Thaddeus Mason Pope and Kristin Kemmerling, "Legal Briefing: Stopping Nonbeneficial Life-Sustaining Treatment without Consent," *The Journal of Clinical Ethics* 27, no. 3 (Fall 2016): 254-64.

Law

Legal Briefing: Stopping Nonbeneficial Life-Sustaining Treatment without Consent

Thaddeus Mason Pope and Kristin Kemmerling

ABSTRACT

In the United States, authoritative legal guidance remains sparse on whether or when clinicians may stop life-sustaining treatment without consent. Fortunately, several significant legislative and judicial developments over the past two years offer some clarity. We group these legal developments into the following seven categories:

1. Lawsuits for Damages
2. Amendments to the Texas Advance Directives Act
3. Constitutional Attack on TADA
4. Legislation Prohibiting Clinicians
5. Legislation Authorizing Clinicians
6. Cases from Canada
7. Cases from the United Kingdom.

INTRODUCTION

For two decades, medical futility disputes have been one of the most frequent reasons for clinical ethics consultations. Consequently, it is no surprise that medical futility has been the subject of many articles in *JCE*.[1] As is appropriate, clinicians and families eventually reach consensus in the overwhelming majority of these cases. Usually, the original parties reach agreement. Even when this is not possible, sometimes, the patient can be transferred to a new facility that is willing to provide the disputed treatment. Other times, the hospital is able to designate (or have a court designate) a new surrogate, by demonstrating that the current surrogate is not acting consistent with the patient's wishes or best interests. In either of these situations, by replacing one of the parties to the dispute, consensus is still achieved.

Clinicians and families cannot always reach consensus, particularly when the treatment requested is religiously motivated. Conflict in around 5 percent of medical futility disputes remains intractable to communication, negotiation, and mediation. In many of these residual cases, clinicians want to stop life-sustaining treatment, even though they have been unable to obtain the patient's or surrogate's consent. This approach is laden with ethical and legal uncertainty and risk. We lack authoritative guidance on whether or when clinicians may stop life-sustaining treatment without consent. Fortunately, several significant legislative and judicial developments over the past two years offer some clarity. We group these legal developments into the following seven categories:

1. Lawsuits for Damages

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2. Amendments to the Texas Advance Directives Act
3. Constitutional Attack on TADA
4. Legislation Prohibiting Clinicians
5. Legislation Authorizing Clinicians
6. Cases from Canada
7. Cases from the United Kingdom.

We have previously described and assessed the nature, prevalence, causes, and approaches to medical futility disputes.[2] We have also previously analyzed the legal rights, obligations, and risks of clinicians and hospitals that withhold or withdraw life-sustaining treatment without consent.[3] We will neither repeat nor summarize that material here. Instead, our goal is to update the reader on recent legal milestones. In this article, we focus on significant judicial and legislative developments from 2015 and 2016.[4]

1. LAWSUITS FOR DAMAGES

Perhaps the majority of medical futility cases adjudicated by the courts have been *ex ante* cases (that is, lawsuits that are filed before treatment is stopped).[5] These include many of the most famous and familiar cases, such as *Wanglie* and *Baby K*.[6] These cases typically take the following path. Clinicians judge that continued life-sustaining treatment is inappropriate and nonbeneficial. So, they recommend comfort measures only, but the patient's surrogate rejects that proposal even after the involvement of other institutional resources (such as ethics consultants, social workers, chaplains, and palliative care clinicians). Eventually, even though clinicians are unable to obtain consent for their recommended treatment plan, they announce their intent to unilaterally stop life-sustaining treatment. Many (perhaps most) patients' families accept or assent to such announcements, but some file lawsuits. In these lawsuits, the family asks the court to issue an injunction prohibiting the hospital from stopping life-sustaining treatment. The goal of *ex ante* cases is to keep the patient alive.

In contrast, *ex post* cases occur when a patient's family members bring a lawsuit after clinicians have already withheld or withdrawn life-sustaining treatment and the patient has died. The goal of *ex post* cases is to obtain monetary damages. While money cannot restore the patient's life, a verdict or settlement compensates the patient's family members for their legal injury.[7] Over the past two years, U.S. courts have issued two appellate opinions in *ex post* medical futility cases. One opinion is from the state of Indiana and the other opinion is from the state of Connecticut.

The reader should remember that very few disputes result in written, published, appellate court opinions. While there have been only two appellate opinions in the past two years, that represents only the tip of a "lawsuit iceberg." Below the surface of this iceberg, more cases are pending in the trial courts. We offer two active, illustrative cases from Ohio.

Connecticut

In the summer of 2010, Helen Marsala was transferred to Yale New Haven Hospital after a lengthy stay in another Connecticut hospital. She had multiple organ system failures and was on a ventilator, dialysis, and artificial nutrition and hydration. On 24 July 2010, Yale clinicians changed Mrs. Marsala's status to comfort care only, over the objections of her family. Earlier, the hospital had repeatedly tried to get the family's consent for their recommended treatment plan. But ultimately the team consulted the ethics committee and proceeded without consent.[8]

Mrs. Marsala's family filed a lawsuit against Yale in August 2012. Clarence Marsala, her husband, asserted claims for wrongful death, loss of consortium, and medical malpractice. Mrs. Marsala's five children sued for intentional infliction of emotional distress (IIED) and negligent infliction of emotional distress (NIED). Specifically, they alleged that they suffered "serious, painful and permanent injuries" including: "(a) severe emotional distress; (b) loss of opportunity to say goodbye; (c) depression; (d) loss of sleep; (e) stress; (f) anxiety; and (g) pain and suffering."

In late 2013, a Connecticut Superior Court judge denied Yale's motion to dismiss the IIED claim.[9] The court ruled that a jury could find that "terminating a patient's life support with an awareness of her contrary wishes constitutes unacceptable behavior and would readily be considered extreme and outrageous."[10] But the trial court later dismissed the Marsala children's IIED and NIED claims. In late June 2016, the Connecticut Appellate Court affirmed.[11] Key to the court's analysis were limitations on "bystander" IIED and NIED claims under Connecticut law. None of the children contemporaneously witnessed Yale's decision-making process and none was present when Yale made the ultimate decision to transition their mother to comfort care only.

