

Legal Implications and Ethical Considerations of "Do Not Resuscitate"

Vincent Ober, MD
Cynthia L. Cambron, Esq.

A DNR order is a physician order that instructs health care professionals that a patient is not to receive any, or only limited, resuscitative efforts in the event the patient's heart stops beating or the patient stops breathing. A DNR can be ordered by a physician when it is expressly requested by the patient or, if a patient is unable to express his or her wishes, by the patient's surrogate or proxy. Florida law provides that a DNR order is only to be entered 1) when the patient is capacitated and specifically requests an order during a particular hospitalization or 2) when the patient is incapacitated without the possibility of recovering capacity, i.e., in a terminal condition, an end-stage condition, or a persistent vegetative state.

Whether a DNR order should be entered also has ethical considerations. The primary principles of medical ethics are autonomy, nonmaleficence, beneficence, and justice. Autonomy is the basis for informed consent and means that the patient has the capacity to act voluntarily and with an understanding of the consequences of his or her actions. Nonmaleficence means that patients should not be put in a position where they could experience unnecessary harm or injury. Beneficence, on the other hand, means that the care given to patients should be care that will benefit the patient. Justice requires that patients be treated equally and fairly.

DNR orders, ethics, and the law will be discussed in the following cases.

Case 1

A 39-year-old man with chronic lung disease is admitted to the hospital with shortness of breath. He is treated but does not improve. His physicians recommend treatment with a ventilator to help him breathe temporarily. Recovery from this problem is very likely. The patient, however, refuses to be treated with a ventilator. His physician and other members of the health care team discussed this treatment with the patient upon his admission to the hospital, as well as several times throughout the hospitalization. The patient has discussed this decision with his wife many times, and she agrees that he has thoughtfully considered and rejected this treatment option. The patient does not have a living will and does not have a "prehospital DNR" but does request that a DNR order be entered by his physician.



In this case, ethical principles should be considered. The patient would greatly benefit from treatment on a ventilator and would very likely recover and leave the hospital. Without ventilator treatment he will probably die. Short-term ventilator treatment is frequently used to help patients overcome temporary breathing problems, and the treatment is usually well tolerated and has few major complications.

Risk Rx

Vol. 2 No. 3 July-September 2005
Copyright © 2004 by University of Florida

Understanding all of the risks and benefits of ventilator treatment, however, the patient decided not to be treated with a ventilator and requested a DNR.

Florida courts have stated that "One has the inherent right to make choices about medical treatment...this right encompasses all medical choices. A competent individual has the constitutional right to refuse medical treatment regardless of his or her medical condition." In Re Guardianship of Browning, 568 So. 2d 4, Fla. (1990).

The benefits of treatment in this case (i.e., life versus probable death) clearly outweigh the disadvantages and risks of treatment (i.e., patient discomfort, ventilator complications). However, the patient has full capacity to understand the risks, benefits, and consequences of his choices. Therefore, the physician should not force ventilator treatment for the patient and should enter a DNR order as requested.

Case 2

A 70-year-old female has breast cancer that has spread throughout her body. Her disease has been treated over the last year but has not responded to treatment and no additional treatment for the cancer is considered helpful. She is now incapacitated and unable to make any decisions about her health care. She has completed a living will that stipulates that she does not want any resuscitative efforts performed on her. She did not designate a healthcare surrogate.

The patient has clearly expressed her treatment decisions. Resuscitation may restore breathing and cardiac functioning but would not change the long-term outcome for this patient. Resuscitation might be well tolerated but could be needed for a long period. The treatments can be very uncomfortable for the patient and

HSC Self-Insurance Program

interfere with the patient's ability to interact with others.

Florida law provides that "if a person has made a living will expressing his or her desires concerning life-prolonging procedures, but has not designated a surrogate to execute his or her wishes concerning life-prolonging procedures, the attending physician may proceed as directed by the [patient]." However, "before proceeding in accordance with the [patient's] living will, it must be determined that the [patient] does not have a reasonable medical probability of recovering capacity so that the right could be exercised directly by the [patient]; the [patient] has a terminal condition, has an end-stage condition, or is in a persistent vegetative state; and any limitations or conditions expressed orally or in a written declaration have been carefully considered and satisfied." §765.304, F.S.

