The Need for an Effective Process to Resolve Conflicts Over Medical Futility: A Case Study and Analysis

Jocelyn A. Olmstead, RN
Michael D. Dahnke, PhD

The issue of medical futility requires a well-defined process in which both sides of the dispute can be heard and a resolution reached in a fair and ethical manner. Procedural approaches to medical futility cases provide all parties involved with a process-driven framework for resolving these disputes. Medical paternalism or the belief in the absolute rightness of the medical model will not serve to resolve these disputes. Although medical futility is first determined by medicine, in order for the determination to meet legal criteria, it must be subject to review. The hope is that through a review process that meets legal criteria, the issue can be resolved without the need for court proceedings. If resolution cannot be obtained through this process, surrogates still have the right to seek court intervention. This issue is of relevance and importance in critical care nursing because of the role and position of critical care nurses, who have direct contact with patients and patients’ families, the potential for moral distress in cases of possibly futile treatment, and the expanding roles of nurses, including critical care nurses and advanced practice nurses, in management and policy development. (Critical Care Nurse. 2016;36[6]:13-23)

Mrs. J, an 88-year-old woman with an admitting diagnosis of change in mental status, originally on a nonmonitored medical surgical unit, was a full code. During her stay in the hospital, she had pneumonia develop. Mrs. J underwent cardiopulmonary resuscitation (CPR) several times and was transferred to the intensive care unit, back to the medical surgical unit, then to an intermediate care unit, and back to the intensive care unit. During the last CPR attempt, Mrs. J was intubated and became ventilator dependent. During her admission, Mrs. J had been deemed not competent to make her own decisions by...
hospital psychiatrists. The patient’s daughter had her legal power of attorney and was the surrogate decision maker; she refused to have the patient’s status changed to do not resuscitate, even after several resuscitations. The patient’s attending physician had deemed continued life support medically futile. The ethics committee was consulted, but they were unable to persuade the patient’s daughter, and the patient continued to receive mechanical ventilation. The patient’s surrogate decision maker was notified of the hospital’s intent to discontinue mechanical ventilation, and the hospital’s legal department began court proceedings.

Before the court proceedings started, the patient died in the hospital while being maintained on life support. Situations such as this one are difficult for everyone involved, and the courtroom is not the ideal place to resolve medical disputes. As this case illustrates, many patients suffer because of disputes over medical futility. Unfortunately, many states do not have laws in place to resolve disputes about medical futility, and many facilities do not have effective policies to resolve such disputes. In order to ensure the protection of patients unable to make end-of-life decisions, conflicts over medical futility must be resolved through a procedural approach that protects physicians and health care systems. Mickelsen et al note that actions by health care organizations, “acting as unique moral communities, may contribute to a tipping point in our cultural perception of the proper resolution of disputes on futile medical treatment.” With increases in life-sustaining technologies, the need to establish a procedural approach to conflict resolution in medical futility cases will increase as well.

Although such decisions may appear to be primarily the purview of physicians and patients or patients’ families, these cases are ethically relevant for critical care nurses as well. In a case of providing futile care, it is primarily the critical care nurse who will see to the delivery of that care and will have the majority of contact with the patient and the patient’s family. Delivery of such care and constant contact with such patients can lead to despair (feelings of futility in nurses themselves) and moral distress. In addition, nurses, including critical care nurses and especially advanced practice nurses, have an important and expanding role in the decisions regarding the care of patients. Because of the nurses’ position in the direct delivery of care to patients and day-to-day interaction with patients and patients’ families, nurses should have a voice in these matters and in the development of policies to aid in the resolution of these cases. In the following sections, we investigate the ethical problems that arise from seemingly intractable futility conflicts, argue for a procedural approach toward addressing these conflicts, and analyze and evaluate the Texas law designed to address these types of conflicts as a possible template for resolution.

