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March 7, 2012

Stephen T. Rust, MD, FACP, FAAHPM
Director of Palliative Care
Providence Alaska Medical Center
3200 Providence Drive
Anchorage, AK 99508

Re: CSSB 172

Dear Dr. Rust:

This will respond to your request for a legal analysis of the most current version of the Committee Substitute for Senate Bill 172 (CSSB 172), which changes current law on Do Not Resuscitate orders.

We have analyzed the most recent version of Senate Bill 172, along with the 11 numbered changes in the most recent version of the committee substitute for that bill. While the changes in CSSB 172 eliminate the exposure to criminal penalties that were in the original bill, the fundamental change in the current law is still reflected in the committee substitute. CSSB 172 still requires a physician to perform procedures that may violate his or her conscience, violate recognized standards of medical care, or what could constitute medically ineffective health care, contrary to generally accepted health care standards. Sections 2, 3, 6 and 13 of the bill still require a physician to perform cardio-pulmonary resuscitation on a patient who has arrested even when such medical procedure is medically contra-indicated.

The current bill also directly contradicts provisions in three different places in the current Alaska Health Care Decisions Act. First, in AS 13.52.060(e), a health care provider may decline to comply with "an individual instruction," meaning the patient's instruction, "for reasons of conscience." Currently, the exception is that if there is a Do Not Resuscitate order, all health care providers must abide by it and cannot resuscitate a patient for which there is a DNR in place. AS 13.52.060(e) also permits a physician to decline complying with a patient's instruction if the instruction is "contrary to a policy of the institution or facility that is expressly based on reasons of conscience. . ." Consonant with the Ethical and Religious Directives for Catholic Health Care Services, Catholic hospitals do not require resuscitation when such is medically and clinically contra-indicated. Requiring a Catholic hospital to provide or allow the provision of such a procedure when not medically indicated may raise First Amendment, Freedom of Exercise implications.

Second, AS 13.52.060(f) permits a physician to decline a patient's instruction that "requires medically ineffective health care or health care contrary to generally accepted health care standards . . ."

Third, AS 13.52.120(e) states "this chapter does not authorize or require a health care provider or institution to provide health care contrary to generally accepted health care standards applicable to the health care provider or institution."

Although CSSB 172 purports to leave all of that language in, it essentially eliminates those provisions when a patient instructs a physician to attempt to resuscitate the patient after the patient has arrested, meaning stopped breathing or the patient's heart has stopped beating or both; in other words, after the patient has died a natural death. In essence, the CSSB 172 still permits, as the original bill did, the patient to dictate what health care the physician must provide. This is contrary to the entire spirit of the Health Care Decisions Act when it was enacted in 2004, later when it was amended in 2006, and again when it was amended in 2008.

As you may know, Alaska's Health Care Decisions Act was patterned on and very closely follows the Uniform Health Care Decisions Act drafted by the National Conference of Commissioners on Uniform State Laws. The act represents a very comprehensive and cohesive treatment of health care decisions, including but not limited to end of life decisions. As is the case with all uniform laws, they are intended to be uniform so that when people travel from one state to another, they will have the benefit of the same or similar laws on similar subjects. In addition, uniformity assists courts when it is necessary for them to interpret the laws. The changes proposed in CSSB 172 would very significantly destroy that uniformity with the other acts that have been passed in other states. One of the Legislative Research Services memorandums to Senator Dyson dated January 19, 2012, acknowledges that Alaska's act came from the Uniform Health Care Decisions Act. The section from the Uniform Health Care Decisions Act cited in the Legislative Research Services memo is identical to the Alaska equivalent statute, AS 13.52.060(d). That uniformity would be destroyed by the proposed legislation.

Another fundamental point is that the proposed CSSB 172 is not needed. The existing statute already has a mechanism to deal with the situation that apparently provided the impetus for CSSB 172. In that situation, the physician's clinical judgment was that attempted resuscitation following arrest was not clinically indicated while the patient wanted such medical care to be provided anyway. The Alaska Health Care Decisions Act provides a mechanism that comes into play when there is such a dispute between physician and patient or surrogate decision maker. AS 13.52.060(g) provides that when the patient has requested care that the provider is unwilling to provide, care for the patient is transferred to other providers. Subsection (g) sets up a procedure under which the physician informs the patient of the physician's declining to carry out the patient's instructions. The physician then "provides continuing care to the patient until a transfer is affected." Assuming the patient or surrogate assists with the transfer, a physician also

then has the duty to "immediately cooperate and comply with the decision by the patient . . . to transfer . . . to another health care institution, to another health care facility, to the patient's home, or to another location chosen by the patient." This authority would include the ability to transfer to another physician.

Thus, the Health Care Decision Act already provides a mechanism for resolving disputes between patients and their physicians when the patient wants some procedure or medical care that the physician thinks is medically ineffective, unethical or is contra-indicated. When the opposite situation occurs, that is a physician recommending certain care but the patient refusing to consent to it, the result is already established: the patient will not receive the care. The only problem arises when the patient wants affirmative care to be provided that the physician thinks is clinically inappropriate. The statute already provides a way to resolve that situation.