In this case, the patient made an advance directive in the form of a living will to indicate the types of treatment she would want in the event she was not able to speak for herself. Although she has not designated a surrogate to make her decisions, Florida law allows her physician to follow her living will and enter a DNR order as long as the criteria regarding her condition have been met.



Risk Rx

Vol. 2 No. 3 July-September 2005
Copyright © 2004 by University of Florida

HSC Self-Insurance Program

Case 3

An 80-year-old patient has several chronic medical problems (hypertension, arthritis, and asthma). She expressed to her physician that she wants and would always want full medical care and treatment. A recent heart attack and stroke has left her severely impaired and unable to make her healthcare decisions. Her chance of recovery is very low. Her current treatments are painful and poorly tolerated. Pain medications only cause her condition to worsen. She has no living will and no one is available to act as her proxy. The patient's health care team feels that a DNR order would be appropriate.



This case presents an ethical dilemma. Although the patient always wanted to continue all treatments, she never discussed the care she would want in the event she was in this type of condition. Aggressive treatment, including resuscitation, will prolong the life of the patient, but she will probably die despite the treatments. Furthermore, the burden of treatment in this case is high. The patient is in pain and effective medication makes her medical problem worse.

Florida law provides that "if an incapacitated or developmentally disabled patient has not

executed an advance directive, or designated a surrogate to execute an advance directive...health care decisions may be made for the patient by any of the following individuals, in the following order of priority...(a) judicially appointed guardian...; (b) the patient's spouse; (c) an adult child of the patient...; (d) a parent of the patient; (e) the adult sibling of the patient...; (f) an adult relative of the patient...; (g) a close friend of the patient; or (h) a [licensed] clinical social worker...selected by the provider's bioethics committee..." who is not employed by the provider. This statute further provides that when the proxy is a licensed clinical social worker appointed by the bioethics committee, "decisions to withhold or withdraw life-prolonging procedures will be reviewed by the facility's bioethics committee." §765.401(1), F.S.

In this case, until and unless a social worker proxy is appointed or another proxy is located to make healthcare decisions for this patient, a DNR order should not be entered and the patient should continue to receive effective treatments. In the event a social worker proxy is appointed and determines it to be in the best interest of the patient to request a DNR order be entered, it will first require approval of the hospital's bioethics committee.

Case 4

A woman who is 22 weeks pregnant has a severe automobile accident. She is incapacitated with no probability of regaining capacity and she is being treated on a ventilator. She is not expected to recover. In the past, she told her family many times that she would not want to be kept alive on a breathing machine if something happened to her and there was no hope of recovery. Other than this verbal directive of her wishes, she has no other advance directive. Her family would like her

Risk Rx

Vol. 2 No. 3 July-September 2005
Copyright © 2004 by University of Florida

HSC Self-Insurance Program

ventilator withdrawn, but her husband does not want to discontinue the ventilator.

This case presents an ethical dilemma. Not only do the spouse and family disagree on treatment, but there is also a fetus involved. The patient has clearly stated that she does not want to be continued on a ventilator if she is not expected to recover. However, she may not have considered that she would be in this condition while pregnant. Clearly, the patient will continue to live if kept on a ventilator and will die if removed from the ventilator. The burden of treatment for the patient includes the ventilator, medication to keep her sedated, and complications of the ventilator treatment. The patient will not be in pain.

Florida law provides that "unless the [patient] expressly delegates such authority to the surrogate in writing, or a surrogate or proxy has sought and received court approval...a surrogate or proxy may not provide consent for...withholding or withdrawing life-prolonging procedures from a pregnant patient prior to viability..." §765.113, F.S. Therefore, the patient cannot be withdrawn from the ventilator unless and until the fetus is able to live outside the mother's womb or unless and until a court order is obtained.

Furthermore, as discussed in Case 3, a spouse is higher in priority than other family members for acting as proxy for the patient. According to Florida law, the proxy is to make health care decisions based on the decision the proxy reasonably believes the patient would have made under the circumstances. The patient's husband, therefore, is the proper person to act as proxy for his wife. Notwithstanding the viability of the fetus, the husband should make his wife's decisions based on what he believes she would have wanted considering the circumstances. The health care team

should honor the decision of the husband proxy.

