Conflict over End-of-Life Care:

How Lawyers and Mediators Can Help Physicians and Families

Douglas White, MD

Robyn Shapiro, Esq.

Haavi Morreim, JD, PhD

DOUGLAS WHITE, MD, MAS

- Vice Chair and Professor of Critical Care Medicine at University of Pittsburgh School of Medicine
- Director, Program on Ethics and Decision Making in Critical Illness
- UPMC Endowed Chair for Ethics in Critical Care Medicine
- Conducts research on developing strategies to resolve conflict and improve surrogate decision-making in intensive care units

ROBYN SHAPIRO, ESQ.

- Attorney, founder of Health Sciences Law Group LLC
  - Healthcare compliance, research compliance, corporate compliance, medical staff issues, bioethics, HIPAA, corporate & commercial issues for pharma and device mfgrs
- Counsel to policy makers, state and federal
  - NIH Recombinant DNA Advisory Committee
  - FDA Drug Safety & Risk Management Advisory Committee
  - DHHS Advisory Committee on Xenotransplantation
- Presenter and author
  - More than 60 articles and book chapters

Haavi Morreim, JD, PhD

- Professor, College of Medicine, University of Tennessee
  - Health law, bioethics, conflict resolution
  - Primarily clinically-based teaching (daily rounds, conferences)
- Mediator: TN Supreme Court Rule-31 listed
  - Civil and family mediation
  - Clinical-setting mediations for healthcare
    - Discharge plans
    - Treatment decisions
    - Employee relationships
    - Other kinds of conflict
- Principal, Center for Conflict Resolution in Healthcare LLC
- Attorney

DOUGLAS WHITE, MD, MAS

Responding to Requests for Potentially Inappropriate Treatment

Disclosures

- Research Funding
  - National Institutes of Health (NIH)
  - Patient Centered Outcomes Research Institute (PCORI)
  - Gordon and Betty Moore Foundation
  - Greenwall Faculty Scholars Award in Bioethics
  - UPMC Innovation Fund
  - Beckwith Foundation

- Royalties
  - UpToDate

What to do?

- 81 year old man with severe dementia and severe COPD admitted with respiratory failure, septic shock and multi-organ failure. No advance directive.
  - 6 weeks in ICU
  - Minimally responsive after watershed infarcts
  - Ventilator and dialysis dependent
  - Off pressors; stable vital signs
  - Necrotic extremities and pressure ulcers requiring serial debridement.
- Family requests ongoing treatment, saying "Please do everything to keep him alive. We can't let him go ...and life is sacred...and he'd want to live."

AMERICAN THORACIC SOCIETY 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, J. Randall Curtis, Dee W. Ford, Molly Osborne, Cheryl Misak, David H. Au, Elie Azoulay, Baruch Brody, Brenda G. Fahy, Jesse B. Hall, Jozef Kesecioglu, Alexander A. Kon, Kathleen O. Lindell, and Douglas B. White; on behalf of The American Thoracic Society *ad hoc* Committee on Futile and Potentially Inappropriate Care

This Official Policy Statement of the American Thoracic Society (ATS) was approved by the ATS, January 2015, the American Association for Critical Care Nurses (AACN), December 2014, the American College of Chest Physicians (ACCP), October 2014, the European Society for Intensive Care Medicine (ESICM), September 2014, and the Society of Critical Care Medicine (SCCM), December 2014

http://www.atsjournals.org/journal/ajrccm

Bosslet G. AJRCCM 2015

Participants

Participating Professional Societies

- American Thoracic Society
- Society for Critical Care Medicine
- American Academy of Critical Care Nurses
- American College of Chest Physicians
- European Society of Intensive Care Medicine

Medicine
- Gabriel Bosslet
- Gordon Rubenfeld
- J. Randall Curtis
- Dee Ford
- Elie Azoulay
- Jozef Kesecioglu
- Molly Osborne
- Jesse Hall
- David Au
- Brenda Fahy
- Douglas White

Pediatrics
- Robert Truog
- Alexander Kon

Nursing
- Cynda Rushton
- Kathy Lindell

Public/patients
- Jill Raleigh
- Cheryl Misak

Law
- Thaddeus Pope

Bioethics
- Bernard Lo
- Baruch Brody

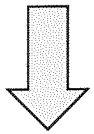
The Gist

Intensive communication

Expert consultation

Fair process of dispute resolution

Intensive communication



Expert consultation

Fair process of dispute resolution

AMERICAN THORACIC SOCIETY 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, J. Randall Curtis, Dee W. Ford, Molly Osborne, Cheryl Misak, David H. Au, Elie Azoulay, Baruch Brody, Brenda G. Fahy, Jesse B. Hall, Jozef Kesecioglu, Alexander A. Kon, Kathleen O. Lindell, and Douglas B. White; on behalf of The American Thoracic Society *ad hoc* Committee on Futile and Potentially Inappropriate Care

This Official Policy Statement of the American Thoracic Society (ATS) was approved by the ATS, January 2015, the American Association for Critical Care Nurses (AACN), December 2014, the American College of Chest Physicians (ACCP), October 2014, the European Society for Intensive Care Medicine (ESICM), September 2014, and the Society of Critical Care Medicine (SCCM), December 2014

Recommendation 1

Institutions should implement strategies to prevent intractable treatment conflicts, including proactive communication and early involvement of expert consultation.