Claims for NIED and IIED are typically the most successful in medical futility cases.[12] Therefore, the *Marsala* case stands out as an exception to a general

trend in which families have successfully asserted claims for NIED and IIED against hospitals that unilaterally withdrew life-sustaining treatment. Mr. Marsala is still proceeding against Yale on his claims for wrongful death, loss of consortium, and medical malpractice.[13] Trial is scheduled for November 2017. If he obtains a verdict or settlement, that will likely have a "chilling" effect on the willingness of other hospitals to stop life-sustaining treatment without consent.

Indiana

In November 2007, Geraldine Siner was an 83-year-old, advanced dementia patient in the rehabilitation unit of Kindred Hospital following a stay in the intensive care unit (ICU) for aspiration pneumonia. To the hospital's apparent consternation, the patient's status remained "full code" (that is, she would receive all life-sustaining therapies in the case of a cardiac or pulmonary arrest—Mrs. Siner did not have a do-not-resuscitate order, or DNR, in her medical record).

When Mrs. Siner's daughter, Kathy L. Siner, visited the patient at Kindred Hospital on 11 November 2007, she alleged that her mother became motionless and nonresponsive, but hospital staff delayed performing emergency procedures despite the fact that she was a full code.[14] Kindred Hospital alleged that Mrs. Siner never required resuscitation during these events.

Kindred Hospital's ethics committee met and decided to override the Siner family's decision, that the patient be a full code. Her treating clinicians made Mrs. Siner a "no code" (that is, she would not receive resuscitation). Following the meeting, Kindred Hospital informed Mrs. Siner's family that they needed to find another hospital to care for Mrs. Siner, if they wanted her to be a full code.

In December 2007, the Siners transferred Mrs. Siner to Methodist Hospital, but it was apparently too late for Mrs. Siner to make a recovery. For weeks before the transfer, she had apparently received less aggressive treatment at Kindred. At Methodist, Mrs. Siner was treated for a collapsed lung, facial wounds, infection, and sepsis. She died there on 28 December 2007.

The Siner family planned to file a lawsuit. Pursuant to Indiana law, their case was first submitted to a Department of Insurance Medical Review Panel composed of three physicians. The purpose of this review was to determine whether Mohammed Majid, MD, and other hospital staff failed to comply with the appropriate standard of care. In January 2013, the review panel issued a unanimous decision finding that there was sufficient evidence to support the conclusion "that the defendants failed to comply with the appropriate standard of care, and that their conduct may have been a factor of some resultant damages, but not the death of the patient."[15] Following the decision, James Krueger, MD, one of the panel members, did an additional review of Geraldine Siner's medical records and submitted an affidavit stating he incorrectly attributed the care in question to Majid. Krueger concluded that since a pulmonologist had been involved in Siner's care, it was acceptable for Majid to defer to the pulmonologist's judgment.[16]

In May 2013, the Siners filed a lawsuit against Kindred Hospital, Mohammed Majid, and others. They alleged that the defendants' inadequate treatment of Mrs. Siner, as a result of the unilateral DNR order, led to damage that could not be reversed. Apparently, the Siners did not name the Indiana University Pulmonary and Critical Care Service as a defendant, because its treatment was recommended as a result of Mrs. Siner's designation as a "terminal patient" by her attending physician. Alternative treatments such as tracheotomy and intubation were not deemed appropriate for terminal patients.

Late in 2013, the defendants moved for summary judgment. Both Kindred Hospital and Majid cited the opinion of the Department of Insurance Medical Review Panel, as well as Krueger's affidavit, in their motions. The defendants argued that Krueger's affidavit shifted the burden of proof to the Siners to show that sufficient evidence existed to establish an issue of material fact regarding the defendants' role in causing Mrs. Siner's injuries. The defendants also argued that the medical review panel's opinion was too speculative in nature to establish that their actions were sufficiently related to Mrs. Siner's injury to be the cause of her injury. The Siner family responded to these motions with additional affidavits from two doctors: Lawrence Reed, II, MD, and Timothy Pohlman, MD. The trial court found that these additional affidavits did not address causation and granted the defendants' motions based on the absence of expert testimony to establish a claim for medical negligence.

On appeal, the Indiana Court of Appeals set out to determine whether the trial court erred in holding that the Siner family failed to produce evidence to establish an issue of fact regarding the defendants' role in causing Mrs. Siner's injuries.[17] The court of appeals discussed Pohlman's affidavit, which the trial court determined did not contain testimony about causation. The court of appeals concluded that the trial court erred, because Pohlman's affidavit dis-

cussed how the collapsed lung, infections, and sepsis were likely the result of Kindred Hospital's refusal to treat under the unilateral DNR order.[18] For example, Pohlman discussed how Mrs. Siner suffered from septic shock at the time of her intake at Methodist Hospital, and how Kindred Hospital failed to treat her according to the Society of Critical Care Medicine's Surviving Sepsis Guidelines because of her DNR order. The court of appeals reversed summary judgment for Kindred Hospital, because Pohlman's affidavit established a genuine issue of fact for causation.

In April 2016, the Indiana Supreme Court vacated the court of appeals' decision and reversed the trial court's grant of summary judgment to both Kindred Hospital and Majid.[19] Chief Justice Loretta H. Rush discussed the heavy factual burden on moving parties to negate the existence of any genuine issue of fact for any element of the claim. A "unanimous opinion of a medical review panel" in favor of the movant would usually be enough to shift the burden to the nonmoving party, but Mrs. Siner's case still involved disputed facts.[20] Specifically, the affidavits submitted by the defendants pertained solely to the issues related to pulmonary care and failed to address all of the injuries alleged by the Siner family. Kindred Hospital and Majid failed to negate the Siner family's claim, and material issues of fact were still in dispute. Summary judgment was inappropriate. By reversing the grant of summary judgment, the Indiana Supreme Court will allow the case to proceed to trial. It is set to begin 4 December 2017 in Marion County Superior Court.