The Concept of Medical Futility

The concept of medical futility appears in writing during the times of the ancient Greeks. Fine notes the following passage from the Hippocratic treatises as referring to medical futility without the direct use of the term, “refusal to treat those overmastered by disease.” Given the severe limits of Hippocratic medicine, as compared with modern Western medicine, it is not difficult to imagine that patients were commonly overmastered by their disease. Because of the rapid advances in medicine during the late 19th and 20th centuries, the 1950s and 1960s saw modern medicine geared at preserving life at all costs. Medicine primarily relied on paternalistic application of the ethical principles of beneficence and nonmaleficence, with attention to patients’ autonomy not as paramount in importance as it has become in contemporary medicine and medical ethics. At the time, this meant that medical professionals were expected to benefit patients by keeping them alive. The standard of care was to provide life-sustaining interventions without consent from the patient, with CPR common practice for all patients.

During the 1970s, some began to question resuscitation efforts and the prolonging of the dying process in critically ill patients, also, ironically, due to advances in the techniques and capabilities of modern medicine.

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With that, questions about the legal and ethical ramifications of withholding CPR and/or life-sustaining support also emerged.\textsuperscript{4} By the 1980s, with the use of more and more life-sustaining equipment, the concept of medical futility came into play, and the ethical principle of autonomy became central to the debate.\textsuperscript{5} By the 1990s, US hospitals no longer maintained universal CPR policies. Upon admission, patients were asked about their wishes for treatment should CPR become necessary.\textsuperscript{4} With patients having the right to decide whether or not they would want life-support measures, surrogates were now requesting that measures viewed as medically futile in particular situations be continued. Surrogates opposed to the withdrawal of life support appealed to the ethical principle of autonomy and the concept of vitalism to support the continued use of life-sustaining measures.\textsuperscript{2} In addition, opponents of the belief that physicians had a right to determine futility felt that this label used by physicians was reverting back to a form of medical paternalism in which physicians may be “given the power to impose on their patients their own personal values under the guise of medical expertise.”\textsuperscript{5(p369)}

In response to objections such as this, many attempts were made to reach a concrete definition of what medical futility is. Much work was done to establish an agreed-upon definition, but as the debate was so heated and the concept so value-laden, no consensus could be established. Nonetheless, the next step was to attempt to develop policies and procedures on handling cases of medical futility. This process continues today without a standardized approach throughout the United States.\textsuperscript{5} In a recent policy statement, the American Thoracic Society (ATS) has recommended more specific terminology to describe situations that typically would be described as “futile.”\textsuperscript{6} These include “potentially inappropriate,” “legally prescribed,” and “legally discretionary” treatments. Further, the term “futile,” per the ATS statement, should be reserved for “the rare circumstance that an intervention simply cannot accomplish the intended physiologic goal.”\textsuperscript{6(p1319)}

### The Case for a Procedural Approach

Given the intractable equivocation of the concept of medical futility, difficult-to-resolve conflicts regarding the continued treatment of patients in critical care will be inevitable. Approaches to dealing with such events are limited. One very important strategy that should be implemented in every health care institution is proactive communication that makes clear to patients and surrogates the limitations of medical technology as well as any relevant policies in place regarding such situations.\textsuperscript{6-15} This strategy may prevent some cases from reaching points of intractable conflict but most likely not all cases. For cases that reach these levels of contention, one could take a paternalistic view, in which the view of the physician and the health care team, based on an assumption of technical expertise, should be ultimately authoritative. Alternatively, one could accept the full authority of patient/surrogate autonomy.

Yet either of those options results in simply the denial of a true conflict of principle and the neglect of either patient or professional autonomy. Further, absolute authority in the hands of surrogates ignores the problem of emotional obstacles for surrogates in choosing to withdraw life-sustaining treatment, even when such a decision may be the one the patient would choose.\textsuperscript{6} Placing the decision solely in the hands of clinicians neglects the fact that such decisions are based not only on technical knowledge but values as well and provides an excuse for physicians not to engage in the open communication that should be occurring with surrogates.\textsuperscript{6} A procedural approach has the advantage of carving out a middle path between these 2 extreme options that acknowledges the existence of a true conflict and respects the rights on both sides of the conflict. A procedural approach also encourages discussion and understanding between different viewpoints, acknowledging the deep controversy of the disagreements involved that cannot be resolved through simplistic application of rules or policies but only through the contribution of the different viewpoints involved. In this way, procedural approaches can better reflect or achieve important decision-making ideals such as “transparency, legitimacy, accountability, and opportunity for appeal.”\textsuperscript{6(p1323)}