Bosslet G. AJRCCM 2015

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

Alexander A. Kon, MD, FCCM[1,2]; Judy E. Davidson, DNP, RN, FCCM[3];
Wynne Morrison, MD, MBE, FCCM[4]; Marion Danis, MD, FCCM[5]; Douglas B. White, MD, MAS[6]

Table 2. Recommended Practices for Improving Communication and Support for Surrogates in the Intensive Care Unit

Systems-level interventions
Conduct regular, structured interprofessional family meetings (63–68)
Integrate palliative care and/or ethics teams into ICU care for difficult cases (11, 14, 68–71)
Provide printed educational materials to family (66, 67, 72, 73)
Maintain dedicated meeting space for ICU family meetings
Clinician-level skills
Coordinate an effective ICU family meeting
Establish consensus among treating clinicians before the meeting (68, 74)
Use a private, quiet space for family meetings (68, 74)
Introduce all participants
Use patient/family-centered communication strategies (*see below*)
Affirm nonabandonment and support family decisions (12, 75)
Provide family-centered communication
Elicit surrogates' perceptions first (76)
Use active listening skills and deliver information in small chunks (77, 78)
Respond to questions and check for understanding of key facts (12, 76, 79)
Acknowledge and address emotion (13, 68, 75, 79, 80)
Support religious/spiritual needs and concerns (68, 81)
Foster shared decision making (15–17, 68, 82)
Assess clinical prognosis and degree of certainty
Evaluate surrogate preferences for decision-making responsibility (18, 19, 21, 22)
Elicit the patient's treatment preferences and health-related values (83)

Crit Care Med. In press

Intensive communication

Expert consultation

Fair process of dispute resolution

AMERICAN THORACIC SOCIETY 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, J. Randall Curtis, Dee W. Ford, Molly Osborne, Cheryl Misak, David H. Au, Elie Azoulay, Baruch Brody, Brenda G. Fahy, Jesse B. Hall, Jozef Kesecioglu, Alexander A. Kon, Kathleen O. Lindell, and Douglas B. White; on behalf of The American Thoracic Society *ad hoc* Committee on Futile and Potentially Inappropriate Care

This Official Policy Statement of the American Thoracic Society (ATS) was approved by the ATS, January 2015, the American Association for Critical Care Nurses (AACN), December 2014, the American College of Chest Physicians (ACCP), October 2014, the European Society for Intensive Care Medicine (ESICM), September 2014, and the Society of Critical Care Medicine (SCCM), December 2014

Recommendation 1

Institutions should implement strategies to prevent intractable treatment conflicts, including proactive communication and early involvement of expert consultation.

Bosslet G. AJRCCM 2015

Intensive communication

↓

Expert consultation

↓

Fair process of dispute resolution

AMER
DOCU

An Offici
Respond
Intensive

Gabriel T. Boss
J. Randall Curti
Brenda G. Fahy
on behalf of Th

THIS OFFICIAL POLIC
CRITICAL CARE NURS
INTENSIVE CARE MED

Recommendation 2

The term "potentially inappropriate" should be used, rather than "futile," to describe treatments that have at least some chance of accomplishing the effect sought by the patient, but clinicians believe that competing ethical considerations justify not providing them. Clinicians should communicate and advocate for the treatment plan they believe is appropriate. Requests for potentially inappropriate treatment that remain intractable despite intensive communication and negotiation should be managed by a fair process of dispute resolution.