Ohio

Marsala and *Siner* are the only two U.S. medical futility cases from 2015 and 2016 that resulted in appellate opinions. But they are hardly the only medical futility conflicts to reach the courts. While they have not yet been adjudicated or settled, patients' families have filed other lawsuits. For example, the family of Edna Moomaw is continuing to litigate a $2.5 million medical malpractice and wrongful death lawsuit against Summa Health System and several individual clinicians in Akron, Ohio.[21] Ms Moomaw was an 89-year-old woman who had been taken to Summa Akron City Hospital for a heart attack on 15 December 2012. On 20 December, Summa clinicians entered a DNR/comfort care only (DNR/CCO) order. This normally requires the consent of the patient or a surrogate. Ms Moomaw died on 22 December.

Ms Moomaw's family contends that clinicians entered the DNR/CCO order without her or their consent. Although she was seriously ill, the patient had been insisting on full efforts to keep her alive. There is no evidence that Ms Moomaw had been determined to lack capacity. So, her directions were controlling. But even had Ms Moomaw been determined to lack capacity, her family would have been the authorized decision maker. Ms Moomaw's family denies that they discussed, much less authorized, the DNR/CCO order. The case is proceeding toward trial.

Interestingly, another family has also recently asserted medical futility claims against Ohio's Summa Health System. Minnie King had been a patient at Akron City Hospital in February and March 2013. She died there on 23 March 2013. In March 2015, Ms King's family filed a medical malpractice lawsuit against Summa and an individual clinician. They alleged that "Summa withheld or withdrew life-sustaining treatment from Minnie King, without consent, including taking away her medications, putting her on the palliative care unit, ordering hospice involvement, and making her comfort care only."[22] The court is now considering the hospital's motion for summary judgment. A jury trial is scheduled for December 2017.

2. AMENDMENTS TO THE TEXAS ADVANCE DIRECTIVES ACT

As the previous cases illustrate, removing a patient's life-sustaining treatment without consent entails a risk of liability in many states. To eliminate that risk, many clinicians and commentators have been calling for the establishment of special adjudicatory dispute resolution mechanisms to resolve intractable medical futility disputes. As a leading model to follow, policy makers in the U.S. and around the world have been looking to the conflict resolution provisions in the 1999 Texas Advance Directives Act (TADA).[23] Basically, TADA allows clinicians to stop life-sustaining treatment over a surrogate's objections, so long as the clinicians' own hospital review committee agrees.[24] So long as the clinician follows the specified process, the statute provides safe harbor legal immunity.[25]

While admired by many, TADA has proven extremely controversial. Over a ten-year period spanning five legislative sessions (2005, 2007, 2009, 2011, and 2013) state legislators introduced dozens of bills to amend TADA. Ultimately, none of these bills were enacted. As the 2015 legislative session began, it was clear that Texas legislators would again try to tackle TADA. The Texas Medical Association (TMA) observed: "In anticipation of another round of debates

over end-of-life care, TMA's work group dedicated to the issue will work to protect physicians' ability to do what's best [including the ability to decide unilaterally] for patients in their final days."[26] Indeed, defending TADA was part of the TMA's strategic road map for state advocacy initiatives. Other organizations similarly expressed interest in protecting, improving, or destroying TADA.[27]

Apparently, the sixth time was the charm. For the first time since 2003, Texas actually amended the "futility" provisions in the TADA. In March 2015, Representative Drew Springer introduced H.B. 3074. Basically, this legislation exempts artificially administered nutrition and hydration (AANH) from the scope of life-sustaining treatment subject to TADA's dispute resolution procedures. This special treatment is not surprising, particularly since the intense and prolonged international media attention on the legal dispute concerning Terri Schiavo, many state legislatures have tried to regulate AANH differently from other forms of life-sustaining medical treatment.[28]

Today, clinicians can continue using TADA to stop life-sustaining medications, mechanical breathing machines, and kidney dialysis treatment. But clinicians may not use TADA to stop AANH unless it would either not work at all or would directly harm the patient. The statute unpacks these exceptions, allowing clinicians to unilaterally withhold or withdraw AANH if it would: (1) hasten the patient's death; (2) seriously exacerbate other major medical problems not outweighed by the benefit of the provision of the treatment; (3) result in substantial irremediable physical pain, suffering, or discomfort not outweighed by the benefit of the provision of the treatment; or (4) be medically ineffective. It is important to note that clinicians may not stop AANH under TADA because of a patient's permanent unconsciousness or quality of life.

In addition to the AANH limitation, H.B. 3074 also clarified that TADA "does not authorize withholding or withdrawing pain management medication, medical procedures necessary to provide comfort, or any other health care provided to alleviate a patient's pain." Finally, H.B. 3074 added a requirement that a hospital provide the patient's surrogate with the portion of the patient's medical record related to the treatment received in the facility during the current admission or during the preceding 30 calendar days. By the end of May 2015, H.B. 3074 was passed by both the Texas House and Texas Senate. On 12 June 2015, the governor signed the enrolled bill. The amendment took effect on 1 September 2015.

While only H.B. 3074 was enacted, the Texas legislature considered five other bills to amend TADA in 2015. First, consistent with his track record for over a decade, Representative Bryan Hughes introduced H.B. 2984. Like many of Hughes's prior bills, this one would require that clinicians continue life-sustaining treatment until a patient is actually transferred to another facility. If the patient cannot be transferred, then the treating facility cannot withdraw life-sustaining treatment with the immunity provided by TADA.

With a pro-life agenda similar to Hughes, Senator Kelly Hancock introduced S.B. 1163. Similar to Hughes's H.B. 2984, Hancock's bill was not designed to improve the fairness of TADA. Instead, S.B. 1163 was designed to wholly eliminate TADA's dispute resolution provisions.[29] Instead of requiring treatment until transfer, like Hughes's bill, S.B. 1163 would have added a new statutory section that specifies two reasons on which a hospital review committee may not base a determination of medical inappropriateness. Specifically, it prohibits a hospital review committee from determining life-sustaining treatment to be inappropriate based on either:

> (1) the lesser value the physician or professional, facility, or committee places on sustaining the life of an elderly, disabled, or terminally ill patient compared to the value of sustaining the life of a patient who is younger, not disabled, or not terminally ill; or
>
> (2) a disagreement between the physician or professional, facility, or committee and the patient, or the person authorized to make a treatment decision for the patient . . . , over the greater weight the patient or person places on sustaining the patient's life than the risk of disability.