It is also important to note that Florida law provides that "...a proxy's decision to withhold or withdraw life-prolonging procedures must be supported by clear and convincing evidence that the decision would have been the one the patient would have chosen had the patient been competent or, if there is no indication of what the patient would have chosen, that the decision is in the patient's best interest." §765.401(3), F.S. Therefore, even if withdrawal of the ventilator was an option, a determination should be made that this is what the patient would have wanted.

Florida law does provide that the patient's family may seek expedited judicial intervention if they believe the husband's proxy decision is not in accord with the patient's known desires or is contrary to the law. §765.105, F.S. Unless and until that intervention and subsequent order of the court, the health care team should continue to follow the husband's proxy decisions.



Case 5

A newborn patient has severe medical problems and is not expected to live. The infant was resuscitated when she was in cardiac/respiratory distress. The parents would like a DNR order to limit resuscitation if the child arrests again.

Risk Rx

Vol. 2 No. 3 July-September 2005
Copyright © 2004 by University of Florida

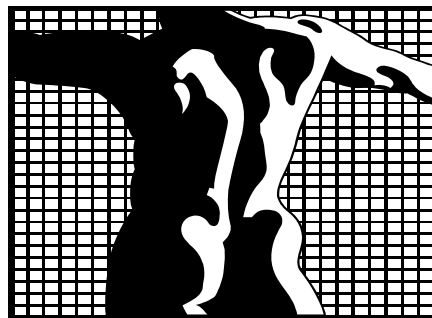
HSC Self-Insurance Program

This is the situation of a patient who has never had the capacity to understand and choose different treatments. Resuscitation is likely to be effective to revive this severely ill patient but will probably not be effective in correcting the patient's problems. In addition, resuscitative treatments are painful, very technical, and limit the patient's ability to interact with other people.

Florida law states that a natural or adoptive parent, legal guardian, or legal custodian has the power to consent for medical treatment of a minor. This includes the power to refuse care or treatment based upon the best interest of the patient. However, if a health care provider has reason to believe that the parent's decision to withhold care is medical neglect, it should be reported to the Florida Department of Children and Family Services. "Neglect" occurs when a child is deprived of, or is allowed to be deprived of, necessary food, clothing, shelter, or medical treatment...." §39.01(45), F.S. In this case, because of the patient's condition, the decision of the parents to request a DNR order probably does not equate to neglect and should be honored.

The cases discussed above are samples of cases health care teams could face on a daily basis. The facts of each case must be considered using ethical, as well as legal, principles. Shands HealthCare Core Policy regarding DNR orders describes the procedures to be taken in accordance with the law and ethical considerations. The most important lesson to be learned from this article is the legal principle of autonomy that was recognized in 1914 and provides that "every person of adult years and sound mind has the right to determine what shall be done with his own body." Every patient has autonomy and, although a patient may make decisions based on end-of-life care

that others think are incorrect, it is every patient's choice to make those decisions for themselves. It is the duty of the health care providers to honor and respect those decisions.



The SKINny on Pressure Ulcer Prevention

Jan Rebstock, RHIT, LHRM, CPHRM

Pressure ulcers remain a common problem in all health care settings. It is estimated that 1.3 million to 3 million adults develop pressure ulcers with an estimated cost of \$500 to \$40,000 to heal each ulcer.¹ Failure to prevent or heal avoidable pressure ulcers can also result in costly litigation.

The Agency for Healthcare Research and Quality (AHRQ) prevention guidelines indicate that most pressure ulcers can be prevented and that early stage pressure ulcers need not worsen under most circumstances.² This does not mean that every pressure ulcer is preventable or avoidable. The Centers for Medicaid and Medicare (CMS) State Operations Manual for long term care describes a pressure ulcer as unavoidable when a patient develops a pressure ulcer even though the facility has evaluated their clinical condition and pressure ulcer risk factors; defined and implemented interventions that are consistent with their needs, goals, and recognized standards of practice; monitored

Risk Rx

Vol. 2 No. 3 July-September 2005
Copyright © 2004 by University of Florida

HSC Self-Insurance Program

and evaluated the impact of the interventions; and revised the approaches as appropriate.³

It is also important to recognize that not all skin ulcers are "pressure ulcers" and an accurate diagnosis is very important from a risk management/claims perspective. Pressure ulcers are defined as "any lesion caused by **unrelieved pressure that results in damage to the underlying tissues(s).**"⁴ However, clinically prone patients also develop arterial skin ulcers, diabetic skin ulcers, venous insufficiency, or stasis skin ulcers that are unrelated to skin ulcers caused by unrelieved pressure. Improper classification of a skin ulcer can make a legal team's ability to defend an alleged pressure ulcer claim more difficult.