The ATS has proposed a 7-step process for addressing requests for inappropriate treatment that remain intractable (Table 1).\textsuperscript{6} This process included continued negotiation, surrogate notification, second opinion, committee review, patient transfer, and extramural appeal. Steps such as these increase the likelihood that understanding of concerns and goals across both sides

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**Table 1:**

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<thead>
<tr>
<th>Step</th>
<th>Description</th>
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<tr>
<td>1.</td>
<td>Continue negotiation</td>
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<td>2.</td>
<td>Notify surrogate</td>
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<td>3.</td>
<td>Request second opinion</td>
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<td>4.</td>
<td>Conduct committee review</td>
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<tr>
<td>5.</td>
<td>Transfer patient</td>
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<tr>
<td>6.</td>
<td>Appeal extramurally</td>
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Absolute authority in the hands of surrogates ignores the problem of emotional obstacles for surrogates in choosing to withdraw life-sustaining treatment.
of the dispute occurs and a resolution that recognizes the rights and ethical views of all is reached. Absent a procedural approach, judicial appeals would be more likely and common. Although the court system can be an excellent place to address new and revolutionary issues that our society faces, for most cases of these types of conflict, the judicial process can be too costly, adversarial, and time-consuming.

A procedural approach to resolving futility disputes rests on a foundation of procedural justice, the social, ethical, and legal concept that fair and just outcomes are to be found through delineated processes for resolving disputes. Through a procedural approach to dispute resolution, general norms are particularized in order to guide action, all parties are guaranteed meaningful participation in the process, decisions are made through publicly available and acceptable standards and rationale, vague and general policies and principles are specified and disambiguated, and objectivity is attained by transcending the partiality of the individual, conflicting interests. Norman Daniels and James E. Sabin have notably addressed this concept of procedural justice from specifically within a health care context, identifying the procedural qualities of transparency, publicly available reasoning, and procedures for revising decisions when justified as what they call “accountability for reasonableness.”

**Ethical and Legal Issues**

A core ethical principle in making end-of-life decisions for patients is respect for patients’ autonomy. Patients have the autonomy to choose what medical treatments they want or do not want; however, they do not have the right to demand that physicians provide treatments that are nonbeneficial. That is to say, physicians also have professional autonomy, the right to act in a manner that is medically and ethically warranted. So, physicians have the right to refuse to offer treatments that they deem nonbeneficial and outside standards of care. In addition, physicians have an ethical duty to provide treatment that honors the ethical principles of beneficence and nonmaleficence. By providing medical treatment that goes against these ethical principles and continuing to offer life-sustaining treatments in futile cases, physicians are operating outside professional boundaries. Procedural processes are needed to fairly and effectively adjudicate disputes regarding putatively futile treatment. The

| Table 1 | American Thoracic Society 7-step process for addressing intractable requests for inappropriate treatment
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<tr>
<td>1. Enlist expert consultation to continue negotiation during the dispute-resolution process</td>
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<td>2. Give notice of the process to surrogates</td>
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<td>3. Obtain a second medical opinion</td>
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<tr>
<td>4. Obtain review by an interdisciplinary hospital committee</td>
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<tr>
<td>5. Offer surrogates the opportunity to transfer the patient to an alternative institution</td>
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<td>6. Inform surrogates of the opportunity to pursue extramural appeal</td>
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<tr>
<td>7. Implement the decision of the resolution process</td>
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*a Based on information from Bosslet et al.*

not just the determinations of clinicians, but also the hospitals and health care systems of which they are a part. In addition, hospitals must involve a number of departments in managing these disputes, including ethics committees, consulting physicians, risk management, internal and external communications, and the hospital’s legal department.

Because of the sensitivity of the issue, health care organizations need to protect the integrity of their organization and the health care team that provides patient care. The health care team, including critical care nurses, may be at risk legally, emotionally, and morally in such cases without a procedural approach in place to resolve these disputes. These risks include possible legal repercussions depending on one’s response to the request for the provision of care one believes is futile, despair and moral distress associated with providing futile care, and loss of moral integrity in feeling professionally compelled to provide treatment with which one disagrees. Of course, the patients and their families clearly have the most at stake in such cases. Thus, for patients, clinicians, hospitals, and the various departments in hospitals managing disputes, having a clear and uniform procedure for resolving these disputes can better guarantee protection of all that is at stake, whether that be unnecessary suffering, medical and ethical integrity, or the reputation of a caring, proficient, and capable medical institution.