S.B. 1163 also specified that the only bases on which a hospital review committee may determine life-sustaining treatment to be inappropriate are: (1) physiological futility and (2) when "providing the treatment to the patient would clearly create a substantially greater risk of causing or hastening the death of the patient than would withholding or withdrawing the treatment."

Like S.B. 1163, Texas Representative Garnet Coleman's H.B. 4100 would also narrow the scope of a hospital review committee's discretion. Under H.B. 4100, a review committee could deny requested treatment only if it would: (1) threaten the patient's life, (2) seriously exacerbate other major medical problems not outweighed by the benefit of the provision of the treatment, or (3) result in substantial irremediable physical pain or discomfort not out-

weighed by the benefit of the provision of the treatment. H.B. 4100 would have also prohibited the review committee from determining medically appropriateness on the basis of "permanent disability, advanced age, gender, religious or cultural differences, or financial circumstances."

In addition to specifying legitimate and illegitimate grounds for determining life-sustaining treatment to be inappropriate, S.B. 1163 offered four other amendments focused on procedural due process. First, the bill would extend the minimum notice of a hospital's review committee meeting from 48 hours to seven days. Second, H.B. 4100 would extend the minimum period for transfer from ten days to 21 days. Third, it would require a hospital to offer a patient's surrogate a patient liaison, quick access to the patient's medical record, and an advisory consultation. Fourth, like S.B. 1163, H.B. 4100 would exempt AANH from the scope of life-sustaining treatment that can be refused.

Finally, Representative Patricia Harless introduced H.B. 2351. This bill would have required hospital review committees to adopt two types of policies: (1) "to prevent financial and health care professional conflicts of interest" and (2) "to prohibit consideration of a patient's permanent physical or mental disability during a review."[30]

In short, the battle over TADA has been largely fought between those who want to improve the fairness of TADA and those who are opposed to the very concept that hospitals and physicians should be authorized to stop life-sustaining treatment without the consent of a patient or a patient's surrogate. The former have been thwarted in their efforts to improve TADA, because to improve it, is also to preserve it. For example, former Texas State Senator Bob Deuell was a significant force in improving TADA's fairness. But since his bills still preserved hospitals' rights to stop treatment, he was attacked by Texas Right to Life and was not re-elected.[31] As the 2017 legislative session draws near, familiar debates will again echo through the halls of the Texas Capitol.

3. CONSTITUTIONAL ATTACK ON TADA

While most opponents of TADA have attacked it in the state legislature, some have challenged TADA in the courts. Specifically, several lawsuits have alleged that TADA is unconstitutional, because it authorizes hospitals to deprive patients of their life without the procedural due process protections required by the U.S. Constitution.

For example, in 2007, Children's Hospital of Austin planned to use TADA to withdraw life-sustaining treatment from Emilio Gonzalez, a 17-month old baby with Leigh's disease. This incurable degenerative disorder destroys brain function and eventually results in the death of the patient. The baby's mother filed a federal lawsuit alleging that the TADA process violated her son's rights under the 14th Amendment to the U.S. Constitution.[32] But the case was dismissed because a similar lawsuit was already pending in a state court. The state case was also dismissed. No court ever ruled on the constitutional claims.[33]

But one constitutional challenge to TADA is now proceeding. In the fall of 2015, Christopher Dunn was a patient receiving life-sustaining treatment for a mass on his pancreas at Methodist Hospital in Houston, Texas.[34] Dunn had been "on ventilator support, unable to communicate verbally, sedated, largely unresponsive, and wholly unable to participate in health care or other decisions" since October 2015.[35] On 10 November 2015, following a hospital committee meeting, Methodist informed Dunn and his family that the facility planned to discontinue his life-sustaining treatment on 24 November 2015 pursuant to TADA.[36]

Ten days later, Dunn filed a petition for a temporary restraining order to prevent Methodist Hospital from ceasing his life-sustaining treatment on 24 November 2015. In his petition, Dunn raised a variety of issues about the constitutionality of TADA, including infringement of his right to procedural and substantive due process.[37] He argued that TADA infringed on his right to procedural due process under the 14th Amendment of the U.S. Constitution and Article I, Section 19, of the Texas Constitution, because: (1) the statute failed to provide adequate venue for Dunn to be heard regarding a critical medical decision; (2) failed to produce sufficient evidentiary safeguards against medical providers, leaving them free to make life-determining medical decisions with unregulated discretion; and (3) failed to provide a reasonable amount of time for a patient to be transferred. In essence, Dunn alleged that TADA is unfair to patients because it provides no opportunity for patients to be heard in life-altering medical decisions. Dunn also argued that his right to substantive due process was violated because TADA deprived him of a substantive privacy right to make his own medical decisions.

Dunn sought relief in the form of both a temporary and permanent injunction, as well as a declaratory judgment from the court stating that Methodist's actions and planned discontinuance of treatment violated his right to due process. On 20 November 2015, the district court issued an order granting

Dunn's petition for a temporary restraining order, reasoning that Dunn would suffer immediate and irreparable harm if the injunction were not granted, because the likely result of withdrawing treatment would be death. The temporary restraining order required Methodist Hospital to cease and desist all efforts to remove Christopher Dunn's life support through 4 December 2015.[38]

In early December, Methodist Hospital filed a plea in abatement and answer to Dunn's petition. (A plea in abatement is a response that objects to the time, place, or mode of trying a case and seeks to suspend the case until a more appropriate time.) In this case, Dunn's condition prevented him from actively participating in his medical decisions, yet he was named as the plaintiff propelling the case forward. Methodist's plea in abatement argued that Christopher Dunn lacked the capacity to proceed with the lawsuit and requested that the case be abated until the issue regarding capacity was resolved. This would delay Dunn's suit until a guardian and legal representative were appointed or until Dunn was again able to act on his own behalf.