Bosslet G. AJRCCM 2015

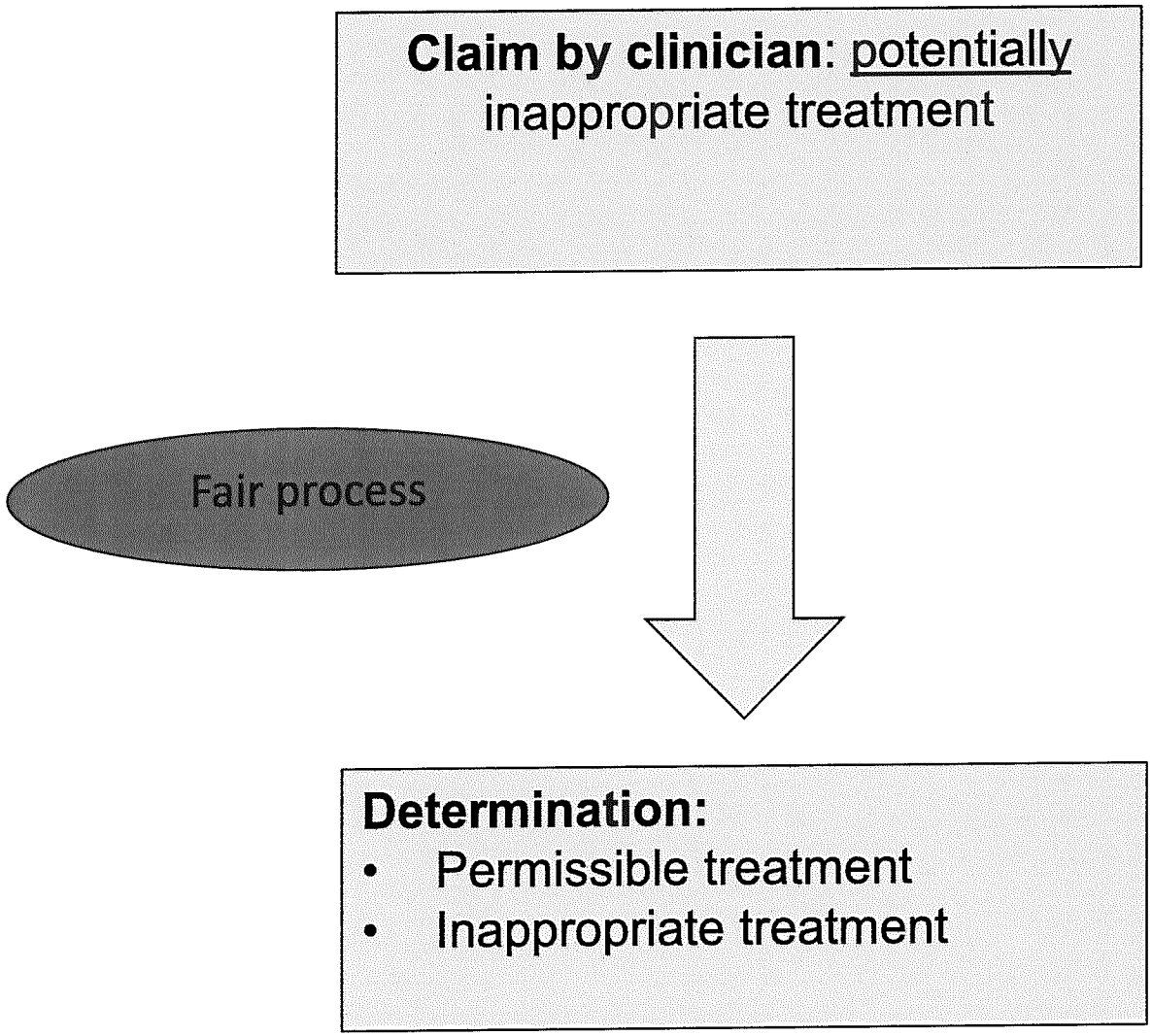
The Actual Ethical Question in Most Cases

- "Are there situations in which the patient's life could be extended (and doing so is requested by the patient/proxy), but doing so would be ethically wrong?"

Guiding Considerations of the Policy

- Neither individual clinicians nor families should be given complete authority to make unilateral decision.
- Clinicians should not simply acquiesce to requests they believe are harmful to the patient or violate professional integrity.
- In response to intractable conflict, the process of decision making should satisfy basic aspects of procedural fairness.

Last Resort: Process-based Approach to Dispute Resolution



Recommendation 2

Managing Requests for Potentially Inappropriate Treatment

1. Give notice of the process to surrogates
2. Continue negotiation during the dispute resolution process
3. Obtain a second medical opinion
4. Obtain review by an interdisciplinary hospital committee
5. Offer surrogates the opportunity to transfer the patient to an alternate institution
6. Inform surrogates of the opportunity to pursue extramural appeal
7. Implement the decision of the resolution process

Early Experience with the Texas Advance Directives Act (TADA)

Procedural Approach to Manage Requests "Medically Inappropriate" Treatment

- 47 consults over 2 years at Baylor U.:
  - 37 (78%) resolved with routine ethics counseling
  - 10 (22%) proceeded to the more formal ethics committee review following Texas law
    - 4 cases: ethics committee disagreed w/ clinicians that further non-comfort treatments were medically inappropriate.
    - 6 cases: a 10-day letter was issued.
      - 3 cases family agreed to stop treatment before 10 days elapsed.
      - 3 cases patients died during 10-day period.

