatic lung cancer no longer responding to chemotherapy, who is

- On ventilator for respiratory failure due to volume overload, receiving hemodialysis for acute renal failure
- Awake, alert, without delirium
- Wants to leave hospital (with hospice)

Case 1a: DPOA-HC disagrees, wants continued disease-directed therapy
Case

- Patient with widely metastatic cancer no longer responding to chemotherapy, who is
  - On the ventilator for respiratory failure due to pulmonary embolism and is unresponsive
  - Living will indicates patient would not want prolonged life support in case of terminal condition
  - POA-HC does not want patient to suffer any more
Case

- Patient with end-stage congestive heart failure (not a candidate for VAD or transplant), who is:
  - On the ventilator for respiratory failure due to volume overload, unresponsive, not tolerating volume removal with ultrafiltration or meds
  - No Living Will
  - POA-HC feels patient would not want to remain on life support in this situation
Case

- 95 y.o. with chronic respiratory insufficiency in a nursing home, totally dependent aspirates, has a respiratory arrest and now a severe hypoxic encephalopathy
  - The patient is on a ventilator and the medical team discusses taking the patient off of life-support
  - The POA-HC wants “everything done”
  - There is information that the POA-HC is collecting his grandmother’s social security check
Ohio Law and Medical Futility

- Physicians are not obligated to provide (most) treatments that are not medically warranted.
- However, must notify surrogate if considering withdrawal of life-sustaining treatments; if surrogate disagrees, has *** days to find alternate physician or facility to accept patient in transfer.
Question

Which of the following is true regarding preferences for advanced COPD patients who have had extensive education regarding life support and end of life issues:

- Family members/surrogate decision makers can predict the patient’s preference over 75% of the time
- The patient’s physician can predict the patient’s preference less than 50% of the time
- Men are much more likely than women to want life-sustaining treatment at the end of life
Case

- 54 y.o COPD patient (BMI – 29) is admitted with severe dyspnea and anxiety. Most recent PFTs show an FEV1 of 52% of predicted and 6 minute walk of 1310 feet:
  - Because of severe dyspnea the hospitalist refers to the palliative team for consideration of hospice
  - The patient is interested; should hospice be recommended
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Case

- Your 74 y.o. patient with GOLD Stage 4 COPD requests assisted suicide. What do you recommend?