In its answer, Methodist objected to Dunn's petition in its entirety and argued that Dunn's only opportunity for relief required proof that, under TADA, there was a reasonable expectation that another physician or medical facility would be found that would honor the patient's directive.[39]

The court granted Methodist's plea in abatement pending the appointment of a guardian.[40] Christopher Dunn died on 23 December 2015.[41] The case's abatement status was removed in January 2016 and an order was issued substituting Dunn's mother, Evelyn Kelly, as plaintiff individually, and on behalf of the estate of Christopher Dunn. In February 2016, Kelly filed plaintiff's first amended petition with the court. The amended petition included the same constitutional claims that were laid out in Dunn's original petition, and included a new claim for intentional infliction of emotional distress, alleging that Methodist Hospital caused Kelly severe emotional distress when it informed her it would be withdrawing life-sustaining treatment resulting in her son's certain death in November 2015.[42] A trial date is set for 9 January 2017.

4. LEGISLATION PROHIBITING CLINICIANS

The move in Texas to restrict the scope of TADA seems to be indicative of a broader trend to constrain and narrow clinicians' discretion to stop life-sustaining treatment without the consent of a patient or surrogate. We have described these as "red light" laws, because they "stop" clinicians from proceeding with the treatment plan that they judge medically and ethically appropriate.[43]

For example, over the past two years, Kansas and Missouri have considered a basically identical version of "Simon's Law." The legislation was inspired by and named for Simon Crosier.[44] Crosier was born on 7 September 2010 with trisomy 18 (Edward's syndrome—a chromosomal abnormality with a very low rate of survival, due to heart abnormalities, kidney malformations, and other internal organ disorders). Crosier's mother discovered that her son's clinicians had placed a DNR order in his records without her knowledge or consent. Chromosomal disorders like trisomy 18 have long been deemed to be "incompatible with life." But the prospects for these children are actually far better than generally believed.[45]

Simon's Law is directed at patients who are under 18 years of age and has two parts. First, it requires healthcare providers to disclose their futility policies. "Upon the request of a patient or resident or a prospective patient or resident, a health care facility, nursing home or physician shall disclose in writing any policies relating to a patient or resident or the services a patient or resident may receive involving life-sustaining or non-beneficial treatment within the health care facility or agency." This probably applies not only to futility policies, but also to conscience-based objection policies.

The second part of Simon's Law prohibits clinicians from withholding or withdrawing the life-sustaining treatment from minors without the consent of at least one parent: "No health care facility, nursing home, physician, nurse or medical staff shall withhold life-sustaining procedures, food, medication or nutrition, nor place any restrictions on life-sustaining procedures . . . without the written permission of at least one parent or legal guardian of the patient or ward," and "no do-not-resuscitate order or similar physician's order shall be instituted either orally or in writing without the written permission of at least one parent or legal guardian. . . ."

While two states considered Simon's Law, neither enacted it. The Kansas bill was introduced in February 2016. It passed the Kansas Senate in March 2016, but died in a Kansas House committee in June 2016.[46] The Missouri bill was introduced in both 2015 and 2016, but failed to advance.[47]

In contrast to the Kansas and Missouri legislation, a Maine bill was enacted; L.D. 1117 was introduced in March 2015 and enacted by June 2015.[48] The new Maine law defines the situations under which the state Office of Child and Family Services

(OCFS) can withhold or withdraw life-sustaining treatment for children in its custody. There are two conditions: (1) OCFS may withhold or withdraw life-sustaining medical treatment if the parental rights of the child's parents have been terminated (for example, because of abuse or neglect), and OCFS determines that withholding or withdrawing life-sustaining medical treatment is in the best interests of the child;[49] (2) if parental rights have not been terminated, OCFS may stop treatment only with parental consent or with a court declaration.

Three other states considered or enacted related "red light" legislation over the past two years. Utah enacted a statute that prohibits health benefit plans from denying coverage for medically necessary treatment on the basis of life expectancy or the diagnosis of a terminal condition.[50] Oregon considered a bill that would require healthcare facilities to share futility policies within 12 hours of a patient's admission.[51] New York considered a bill that would amend the patients' bill of rights to require that a "patient's religious beliefs be respected with regard to withholding or withdrawing life-sustaining treatment."[52]

5. LEGISLATION AUTHORIZING CLINICIANS

While most of the recent bills addressing medical futility appear to be "red light" laws, there was at least one green light bill (that would authorize clinicians to stop treatment without consent). In January 2015, a Virginia delegate introduced a bill that would strengthen and clarify that state's longstanding futile care law.[53] The physician legislator explained that he wanted to clarify the law to say "a physician has the right to stop care that's medically and ethically inappropriate over the objections of the patient, family or advocate after a 14-day period of trying to transfer the patient to a doctor or hospital who will provide such care."[54]

Since 1992, Virginia law has provided that clinicians are not required to "render health care" that they "determine to be medically or ethically inappropriate." The statute further provides that if a "conflict remains unresolved the physician shall make a reasonable effort to transfer the patient to another physician who is willing to comply with the request." The physician must provide "a reasonable time of not less than fourteen (14) days to effect such transfer." During this 14-day period, the physician "shall continue to provide any life-sustaining care." This is a reasonable requirement that is commonly included in both healthcare decisions acts and institutional policies.

But the law is silent on what can be done once the 14-day time period ends. The 2015 bill would have added the following language to the statute. "If, at the end of the 14-day period, the physician has been unable to transfer the patient to another physician who is willing to comply with the request of the patient, the terms of the advance directive, the decision of the agent or person authorized to make decisions . . . despite reasonable efforts, the physician may cease to provide care that he has determined to be medically or ethically inappropriate." The bill was tabled in committee.

6. CASES FROM CANADA

In October 2013, the Supreme Court of Canada decided a medical futility dispute in favor of the patient's family. In *Cuthbertson v. Rasouli,* the court took a very strong approach.[55] As one Canadian law professor describes it, the court requires physicians to provide life-sustaining treatment even when it is "contrary to their conscientious professional discretion or contrary to the standard of care."[56] Patients or surrogates "can effectively demand treatment—even harmful treatment—by refusing consent to the treatment being withheld. That is, by requiring consent for withholding or withdrawing treatment, the Court created [an] entitlement to treatment."