Fine RL *Annals of Internal Medicine*. 2003; 138: 743-746.

- Policy statement recommends different resolution strategy for:

Situation	Recommended Process
Time pressured situations	1. Abbreviated prospective review 2. Prompt retrospective review
Requests for strictly physiologically futile interventions	1. Refuse to administer intervention 2. Prompt retrospective review

Bosslet G. AJRCCM. 2015

ROBYN SHAPIRO, ESQ.

Addressing Specific Challenges: The Role of the Ethics Committee; Case Law

1. The Role of the Ethics Committee

- To address end of life disputes, links between dispute resolution and ethics committee consultation often promoted;

  but

- Differences between the processes pose challenges.

- Differences:
  - Neutrality
    - Mediator is neutral
    - Ethics committee is tied to institution
  - Decision-makers
    - In medication, parties are decision-makers
    - In ethics committee consultation, patients and their representatives may not be as participatory, or not sole, ultimate decision-makers
  - Communication
    - Mediator listens, reframes, reflects to facilitate mutually acceptable agreement between parties
    - Historically, communication not typically as instrumental in ethics committee consultation process; ethics committee acts as expert, supplies answers and recommendations
  - Group think, bandwagon phenomenon
    - Can occur in ethics committee consultation

2. Case law – Mediation occurs in shadow of health care decisions law, and providers' risk-averse and litigation-averse posture.

Example: In re Edna MF, 210 Wis. 2d 557,563 N.W. 2d 485 (1997)

- Facts:
  - Edna, incompetent 71-year-old with late stage Alzheimer's
  - Betty (sister and guardian) sought discontinuation of her artificial nutrition
  - Ethics committee direction: court order necessary
  - Betty filed petition seeking order confirming her decision to have artificial nutrition withheld, claiming Edna would not want such treatment, citing
    - Fact that Edna had been vibrant, gifted journalist;
    - Statement Edna had made to effect that "would rather die of cancer than lose my mind";
    - Consensus of family and friends that Edna would not want to be kept alive in her condition.

- Ruling:
  - Circuit Court denied guardian's petition
  - WI Supreme Court affirmed, holding that:
    - Guardian may direct withholding of life sustaining treatment if ward is in PVS and decision is in ward's best interests;
    - If ward not in PVS, is not in his/her best interest "as a matter of law" to withdraw life-sustaining treatment unless ward has clearly indicated his/her desires;
    - Edna's statement not sufficiently clear because made more than 30 years previously and under different circumstances.

Query: Does mediation mask normative judgments in controlling case law?

HAAVI MORREIM, JD, PHD

- So . . . what does the foregoing mean for a health lawyer?
- Or for a mediator?
- Or for a mediator in health law cases?

INCREASING RECOGNITION OF NEED FOR CONFLICT RESOLUTION

- **Mediation** is now being brought to a variety of areas
  - Employees/employment/HR, business contracts, peer review, payor/provider, mergers/acquisitions/dissolutions, med-mal, FCA, etc.
  - And now end-of-life disputes
- **Mediators** being brought into new areas
  - Some health systems: in-house mediators
    - Ombuds for employee conflicts
    - Ombuds-mediators for patient-provider disputes
  - Some health systems: availability of outside mediators

MY OWN PERSPECTIVE AS A MEDIATOR

- Mediations in the clinical setting—conflicts, e.g., over:
  - Discharge planning
  - Treatment decisions
  - Employee relationships
  - Many other kinds of conflict
- Mediation: one concept, two very different realities

MEDIATION: CLINICAL v LITIGATION

- Litigation
  - Focused: issues are clear – usually, mainly financial
  - Unitary: one session (occasionally more for complex cases)
  - Comprehensive: if parties reach agreement, all issues usually are permanently and completely resolved
  - Enforceable via contract (barring, e.g., unconscionability)

MEDIATION: CLINICAL v LITIGATION

- Clinical setting
  - Outcome may just be "here's what we'll try next" or "we'll speak to each other differently henceforth"
  - Agreements can be very temporary
    - Patient's changing condition, other issues, can quickly nullify any agreement
  - Agreements are generally unenforceable except to the extent parties genuinely embrace that agreement

MEDIATION: CLINICAL v LITIGATION

- Litigation
  - **Evaluative** style often sought by attorneys, used by mediators

- Clinical setting
  - **Facilitative** or sometimes transformative style fits far better
  - Only a *genuine agreement* will have durability
  - Trust carries even greater importance than in litigation-mediation
  - Mediator who pressures participants quickly becomes just another pair of fists in the fight → loses trust, becomes ineffective

DISCUSSION