**Stakeholders**

Many stakeholders have much to gain from finding a procedural process to resolve medical futility disagreements. End-of-life decision-making involves
inability to act in an ethical manner can instill moral distress, the sense of anxiety caused by a power disparity that results in obstacles to an individual’s ability to act ethically and participating in an ongoing ethical wrong. Moral distress can affect clinicians of all types, but it has been particularly identified as a problem among nurses. Further, futility conflicts have been identified as a major factor in causing moral distress.

In situations where patients are able to make decisions for themselves regarding whether or not they choose to pursue or forgo life-sustaining measures, decision-making is usually without complication. However, when patients are unable to express their wishes, decisions must be made for them through the employment of surrogate decision-making. In such cases, disputes between patients’ families and providers, among patients’ family members, and between surrogates and existing advance directives are all too common. Within such disputes, a negotiation of the principles of autonomy, beneficence, and nonmaleficence is needed. But with so many parties, each with unique investments in the case, without a clear procedure for such negotiation, chaos and moral error are inevitable.

Procedural approaches allow for resolution of medical futility disputes in a manner that considers the interests of all parties in reaching an objective and fair result through transparency of standards, a publicly acceptable rationale, and procedures for revising decisions when needed. Cases must be subjected to independent review with the best interests of the patient as the ultimate goal. This review involves looking at medical indicators as well as individual factors related to patients. Without this process, there are many different ways that physicians can handle these types of situations; however, not having a process in place can leave the health care team and the health care system open to unnecessary moral distress and possible legal consequences. For instance, if a physician decides against his or her better judgment to give in to requests for nonbeneficial treatment, the health care providers that take care of the patient on a day-to-day basis will most likely experience significant emotional stress. A physician can choose to cease life-sustaining treatment without agreement from the patient’s family. However, this practice is not common, as many physicians would not subject themselves to the possibility of legal repercussions.

Some hospitals have adopted policies in which the physician will request an ethics consultation and if the ethics committee comes to the same conclusion as the physician, they will notify the surrogate that they intend to remove life support. However, before removing life support, the process may need to go to court. This process is an effort to protect the hospital from litigation. However, it can be a time-consuming and resource-taxing endeavor if the surrogate does not come to an agreement before the court proceedings begin. With an established procedure in place, these issues can be alleviated.

Ethics Committees

With these disputes, many organizations have adopted the use of ethics committees to offer advice and assist in conflict resolution. Most cases reach conflict resolution at this stage. In a review of ethics consultations in medical futility cases at Baylor University Medical Center, researchers found that 98% of conflicts were brought to closure before going to formal dispute stages. With end-of-life cases, it is important for health care organizations and the physicians that work for them to be united in medical futility decisions. Mickelsen et al note, “When the same organization is unwilling or unable to place itself at public risk when faced with controversial cases, it may contribute to the moral distress of its caregivers and undermine its own integrity.”

The Texas Advance Directives Act of 1999

In response to the need for a concrete process to resolve disputes about medical futility, the state of Texas passed the Advance Directives Act of 1999 (TADA). This act outlines a clear process for resolving futility disputes when a patient or surrogate requests life-sustaining treatment that the treating physician or health care facility believes to be ineffective, inappropriate, or futile (Table 2). The law also clarifies and updates important terminology related to end-of-life decisions and clarifies rights of patients and surrogates. However, the most revolutionary and most commented-on part of the law is Section 106.016, Subsection (e), which provides a legal process for unilateral withdrawal of life-sustaining treatment by a health care facility. Procedural processes can be institutional and extralegal or a procedural process can be supported by force of law. Institutional processes can provide many of the practical and ethical advantages based in procedural justice. Legal support permits individual institutions to implement their own policies and procedures consistent with the minimal
requirements of the law and with protection of the law from criminal and civil complaints for clinicians and the institution.