The court's holding was later codified by the provincial medical board. In late 2015, the Ontario College of Physicians and Surgeons issued its policy on "Planning for and Providing Quality End-of-Life Care."[57] It provides that "a decision regarding a no-CPR order cannot be made unilaterally by the physician." If the patient or substitute decision maker disagrees and insists that cardiopulmonary resuscitation (CPR) be provided, physicians must engage in a specified conflict resolution process. "While the conflict resolution process is underway, if an event requiring CPR occurs, physicians must provide CPR."

The consequences and effects of the effect of the *Rasouli* decision have been even broader than expected. First, the decision only concerns the law in Ontario; since *Rasouli* is grounded in an interpretation of an Ontario statute, it has no direct legal effect in other provinces. Nevertheless, clinicians in other Canadian provinces have been "chilled" from standing up to families who demand healthcare services that the clinicians judged to be inappropriate life-sustaining treatment.[58]

Second, the *Rasouli* court allowed (and even encouraged) clinicians to use the Ontario Consent and Capacity Board (CCB) to resolve medical futil-

ity conflicts under *Rasouli.* The CCB is an "independent, quasi-judicial tribunal," a "neutral, expert board" that replaces surrogates who fail to act in a patient's best interests.[59] Under *Rasouli,* clinicians always need consent to stop life-sustaining treatment. But the CCB can get that required consent, if the surrogate is refusing consent that is inconsistent with the patient's wishes or best interests.[60] But while clinicians had brought dozens of medical futility cases to the CCB before *Rasouli,* they brought almost none after. It appears this is because they are increasingly caving in to surrogate's demands, even when they judge their demands to be medically and ethically inappropriate.[61]

On the other hand, while the volume of cases over the past two years may be lighter than before *Rasouli,* Canadian courts and tribunals have continued to adjudicate medical futility disputes. Indeed, in two recent cases, they have authorized clinicians to stop administering life-sustaining interventions even when requested by the patient's family. One case comes from the Ontario CCB. The other case comes from the Quebec Superior Court.[62]

In *In Re SL,* the attending physician was concerned that many of the treatments being advocated by the patient's surrogate would result in pain and discomfort to the patient.[63] The physician brought the case to the Ontario CCB. The CCB first determined that there was no evidence to suggest that the patient had ever expressed any wishes regarding treatment. Therefore, the CCB applied an objective best interest standard. The CCB noted that "this is an area that the Board found that deference should be given to the medical practitioner." The CCB directed the surrogate to consent to the recommended treatment plan (palliative care only).

Unlike Ontario, Quebec does not have a CCB. But neither is it subject to the *Rasouli* rule that clinicians always need consent to stop life-sustaining treatment. Not subject to the limitations in Ontario, a Quebec court recently authorized clinicians to stop life-sustaining treatment over a surrogate's objections.[64] In *University of Montreal Hospital v. WL,* clinicians felt that it was futile to continue mechanical ventilation and to continue feeding for Mr. L., who was in a vegetative state. Despite the objections of the patient's sisters, the court authorized the hospital to stop any treatment except comfort care.

7. CASES FROM THE UNITED KINGDOM

In contrast to the limited judicial guidance in the U.S. and Canada, there is ample judicial guidance in the United Kingdom. In 2015 and 2016, the courts issued more than a dozen decisions.[65] Almost all of these were of an *ex ante* nature. The questions posed were framed to especially address the appropriateness of life-sustaining treatments. Because these decisions are written and publicly available, they effectively help to move the social debate forward in a way that is beneficial to clinicians, patients, and citizens.[66]

NOTES

1. E.g. T.M. Pope, "Legal Briefing: Medically Futile and Non-Beneficial Treatment," *The Journal of Clinical Ethics* 22, no. 3 (Fall 2011): 277-96; T.M. Pope, "Legal Briefing: Medical Futility and Assisted Suicide," *The Journal of Clinical Ethics* 20, no. 3 (Fall 2009): 274-86.

2. E.g. T.M. Pope and D.B. White, "Medical Futility and Potentially Inappropriate Treatment," in *Oxford Handbook on Death and Dying,* ed. S. Younger and R. Arnold (Oxford, U.K.: Oxford University Press, 2016); T.M. Pope, "The Texas Advance Directives Act: Must a Death Panel Be a Star Chamber?" *American Journal of Bioethics* 15, no. 8 (2015): 42-4; T.M. Pope, "Medical Futility," in *Guidance for Healthcare Ethics Committees,* ed. M.D. Hester and T. Schonfeld (Cambridge, U.K.: Cambridge University Press 2012), 88-97; T.M. Pope, "Surrogate Selection: An Increasingly Viable, but Limited, Solution to Intractable Futility Disputes," *Saint Louis University Journal of Health Law and Policy* 3 (2010): 183-252; T.M. Pope, "Medical Futility Statutes: No Safe Harbor to Unilaterally Stop Life-Sustaining Treatment," *Tennessee Law Review* 75 (2007): 1-81.

3. E.g. T.M. Pope, "Dispute Resolution Mechanisms for Intractable Medical Futility Disputes," *New York Law School Law Review* 58 (2014): 347-68.

4. Brain death cases are a type of medical futility dispute because they involve a clinician-family conflict about the appropriateness of life-sustaining treatment. But because the legal analysis is so different, we do not address those cases here. We have addressed them before. T.M. Pope, "Legal Briefing: Brain Death and Total Brain Failure," *The Journal of Clinical Ethics* 25, no. 3 (Fall 2014): 245-7.

Similarly, we do not discuss nonlegal developments. But we note that there are three new policies from professional organizations: "An Official ATS/AACN/ACCP/ESICM/SCCM Policy Statement: Responding to Requests for Potentially Inappropriate Treatments in Intensive Care Units," *American Journal of Respiratory and Critical Care Medicine* 191, no. 11 (1 June 2015): 1318-30; G.T. Bosslet, "Defining Futile and Potentially Inappropriate Interventions: A Policy Statement From the Society of Critical Care Medicine Ethics Committee," *Critical Care Medicine* 44, no. 9 September 2016):1769-74; A. Kon, "Shared Decision-Making in Intensive Care Units: Executive Summary of the American College of Critical Care Medicine and American Thoracic Society Policy Statement," *American Journal of Respiratory and Critical Care Medicine* 193, no. 12

(15 June 2016): 1334-6.