Because the development of pressure ulcers is often perceived as poor quality of care even though it may not be, it is imperative that the health care team focus on the prevention of pressure ulcers through early identification of "at risk" patients, implementation of proactive, aggressive care interventions and thorough documentation of both.



Some basic recognized **preventive strategies** include, but are not limited to⁵:

- *Assessing a patient's pressure ulcer risk factors on admission and at*

regular intervals (should include post-surgery). Prediction tools such as the Braden or Norton scales are commonly used, and both look at broad clinical categories such as sensory perception, incontinence, mobility, nutrition, friction, and shear to identify "at risk" patients.

- *Thorough daily skin inspections. (Physicians should be sure to include the integumentary system in the admission history and physical and address skin integrity in their progress notes and discharge summary.)*
- *Development and implementation of an appropriate skin care plan based on patient needs.*
- *Removing or redistributing the pressure sensitive areas of the body **at least every two hours.***
- *Use of appropriate pressure reduction support surfaces (intraoperatively as well). For "at risk" patients this could mean static devices such as air, foam, gel overlays or mattresses, or dynamic surfaces such as alternating and low air loss mattresses or air fluidized beds. Keep in mind specialty beds are not a substitute for turning and repositioning the patient.*
- *Use of devices that totally relieve pressure on the heels.*
- *Obtaining a nutrition consult and implementing recommendations for nutritionally compromised patients.*
- *Instituting a rehab program to maintain or improve mobility.*
- *Monitoring and documenting interventions and outcomes.*
- *Implementing educational programs for the prevention of pressure ulcers that are structured, organized, comprehensive, and directed at all levels of health care providers, caregivers, patients, and family.*

Risk Rx

Vol. 2 No. 3 July-September 2005
Copyright © 2004 by University of Florida

HSC Self-Insurance Program

When unavoidable pressure ulcers do occur, accurate, timely documentation of risk identification, preventive care, and treatment measures provide a basis for justification and defense.

¹Courtney, H. Lyder, N.D.; Pressure Ulcer Prevention and Management; JAMA, January 8, 2003, Vol 289, No. 2.

^{2,5}AHCPR Clinical Practice Guidelines, Pressure Ulcers in Adults; Prediction and Prevention, No. 92-0047, 1992.

³CMS Manual System, Pub. 100-07 State Operations, Provider Certification, Transmittal 4, November 12, 2004.

⁴Cuddigan, J., Ayello, E.A., Sussman, C., Baranoski, S. (Eds.). (2001). Pressure Ulcers in America: Prevalence, Incidence, and Implications for the Future. National Pressure Ulcer Advisory Panel Monograph (pp. 181). Reston, VA: NPUAP



Legal Case Review

Cristina Palacio, Esq.

Case Summary: (*Jeanette Wright v. Johns Hopkins Health Systems Corporation et. al* (728 A.2d 166 Md. 1999))

On July 18, 1994, Robert Lee Wright Jr. was admitted to the medicine service of Johns Hopkins Hospital, suffering from acute renal failure secondary to AIDS. After receiving a blood transfusion two days later, Wright was found in full arrest. At the direction of a resident, he was resuscitated, intubated, and transferred to the MICU. The team was apparently unaware that there was a living

will in the chart at the time that the patient was resuscitated.

Wright's parents arrived at the hospital after the incident. A physician informed them that it was their decision whether to maintain or withdraw life support. His mother requested that Wright be extubated, sent back to the medicine service, and provided only comfort care. Based on the mother's direction (not on the living will), Wright was transferred back to the medicine service with a DNR order from the MICU dated July 20. Subsequently, a note on July 21 indicated that Wright's home health nurse informed the medicine team that Wright had written a living will and had indicated a desire to be a DNR. Wright lay in a coma for 2 days and died on July 30, 1994.