If the physician fails to reach an agreement with the family, a medical futility hospital committee will review the case and attempt to resolve the matter. This committee may be the institution’s standing ethics committee or a committee designed specifically for this purpose. The law is silent regarding the specific composition of this committee.26 Whether members with expertise in areas of critical care or bioethics should be included or community members not directly affiliated with the health care institution should be on the committee is not addressed. The attending physician can request a formal meeting to resolve the dispute. The patient’s family is given 48 hours’ notice and an opportunity to attend the meeting. If the review committee agrees with the physician, the family is notified and they have 10 days’ time to find another facility willing to care for the patient. This step is sometimes referred to as the 10-day rule. During this time, the hospital will assist in finding alternative facilities and will maintain life-sustaining processes. If the family wishes, at any time during these 10 days, they can seek court proceedings to extend the time provided to find an alternative facility.27 If an alternative facility willing to provide life-sustaining treatment cannot be found, unilateral removal of the life-sustaining treatment by the facility, without risk of criminal or civil liability, is permitted.2

In many health care facilities outside of Texas, when conflict arises regarding futility, often the institutional ethics committee or physicians will advise the surrogate to search for another facility willing to continue the desired life-sustaining treatment. However, if an alternative facility cannot be found, often the facility has little choice but to continue providing life-sustaining treatment indefinitely. Unilaterally removing life-sustaining treatment risks severe legal ramifications for clinicians and the institution. The option to petition the court for a neutral guardian or for the authority to remove life-sustaining treatment contrary to a surrogate’s wishes exists. However, this route is costly, time-consuming, and, history demonstrates, difficult to achieve.

The case of Helga Wanglie involved just such a dispute.28 Hennepin County Medical Center in Minneapolis, Minnesota, attempted to have a new guardian appointed to make medical decisions for Ms Wanglie, who was in a vegetative state and ventilator-dependent. The court ruled that Ms Wanglie’s husband was the appropriate surrogate, and she continued to receive mechanical ventilation until her death a few days following the decision.

Further cases in the 1990s were similarly decided, although in 2008 and 2009, cases began to be decided for replacing surrogates.29 Although this type of judicial relief may have become a more potentially viable option, this option is still costly, time-consuming, and, as Pope argues, only a partial solution that may still leave surrogates demanding particular futile treatment as “irreplaceable.”29 According to both existing statutes and case law, it is not clear that clinicians and the facilities under which they operate have the legal right to unilaterally withdraw life-sustaining treatment on the basis

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**Table 2** The Texas Advance Directives Act of 1999: procedure for refusing a surrogate’s request to continue life-sustaining treatment

1. Committee review: The physician’s refusal is reviewed by an ethics or medical committee. The physician should not be a member of the committee, and the patient should continue to receive life-sustaining treatment during this process.

2. Patient/surrogate notification: The patient or surrogate is to be given a written description of the review process and any other relevant policies and procedures. The patient or surrogate should be given at least 48 hours’ notice of the review by the ethics or medical committee.

3. Patient/surrogate participation: The patient or surrogate is entitled to attend the meeting and receive a written explanation of the decision reached.

4. Committee decision: If the physician, patient, or surrogate disagrees with the decision of the committee, the facility shall make a reasonable effort to transfer the patient to another facility that is willing to comply with the directive.

5. 10-day rule: The health care facility is required to provide life-sustaining treatment for only 10 days following the written decision.

6. Extension: A court can grant an extension of the 10-day period if there is a reasonable expectation that an alternative, willing facility can be found during the period of the extension.

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a Based on information from McDonagh et al.12
of standards like medical futility.\textsuperscript{30} Without a procedural process founded in the law, clinicians and health care facilities are risking much when following their ethical beliefs and judgments in these cases.

