Overview of State “Futility” Laws

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What is the Provider’s Right to Refuse to Comply with a Patient’s Request for Treatment?

- All but 4 states recognize provider’s right to refuse (2007 survey of advance directive laws)
- Based on:
  - Any criteria (20)
  - Contrary to generally accepted h.c. standards (30)
  - Conscience or personal belief (11)
  - Moral convictions or religious beliefs (14)
  - Determination that treatment is medically ineffective / inappropriate (15)
  - Philosophical beliefs (1 - OR)
  - Futility (2 - ID, NJ)
With a couple exceptions, statutes have avoided the term “futility”

ID Code 39-4514(5). Futile care. Nothing in this chapter shall be construed to require medical treatment that is medically inappropriate or futile.

NJ Stat. Ann. §26:2H-67. Life-sustaining treatment may be withheld or withdrawn from a patient in the following circumstances:
(1) When the life-sustaining treatment is experimental and not a proven therapy, or is likely to be ineffective or futile in prolonging life, or is likely to merely prolong an imminent dying process;
What is “Medically Ineffective”? 

Only 4 states define.

Maryland & Delaware:

…means that, to a reasonable degree of medical certainty, a medical procedure will not:

1. Prevent or reduce the deterioration of the health of an individual; or

2. Prevent the impending death of an individual.

MD Code, Health - General, § 5-601(o)

Del. Code Ann. Tit. 16 §2501(m)
What is “Medically Ineffective”?  

Alaska: … means health care that according to reasonable medical judgment cannot cure the patient’s illness, cannot diminish its progressive course, and cannot alleviate severe discomfort and distress.  

New Mexico: … means that the treatment would “not offer the patient any significant benefit, as determined by the physician”  

Alaska Stat. § 13.52.060(f)  
Provider Obligations Upon Refusal

29 States require notice to patient or surrogate
  – 16 require notice “promptly”
  – 3 require notice only a “reasonable effort to inform the patient” (ND, VA), or only “if possible” (VT)

Some distinguish individual provider notice obligation versus institutional provider obligations. The latter requires a formal institutional policy and may require notice at admission. (CO, MA, NY)
46 states impose a transfer obligation on the provider, either as an affirmative obligation or as a condition of immunity.

But not all transfer obligations are created equal.
Provider Obligations Upon Refusal

**Level of Effort Required** (examples):

- **Low**: “shall not impede the transfer of the patient to another physician or health care provider” (KY)
- **Medium**: “shall reasonably cooperate to assist in the transfer” (AL) or “make all reasonable efforts to assist” (CA)
- **High**: “must within 7 days either: (a) Transfer the patient to another health care provider or facility . . . or (b) If the patient has not been transferred, carry out the wishes of the patient or the patient’s surrogate.” (FL)
Procedures to Resolve Patient-Provider Disputes

Generally non-existent.

Maryland: Attending physician may w/h or w/d medically ineffective treatment only if attending physician and a second physician certify in writing that the treatment is medically ineffective and the attending physician informs the patient or the patient's agent or surrogate of the physician's decision. MD Code, Health-Gen, § 5-611(b)
Texas Procedure

Review by ethics or medical committee

Patient/surrogate:

1. Shall be informed of committee review process not less than 48 hours before review meeting, unless mutual waiver

2. Shall be provided:
   - copy of the statutory notice
   - copy of the registry list of providers & referral groups ready to consider accepting transfer or to assist in locating willing provider (web registry maintained by the Texas Health Care Information Council)

3. Entitled to:
   - attend the committee meeting; and
   - receive a written explanation of the decision reached during the review process (must go in medical record, too).
Texas Procedure

If physician or patient/surrogate disagrees with review:

1. Physician shall make reasonable effort to transfer patient to physician willing to comply with pt’s directive. Facility personnel shall assist transfer to:
   • another physician;
   • alternative care setting within that facility; or
   • another facility.

2. If patient/surrogate is requesting LST, patient is responsible for transfer costs.
Texas Procedure

If physician or patient/surrogate disagrees with review:

3. Provider not obligated to provide LST after the 10th day after written decision, unless court order.

4. Per patient/surrogate’s request, court shall extend time period only if it finds, by preponderance of evidence, a reasonable expectation that a willing physician or facility will be found if time extension is granted.
Paradigms

• Texas: Adjudicatory model (adversarial)

• Everyone else: Unilateral clinical/ethical determination unless kicked into court adjudication.

• The ideal?
  “a relationship between patients and professionals characterized by mutual participation and respect, and by shared decision-making”

President’s Cmsn. for the Study of Ethical Problems in Medicine & Biomedical Behavioral Research (1982)
References

• M. Sethi, “A Patient’s Right to Direct Own Health Care vs. a Physician’s Right to Decline to Provide Treatment,” 29 BIFOCAL 21 (December 2007).
  www.abanet.org/aging/docs/Dec_07_ABA_Bifocal_J.pdf