5. T.M. Pope, "Involuntary Passive Euthanasia in U.S. Courts: Reassessing the Judicial Treatment of Medical Futility Cases," *Marquette Elder's Advisor* 9, no. 2 (2008): 229-68.

6. *In re: Wanglie,* No. PX-91-283 (Minn. Prob. Ct. Hennepin County June 28, 1991); *In re Baby K,* 832 F. Supp. 1022 (E.D. Va. 1993).

7. In addition to compensation, tort damages also (1) determine rights, (2) punish wrongdoers and deter wrongful conduct, and (3) vindicate parties and deter retaliation or violent and unlawful self-help. *Restatement (Second) of Tort*s § 901, cmt. a (2005).

8. E. Stannard, "Seymour Man Sues Yale New Haven over Wife's Death, Says She was Removed from Life Support," *New Haven Register,* 31 July 2016.

9. *Marsala v. Yale New Haven Hospital,* No. AAN-CV12-6011711-S (Conn. Superior Court, Judicial District of Ansonia/Milford 30 Oct. 2013) (Judge Lee).

10. *Marsala v. Yale New Haven Hospital,* No. AAN-CV12-6011711-S (Conn. Superior Court, Judicial District of Ansonia/Milford 19 Mar. 2015) (Judge Tyma).

11. *Marsala v. Yale New Haven Hospital,* No. AC-37821, 166 CA 432 (Conn. App. 28 June 2016).

12. See Pope, "Involuntary Passive Euthanasia in U.S. Courts," note 5 above.

13. *Marsala v. Yale New Haven Hospital,* No. AAN-CV12-6011711-S (Conn. Superior Court, Judicial District of Ansonia/Milford) (Judge Tyma) (docket as of 15 August 2016), *http://civilinquiry.jud.ct.gov/.*

14. *Siner v. Kindred Hospital Ltd.,* No. 49A05-1404-CT-00165 (Ind. App. 9 Oct. 2014) (Appellate Brief).

15. This opinion was focused on the prolonged application of a CPAP (continuous positive airway pressure) mask that may have caused scarring and infection.

16. *Siner v. Kindred Hospital Ltd.,* No. 49A05-1404-CT-00165 (Ind. App. 9 Dec. 2014) (Appellee's Brief).

17. The court of appeals also addressed whether the involvement of Indiana University Pulmonary and Critical Care Service, an independent contractor, in Geraldine Siner's treatment removed potential liability for Kindred Hospital; and whether the medical review panel's opinion provided sufficient expert testimony to establish causation in the Siner family's medical negligence claim. The court of appeals discussed how the involvement of IU Pulmonary Care may remove liability pertaining to the CPAP mask, but would not be enough to invalidate all allegations in the Siner family's complaint pertaining to negligent care and injuries. Lastly, the court examined whether the m,edical review panel was sufficiently expert testimony for causation. The court held that the three-sentence opinion of the review panel failed to provide context sufficient to support a verdict, and was not enough to establish a genuine issue of material fact for causation.

18. *Siner v. Kindred Hospital Ltd.,* 33 N.E.3d (Ind. App. 2015).

19. *Siner v. Kindred Hospital Ltd.,* 51 N.E.3d 1184, 1186 (Ind. 2016).

20. Chief Justice Rush also discusses how the defendants' own submitted evidence created a genuine issue of material fact, because the affidavit by Krueger created a conflict of evidence with the opinion of the medical review panel.

21. *Wagner v. Summa Health System,* No. CV-2013-09-4227 (Court of Common Pleas, Summit County, Ohio 2016).

22. *King v. Summa Health System,* No. 2015-03-1760 (Court of Common Pleas, Summit County, Ohio).

23. T.M. Pope, "Texas Advance Directives Act: Nearly a Model Dispute Resolution Mechanism for Intractable Medical Futility Conflicts," *QUT Law Review* 16, no. 1 (2016): 22-53; T.M. Pope, "Procedural Due Process and Intramural Hospital Dispute Resolution Mechanisms: The Texas Advance Directives Act," *Saint Louis University Journal of Health Law and Policy* 10 (forthcoming 2017).

24. *Tex. Health & Safety Code* § 166.046.

25. *Tex. Health & Safety Code* § 166.045.

26. Texas Medical Association, *Healthy Vision 2020,* 2nd ed., *https://www.texmed.org/uploadedFiles/Current/Advocacy/Healthy_Vision_2020/HV2020.pdf,* pp. 17-8:

> Legislation has been introduced over the past four legislative sessions that would instead require indefinite treatment with no provision for the physician exercising ethics or moral judgment. TMA has opposed these proposals because they would prolong unnecessary—and often painful or even torturous—are that cannot prevent but can only prolong death. They would also require physicians, nurses, and other health care professionals to provide medically inappropriate care, even if that care violates medical ethics or the standard of care. They also would set a dangerous precedent for the legislature to mandate the provision of physician services and treatments that may be medically inappropriate, outside the standard of care, or unethical.

27. E.g. J. Shannon, "Right to Life Groups Battle Each Other," *Examiner,* 12 March 2015.

28. J. Perry, "Biopolitics at the Bedside," *Journal of Legal Medicine* 28, no. 2 (2007): 171-92.

29. Texas Representative James Frank introduced H.B. 3414, the mirror companion to S.B. 1163.

30. The bill would allow consideration of a patient's disability, if it is "relevant in determining whether a medical or surgical intervention is medically appropriate." This is consistent with the rule under the Americans with Disabilities Act. E.g. *Glanz v. Vernick,* 756 F. Supp. 632 (D. Mass. 1991); *McElroy v. Patient Selection Committee of the Nebraska Medical Center,* No. 4:06-cv-03162-RGK-PRSE (D. Neb. 21 Nov. 2007), aff'd, No. No. 07-3877 (8th Cir. 9 Jan. 2009).

31. T. Stutz, "Sen. Bob Deuell Seeks to Stop Radio Ads Targeting End-of-Life Bill," *Dallas Morning News,* 15 May 2014.

32. *Gonzalez v. Seton Family of Hospitals,* No. 1:07-CV-00267-SS (W.D. Tex. 4 April 2007) (Complaint).