**Strengths and Advantages of TADA**

Proponents of the law tout its many strengths and benefits. First, the law can help clinicians preserve moral integrity.\textsuperscript{2,26,27,30} To maintain a patient on a treatment that a clinician finds inappropriate, ineffective, or futile—and possibly harmful—requires the clinician to act against his or her medical and ethical judgment. On the one hand, the importance of respecting patients’ autonomy, even if operational through the request of a surrogate, needs to be recognized. However, on the other hand, recognition of the principles of beneficence, nonmaleficence, and justice may be at odds with the autonomous decisions of the patient or surrogate. According to Mayo, with legal liability at stake, in the case of a futility conflict, physicians might simply adopt “dispute-avoidance strategies.”\textsuperscript{27(p1009)} These strategies would include merely acceding to the wishes of the surrogate or doing what the physician wishes to do without consultation with the surrogate. In the former case, the physician would be ignoring or neglecting her or his own judgment for the sake of expedience. Not only would such an act violate the moral integrity of the clinician himself or herself, but, according to Pellegrino,\textsuperscript{31} it may amount to a form of moral abandonment of the patient. In the latter case, the physician would be acting dishonestly and with no recognition of the patient’s autonomy.

Second, according to the law’s proponents and defenders, while giving more power to the moral authority of clinicians, the law also defines limits to clinicians’ moral authority, for example, through providing for license review for clinician neglect of a living will or surrogate of a terminally ill patient without review of an ethics committee.\textsuperscript{2,26,27} In recognizing legitimate moral concerns on both sides, the law, in the words of Thomas Mayo, “tries to steer a course between the Scylla of judicial review and the Charybdis of unfettered, unexamined physician discretion.”\textsuperscript{27(p1010)}

Third, along with the question of clinician integrity, the law’s defenders also claim that it could help reduce the problem of moral distress. By allowing clinicians to act in the manner they believe to be medically and ethically appropriate in cases of futility conflict, instances of moral distress are likely to decrease. Fourth, the law, according to its proponents, allows for, encourages, and provides moral space for further discussion and dispute resolution.\textsuperscript{2,26,32,33} Fine,\textsuperscript{33} for example, interprets the fact that following implementation of the law, 93% of futility disputes between patients’ families and health care institutions were resolved without use of the 10-day rule as evidence that the law furthers and encourages discussion and dispute resolution. The fact that the vast majority of cases do not reach the most controversial and apparently adversarial step of the 10-day rule, according to Fine, demonstrates the success of the law in providing a framework for resolving disputes between parties.

The law may even encourage dispute resolution for disagreements among other parties. Fine presents the case of an 82-year-old man who has suffered a major stroke followed by additional bilateral strokes.\textsuperscript{32} These events left the man profoundly neurologically impaired, with decubitus ulcers, and general debility, showing “no clear evidence of joy in life” but demonstrating “he felt pain by grimacing and moaning.”\textsuperscript{32(p144)} The man was receiving parenteral nutrition. The treating physician judged that a do-not-resuscitate order be put in place and parenteral feeding and antibiotics be withdrawn. The recognized surrogate, the man’s wife of 3 years, appeared to agree in principle. However, the man’s daughter wanted “everything done.” In an attempt to get along with the man’s family, the wife refused to act contrary to the daughter’s wishes. In a case such as this, a family dispute preventing the agreed-upon choice of both the health care providers and the surrogate may be more effectively negotiated. In this way, the law can be seen as providing the means to address a variety of disputes that prevent the implementation of ethically justified acts.

Finally, defenders of the law often also identify the fact that the law provides for an extrajudicial process for dealing with futility conflicts as a strength.\textsuperscript{2,26,27,32} Even Robert Truog,\textsuperscript{36} a harsh critic of the law and in fact an advocate for resolving such disputes in the court system, notes that the typical slow movement of the court system can be an obstacle in futility cases that are often in need of swift resolution given the critical nature of the
cases. Ethics committees will typically include medical expertise that judges will lack, making the ethics committee better prepared to weigh the complex medical issues that arise in these cases.27 Also, the objectivity that may be one advantage of a judicial process can exist under TADA as well, as the deciding committee will include members not directly involved in the care of the patient in question.27 Just as in a judicial process, the patient or surrogate is given the opportunity to present his or her views to the deciding body.26 Further, even with the extrajudicial process in place, the law “does not preclude resort to the courts by families that are motivated to seek judicial review.”27(p1010) It should also be noted that the law sets minimum standards, and many hospitals in Texas have adopted futility policies that exceed the 48-hour and 10-day time periods indicated in TADA. This situation demonstrates a certain flexibility in the law to make room for a variety of ethical viewpoints regarding the matter of time constraints.