Wright's living will, executed in February 1993, contained typical language directing that life-sustaining procedures be withheld or withdrawn "If at any time I should have any incurable injury, disease or illness certified to be a terminal condition by two (2) physicians who have personally examined me, one (1) of whom shall be my attending physician, and the physicians have determined that my death is imminent and will occur whether or not life-sustaining procedures are utilized and where the application of such procedures would serve only to artificially prolong the dying process...."

Allegation: Wright's mother, as personal representative of his estate, sued Johns Hopkins and the treating physicians alleging, among other things, that the defendants:

1. negligently administered CPR contrary to Wright's living will, and negligently failed to reasonably and timely explore and/or inquire as to his intentions regarding resuscitation, resulting in his experiencing "additional unnecessary

Risk Rx

Vol. 2 No. 3 July-September 2005
Copyright © 2004 by University of Florida

HSC Self-Insurance Program

- neurological impairment, pain and suffering and ultimately ... a prolonged, painful and tragic death ”;
2. conducted an intentional, non-consensual harmful and/or offensive touching (i.e., a battery) against Wright when they resuscitated him contrary to the advance directive; and
 3. failed to obtain informed consent (from a parent) by failing to disclose all material information, including the nature of CPR, the probability of success of the contemplated resuscitation and the alternatives, and the risks and consequences associated with the treatment.

Analysis: The Court’s analysis was done in view of Maryland law. Like Florida, Maryland law recognizes a competent adult’s constitutional and common law right to refuse medical treatment. Additionally, Maryland’s statutory provisions regarding the execution of advance directives and the conditions precedent to withholding or withdrawal of life support based on an advance directive (terminal condition, persistent vegetative state, or end-stage condition) are almost identical to those of Florida, except that Maryland requires documentation that death is “imminent” for a terminal condition.



The Maryland Court enumerated the issues presented by the facts and allegations in the case as follows:

1. Does an individual have a cause of action, either under Maryland

- statute or common law (i.e., case law), for a health care provider’s failure to comply with an advance directive?
2. Were the facts presented sufficient to support a cause of action for negligence, wrongful death, battery, and lack of informed consent?
 3. Does a sudden and unforeseen cardiac arrest render an otherwise non-terminal individual “terminal,” establishing a condition precedent to the operation of an advance directive?
 4. Under the statute or common law, what measures must a health care provider at an institution take to notify other providers at that institution that a patient has an advance directive?
 5. Under the statute, is a health care provider immune from liability for providing life-sustaining procedures to an individual who has directed that such procedures be withheld or withdrawn?
 6. Are the damages resulting from the administration of a life-sustaining procedure a compensable “injury”?
 7. In an emergency situation, is a health care provider liable for providing life-sustaining procedures to a patient who has made an advance directive if the provider was unaware of the directive, believes that the directive is not operative, or cannot ascertain the patient’s intentions?

In its analysis, the Court determined that the answer to Question 1 was “yes” – there is a cause of action under law for failure to comply with a patient’s advance directive. However, the Court concluded that the answer to Question 2 was “no” – the present facts did not support such an action under any of the theories presented by the

Risk Rx

Vol. 2 No. 3 July-September 2005
Copyright © 2004 by University of Florida

HSC Self-Insurance Program

plaintiffs (negligence, wrongful death, battery or lack of informed consent). The Court's conclusion was based mainly on its finding that the patient's advance directive was never operative because there was no certification by a physician that the patient was in the prerequisite "terminal" condition and in "imminent" threat of death, as required by Maryland law and the terms of the living will itself (cited above).

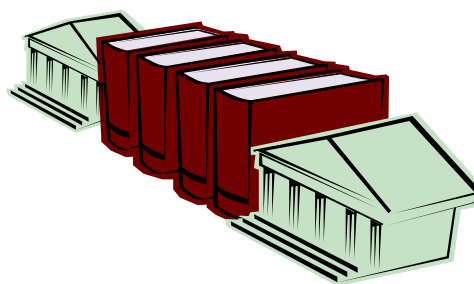
Therefore, even if the physicians had been aware of the living will, in the Court's opinion it would not have precluded them from resuscitating the patient.

Unfortunately, finding that the facts did not support an action meant that the Court did not have to specifically address the other 5 issues listed. Nevertheless, the Court did make a few findings that provide some insight into issues often faced in Florida hospitals.