33. *Gonzalez v. Seton Family of Hospitals,* No. 86427 (Travis County Probate Court, Tex. 20 March 2007) (Complaint).

34. *Dunn v. Methodist Hospital,* No. 2015-69681 (Har-

ris County District Court, Tex. 20 Nov. 2015) (Petition).

35. *Dunn v. Methodist Hospital,* No. 2015-69681 (Harris County District Court, Tex. 2 Dec. 2015) (Plea in Abatement).

36. *Tex. Health & Safety Code* § 166.046.

37. This included a Section 1983 claim in which Dunn argued that he had been deprived of his rights as a result of Methodist Hospital's use of TADA to protect its decision to cease life-sustaining treatment.

38. *Dunn v. Methodist Hospital,* No. 2015-69681 (Harris County District Court, Tex. 20 Nov. 2015) (Order).

39. Methodist Hospital asserted that Dunn failed to prove that another facility or physician would accept him. The hospital also argued that the state constitutional claims in the petition fail, because the Texas Constitution does not provide a direct cause of action for infringement of constitutionally protected rights. Lastly, Methodist argued that Dunn's Section 1983 claim failed because the hospital would not qualify as a state actor and, in either case, it did not deprive Dunn of a liberty or property interest. The court did not rule on these arguments, as the issues were not asserted in the original petition.

40. *Dunn v. Methodist Hospital,* No. 2015-69681 (Harris County District Court, Tex. 4 Dec. 2015) (Order of Abatement).

41. D. Wray, "In Texas, a Hospital Ethics Panel—Not the Patient or Family—Decides Whether to End Care," *Houston Press*, 9 February 2016; "Chris Dunn Dies after Fight over Life-sustaining Treatment, Attorney Confirms," ABC13 Houston, 23 December 2015, *http://abc13.com/news/chris-dunn-dies-after-fight-over-life-sustaining-treatment-attorney-confirms/1133520/.*

42. *Kelly v. Houston Methodist Hospital,* No. 2015-69681 (Harris County District Court, Tex. 2 Feb. 2016) (First Amended Petition).

43. T.M. Pope, "Dispute Resolution Mechanisms for Intractable Medical Futility Disputes," *New York Law School Law Review* 58 (2014): 347-368

44. *http://www.simonismynane.com.*

45. J.D. Lantos, "Trisomy 13 and 18—Treatment Decisions in a Stable Gray Zone," *Journal of the American Medical Association* 316, no. 4 (2016): 396-8.

46. Kan. S.B. 437 (2016) (Committee on Federal & State Affairs).

47. Mo. H.B. 113 92015) (Kidd); Mo. H.B. 1915 (2016) (Kidd).

48. Me. LD 1117 (Cushing), enacted as Me. Pub. L. Ch. 187.

49. The statute provides that stopping treatment is in the best interests of the child "if the child is in a persistent vegetative state or suffers from another irreversible medical condition that severely impairs mental and physical functioning, with poor long-term medical prognosis, and the child would experience additional pain and suffering if life-sustaining medical treatment were administered."

50. Utah S.B. 271 (2015) (Bramble), enacted as Ch. 375, codified at *Utah Code* § 31A-22-644.

51. Ore. S.B. 524 (2016) (Knopp).

52. N.Y. S.B. 1054 (2015) (Hannon); N.Y. A.B. 3767 (2015) (Goldfelder).

53. Va. H.B. 2153 (2015) (Stolle).

54. E. Simpson, "Delegate Wants to Clarify Law on Treatment vs. Suffering," *Virginia Pilot,* 31 January 2015.

55. *Cuthbertson v. Rasouli,* [2013] 3 SCR 341, 2013 SCC 53.

56. H. Young, "Physician Conscientious Professional Discretion in Canada and the United Kingdom," 2016, *http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2802776.*

57. College of Physicians and Surgeons of Ontario, "Planning for and Providing Quality End-of-Life Care," May 2016, *http://www.cpso.on.ca/policies-publications/policy/planning-for-providing-quality-end-of-life-care.*

58. D. Cape et al., "The Impact of the Rasouli Decision: a Survey of Canadian Intensivists," *Journal of Medical Ethics* 42 (2016): 180-5.

59. See note 1 above.

60. R. Cribb et al., "Stalemate: Deciding Life or Death," *Toronto Star,* 26 September 2014.

61. T. Blackwell, "Doctors More Reluctant to Clash with Families over End-of-Life Decisions in Wake of Supreme Court Ruling," *National Post,* 5 September 2014.

62 There have been five other recent Canadian cases. First, in British Columbia, the parents of Mary Jane Pierce obtained an injunction prohibiting clinicians from stopping life-sustaining treatment. But they had earlier signed over medical decision making to Child, Family, and Community Services. *Pierce v. Fraser Valley Aboiginal Children & Youth Society,* No. E152222 (B.C. Supreme Court, 11 Aug. 2015). Second, a Nova Scotia court dismissed an *ex post* damages lawsuit because the family failed to designate an expert witness. *Chan v. White,* 2014 NSSC 383 (Nova Scotia Supreme Court 24 Oct. 2014). Third, another lawsuit for damages is proceeding against Toronto East General. R. Cribb, "Family Sues Physician, Toronto Hospital over No-resuscitation Order," *Toronto Star,* 25 March 2015. Fourth, a medical board imposed discipline against Ontario physicians for writing a unilateral DNR order. *In re Complaint of Wawrzyniak re Chapman & Livingstone,* No. 95903 (College of Physicians and Surgeons of Ontario, 21 May 2015). Fifth, the Court of Appeal for Ontario affirmed a trial court's dismissal of a damages action related to the *Rasouli* case. *Salasel v. Cuthbertson,* 2015 ONCA 115.

63. *In re SL,* 2016 CanLII 46386 (Ont. CCB).

64. *Center Hospitalier de L'universite de Montreal v. WL,* 2014 QCCS 1864 (19 Mar. 2014).

65. These cases are collected at *http://thaddeuspope.com/medicalfutility/futilitycases.html.*

66. G.T. Bosslet, M. Baker and T.M. Pope, "Reason-Giving and Medical Futility: Contrasting Legal and Social Discourse in the United States with the United Kingdom and Ontario, Canada," *Chest* 150, no. 3 (2016).