Criticism or Weakness of TADA

Possibly the most damning ethical criticism of the law is that it places too much power in the hands of the health care institution through the decision-making authority of the ethics committee or some other such designated medical or futility committee.26,30,35-39 Institutional ethics committees traditionally (and it should be noted this is a “tradition” of just a few decades) hold no formal authority. The roles of ethics committees have customarily been largely consultative. Allowing an ethics committee the kind of decisional authority indicated in TADA appears to be a radical departure, establishing these committees, as described by Robert Truog,38 as judge and jury. Fine,31 though, answers this criticism by comparing the authority given an ethics committee under this law with the established and accepted authority of organ transplant committees.

Even more powerfully, Truog describes the procedural provision of the law as an illusory due-process at risk for becoming “a rubber-stamp mechanism for systematically overriding families’ requests that seem unreasonable to the clinicians involved.”38(p619) Following the increasing recognition of the legal and ethical importance of patients’ autonomy among both bioethicists and clinicians in the past few decades, TADA may be perceived as an attempt to correct for recent emphasis on autonomy at the expense of other important values such as beneficence and just distribution of scarce resources. Might it be that TADA overcompensates in pursuit of this goal? That certainly is possible and should be part of the continued discourse regarding this law and any other future laws like it.

A similar complaint, or possibly a more specific form of the complaint just discussed, is that the 10-day rule is coercive and will erode trust between patients (or patients’ families) and clinicians and health care institutions.26,30,35,37 This concern is particularly noteworthy because trust between patients and the health care industry has arguably suffered in the past few decades as a result of the commodification of health care and the too-common reduction of patients to consumers.30

Another criticism questions the justice of the law, alleging that it will disproportionately affect marginalized ethnic or socioeconomic populations.36,40 A law with such an effect would, as described by Truog, instantiate a “tyranny of the majority.”36 If either in principle or in practice the law does disproportionately affect either ethnic minorities or socioeconomically deprived groups, that would be a serious concern that would need to be addressed and should possibly be enough to disqualify the law in a rights-based democracy such as ours. So, this is a concern that without a doubt needs to be studied.

Finally, just as some defenders of TADA judge that the extrajudicial process is a strength of the law, Truog finds this aspect of the law to be a weakness or flaw.36,38 “Legal mechanisms,” asserts Truog, “already exist to challenge surrogates as decision makers.”36(p969) Also, he maintains that our judicial system is designed precisely as “a fair and neutral decisional process,” which is what is needed in these cases.36(p970) So, this issue is a clear point of contention between defenders and critics of the law. One must then consider whether a committee composed of (at least primarily) members internal to one of the parties in the dispute (the health care institution) can be adequately objective and unbiased. But also, can a judge have the requisite understanding of the medical issues at stake to make an informed judgment comparable, if not equal, to that of a hospital’s ethics committee or futility committee?
Improving TADA

Given both the strengths and the weaknesses of the law, as just discussed, some commentators on the law have proposed amendments to improve it. Pope39 proposes that instead of an internal ethics committee given the authority to decide futility cases, a multi-institutional committee would avoid the concerns of bias while retaining the expertise and extrajudicial nature of an ethics committee. Mayo27 offers several possible improvements, including requiring a dispute resolution–style ethics consultation before the committee hearing and immediately after the 10-day post-committee time period and also extending the 48-hour notice before the committee hearing and the 10-day time period following the committee’s decision. These changes will improve the quality of the law that promotes further discussion and dispute resolution and possibly also reduce the coercive aspects of those time limits.

Even Robert Truog,36 possibly the law’s harshest critic, offers suggestions for improvement. Following his concerns for the disproportionate power that the law gives to the ethics committee and the possible bias inherent to an internal ethics committee, he proposes that the decisional authority be removed from the ethics committee and placed under “a more neutral entity.”36(p970) He then suggests that this “more neutral entity” would ideally be the judicial system. Such a change, however, would appear to merely negate the central part of this law.