Wright's mother argued that he was extubated after the physicians realized he had a living will and that they thereby acknowledged that the living will was operative. The Court pointed out that a withdrawal of life support without the conditions precedent noted in the living will (terminality and imminent death) would have been unauthorized. Since the Court found that extubation was done in response to the mother's request, the court noted that she could not complain of a deviation from the authorization of the living will – clearly indicating that such a deviation (i.e., giving effect to a living will without clear documentation of the conditions precedent) would be actionable.

Additionally, it was argued that general comments Wright made previously to an ED physician regarding his desire not to be resuscitated amounted to an oral advance directive. The Court found that such generalized comments, made without

witnesses and without a specific medical context, were not tantamount to an oral advance directive. However, citing a Maryland Attorney General Opinion, the court opined that a competent patient could direct the entry of a DNR order by direct communication with a physician. It would be effective if the patient was later incapacitated, despite the fact that it was not an oral advance directive, as long as the request was a "product of informed consent about contingencies in the discrete context of a discussion of a future course of treatment." In other words, if a competent patient makes an informed decision to forgo resuscitation during a specific hospital episode, regardless of the existence of an underlying terminal condition (or other condition precedent to operation of a living will), later incompetency does not invalidate the DNR. It is an episode-specific informed refusal of care. In this case, the arrest was not an expected outcome of his underlying illness (AIDS), but rather an acute unexpected reaction to the blood transfusion. There had been no discussion about entering a DNR order with his attending during this hospitalization.



There is ample case law relating to plaintiff's lawsuits to require physicians and hospitals to follow an individual's advance directive. The "wrongful life" type case, such as *Wright v. Johns Hopkins* is rare and despite strong statutory and common-law support for an individual's right to refuse life-prolonging procedures even after losing capacity, there is clearly reluctance on the

Risk Rx

Vol. 2 No. 3 July-September 2005
Copyright © 2004 by University of Florida

HSC Self-Insurance Program

part of the courts addressing these issues to find for the plaintiff. In this case and others, the courts seem to imply that the possibility of an action exists, but the "facts" are somehow not quite right for them to want to support it. See *Taylor v. The Woodlands* (727 N.E.2d 466, In. Ct. App. 2000) where the Indiana Court of Appeals considered a case where a patient was provided with artificial nutrition, contrary to the provisions of her living will. The Court found that the family could have taken her to another facility had they wished. See also *Klavan V. Crozer-Chester Medical Center* (60 F. Supp. 2d 436, ED Pa. 1999) where the US District Court in Pennsylvania considered a lawsuit based on the resuscitation of Dr. Klavan contrary to his advanced directive. The lawsuit was based on a claim that the hospital violated Dr. Klavan's Fourteenth Amendment rights. The court found that there was no "state action" and therefore dismissed the case.

management in the event of disagreements between patient, family, and health care team. All three services can be extremely helpful in facilitating solutions and avoiding the potential for litigation.

Risk Reduction Strategies:

- *It is important to be aware of the existence of an advance directive, and the conditions necessary to make one operational, both by law and by the terms of the directive.*
- *In the case of a DNR order, documentation is especially important when it is based on a contemporaneous discussion with the patient regarding conditions particular to the attendant hospitalization to assure the discussion is not characterized as a "generalized" discussion.*
- *Lastly, it is important to know the Shands HealthCare core policies and procedures relative to withholding and withdrawing life-prolonging treatment. You can obtain an ethics consult or contact hospital legal counsel or risk*

Editor:

Jan Rebstock, RHIT, LHRM, CPHRM
UF Self-Insurance Program

Editorial Board:

Larke Nunn, BA, LHRM, CPHRM
Associate Director RMLP
UF Self-Insurance Program

Joseph J. Tepas, III M.D.
Professor Surgery and Pediatrics
University of Florida- Jacksonville campus

Jamie Conti, M.D.
Assoc. Prof. and Prog. Training Dir.
Cardiovascular Med., University of
Florida, Gainesville campus

Gregory A. Chaires, Esq.
Board Certified in Health Law
Webster, Chaires and Partners P.L.
Winter Park, FL 32790

Cristina Palacio, Esq.,
Associate General Counsel
Shands Healthcare

Contact us at
rmeduc@shands.ufl.edu with
comments or article suggestions.