In 2013, Texas State Senator Robert Deuell (R-Greenville) and State Representative Susan King (R-Abilene) introduced a bill that would amend the Texas Advance Directives Act (SB 303/HB 1444).41,42 Proposed changes to the law included clarifying the types of patients to whom the law applies, ensuring that patients receive artificial nutrition and hydration as long as they do not become harmful and until the natural death process begins, establishing clear and objective criteria for the ethics committee’s decision-making process, and clarifying the definition of “medically ineffective” treatment. This bill generated a great deal of controversy in Texas.43 The original bill died in session in 2013 but a similar bill introduced in the 2015 session has been passed and signed by the governor.44

Evaluation of TADA

Given the problems that have arisen during the past few decades regarding the ability to sustain life almost indefinitely (the use of limited resources, the possible suffering and loss of dignity of patients, the moral distress of clinicians), a procedural process for resolving futility disputes appears to be a needed development for the contemporary medical environment. Is TADA the answer? Perhaps it is and perhaps it is not. Perhaps it would be with specific improvements. But it marks an important attempt to resolve some unexpected problems raised by advances in medical technology. As such, a procedural process that attempts to address these problems but works to preserve other ethical values and concerns, as indicated by TADA’s critics, not only may be useful but may be the best ethical option. So, whether or not TADA is the right and correct law to respond to these problems of medical technology, it (and the discourse that surrounds it) represents the attempt to respond to these problems ethically and intelligently. TADA may or may not be the best or right response, but only open and continued dialogue on attempts such as these will lead to the best or right response.

Conclusion

TADA is not the only example of a policy that attempts to address these problems, but it is the one with the most controversy and discourse surrounding it and in that way may be the most instructive as to the best way to approach this issue. Children’s Hospital of Boston (CHB) has a policy that has some similarities to TADA but is wholly internal to the institution and not memorialized and supported in state law2,36,45 (Table 3). The CHB policy does not specify the amount of time allotted to transfer a patient after a futility decision has been made by the ethics advisory committee.2 Also, following a futility determination, the family is notified of their right to seek judicial intervention, an option that is limited in the state of Texas by TADA.2,36 Another important difference is that under the CHB futility policy, without support from a state law, clinicians are not legally immune following unilateral withdrawal of life-supporting treatment.2,36 Absent legal immunity, a futility policy like that of CHB may be hindered or even paralyzed, leaving clinicians to continue a treatment they deem ethically and medically inappropriate and instilling moral distress and risking ethical abandonment.31

The problem of medical futility requires a well-defined process in which both sides of the dispute can be heard and a resolution reached through policies and procedures
in an equitable manner. Procedural approaches to conflict resolution in medical futility cases are the fairest and most ethical way to resolve these disputes. Medical paternalism or the belief in the absolute rightness of the medical model will not serve to resolve these disputes.46

Stewart notes, “The necessarily subjective and nonmedical elements of futility mean that, while the medical profession can speak with some authority about futility, it cannot claim to have complete sovereignty over the definition.”46 Absolute discretion to continued life-supporting treatment on the side of the surrogate also will not resolve these disputes. A procedural approach supported by the law can provide requisite attention to the ethical needs and concerns of all involved stakeholders while providing clinicians with the support to follow their conscience without fear of legal repercussions.

The perception and perspective of critical care nurses will also be relevant and valuable in such disputes, for providing needed plurality to the concept of futility and avoiding a univocal, medical understanding of the concept, and for their position as most directly encountering patients and patient families on a daily basis, “nurses can be the bridge connecting families to clinicians.”34(p26) and, in the words of Thomas Mayo, “the buffer between what is really happening and the family’s perception of what is happening.”34(p26)

With our current state of medical technology, it may be an unfortunate truth, although a truth nonetheless, that, “There are . . . cases in which unilateral withdrawal of life-sustaining treatment is the only course that keeps faith with the duty to do no harm.”27(p1017) Although medical futility is first determined by medicine, in order for the determination to meet ethical standards of fairness and objectivity, it must be subject to review. States, clinicians, health care institutions, and even patients would benefit from the adoption of a procedural process similar to the law passed in Texas, The Texas Advance Directive Act (1999). The exact details of the ideal law concerning these problems should be the subject of continued study and discourse. We do not presume that TADA, even if it is useful, is without flaws. But it is, at the very least, a starting point that recognizes the problems at both ends of the dispute.

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None reported.


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