CSSB 172, including the recent changes, appears to be based upon three fundamental mischaracterizations. First, the changes proposed in CSSB 172 confuse cardio-pulmonary resuscitation, a specific medical procedure brought to bear on a person who has died through the cessation of respiration or the cessation of cardio-activity or both with what are referred to as "life sustaining procedures." Cardio-pulmonary resuscitation becomes relevant only when there has been a cardiac or respiratory arrest. "Life-sustaining procedures," as generally understood and as used by AS 13.52, are "bridge" treatments that keep a person alive. "Life sustaining procedures" are defined in the Act at 13.52.390(26) and are defined to mean "any medical treatment, procedure or intervention that, in the judgment of the primary physician, when applied to a patient with a qualifying condition, [i.e., terminal or permanently unconscious] would not be effective to remove the qualifying condition and would serve only to prolong the dying process . . ." In other words, "life sustaining procedures" are treatments applied to people who are still living. They are further defined in the same section to include "assisted ventilation, renal dialysis, surgical procedures, blood transfusion, and the administration of drugs, including antibiotics, or artificial nutrition and hydration." All these treatments are applied to people who are still living. The changes proposed by CSSB 172 confuse CPR with life-sustaining procedures as if they were all the same thing. They are different procedures with different purposes and applied at different times to the patient.

The proposed changes also confuse resuscitation, a medical procedure which is done on a physician's order (like all other care) or medical staff (of physicians) policy with a decision to withhold or withdraw life-sustaining procedures which is a decision always left to the patient or his surrogates.

The Alaska Health Care Decisions Act distinguishes between cardio-pulmonary resuscitation and life sustaining procedures. The proposed changes will confuse or obliterate those distinctions and thus create ample grounds for disputes over correct statutory interpretation.

The second mischaracterization is that the proposed changes confuse the concept of "consent for treatment." The second numbered change proposed for CSSB 172 gives as the reason for that change that it "reflects the narrow focus of the bill to protect patients from being subject to DNR orders against their consent, ..." The concept of "consent for treatment" applies to treatment that is proposed or recommended by a physician which cannot be administered unless and until a patient consents to the recommended treatment. Procedures performed on the patient to which there has been no informed consent, absent an emergency and presumed consent, are considered battery; and thus all medical treatment requires consent before it can be administered. "Consent for treatment," applies to treatment that is being recommended by the physician. The underlying assumption of the proposed changes for CSSB 172 is that a patient "consents" to a DNR. The DNR is the absence of a medical procedure, not a medical procedure. A patient does not and cannot logically "consent" to treatment that is not being proposed or recommended. This confusion with consent for treatment leads to a transformation of approval of treatment recommended by the physician to a direct order by the patient to the physician that the physician will perform a certain procedure.

It has always been the case, and continues to be the case, that a patient has the option of declining recommended treatment. Even if it is universally accepted that the proposed treatment is good for the patient, the patient can still decline that treatment. But there is a world of difference between a patient's right to decline recommended treatment and a patient's prerogative to demand medical procedures that the doctor thinks are medically ineffective or inappropriate.

The third fundamental confusion is the assumption that the Health Care Decisions Act is ambiguous on whether a physician has the authority to impose or revoke a DNR order. The statute is not ambiguous on that point. AS 13.52.065(f) states that a DNR order may not be revoked unless a physician revokes it. The first sentence in that subsection could be argued to be ambiguous because it also refers to a patient requesting that a DNR order be revoked. But the second and last sentence of subsection (f) makes it clear that it is only a physician who can revoke the DNR order. It states "any physician of a patient for whom a do not resuscitate order is written may revoke the Do Not Resuscitate order if the person for whom the order is written requests that the physician revoke the Do Not Resuscitate order." (Emphasis supplied.) A patient can request it, but a physician's order can be revoked only by a physician. There is really no ambiguity on that point.

If the legislature had intended that when a patient requested the DNR order to be revoked the physician was required to do so, the above underlined word would have been "shall."

The fact that the legislature used the word "may" unambiguously shows that it is the physician who makes the decision. In addition, the definition of "health care decision" found in AS 13.52.390(19) lists five areas upon which the patient can decide the health care that he wants. But requiring resuscitation in the face of a DNR is not among them. The statute thus excludes mandating resuscitation after the patient dies from the definition of "health care decision." Section 9 of CSSB 172 would change that.

Also, Section 10 of CSSB 172 expressly repeals outright A.S. 13.52.060(f) [the current DNR provision] in its entirety, which is a tacit admission that it unambiguously gives the ability to revoke a DNR solely to the physician.

As the Legislative Research Service memorandum dated January 19, 2012 to Senator Dyson sets out, the American Medical Association Code of Medical Ethics has opinions on these issues. E-2.035 provides "physicians are not ethically obligated to deliver care that, in their best professional judgment, will not have a reasonable chance of benefiting their patients. Patients should not be given treatments simply because they demand them. . . ." This is a standard of medical ethics applied across the country.

AMA Code of Ethics Opinion E-2.037 provides that "when further intervention to prolong the life of a patient becomes futile, physicians have an obligation to shift the intent of care toward comfort and closure."

The AMA has a specific medical ethic opinion on Do Not Resuscitate orders. E-2.22 states "when a patient suffers cardiac or respiratory arrest, attempts should be made to resuscitate the patient, except when cardio pulmonary resuscitation (CPR) is not in accord with the patient's expressed desires or is clinically inappropriate." As you know, many patients are inappropriate for resuscitation procedures because of their frailness or other conditions that make the traumatic resuscitation procedures contra-indicated.

In all of medical practice, only a physician has the authority to enter orders calling for the administration of health care to patients in a hospital. The proposed changes would reverse that universal practice when it came to Do Not Resuscitate orders and elevate the patient's desires and demands over the physician's best clinical judgment. Medical care in recent times is always subject to the consent of a patient. Even if the doctor recommends a certain procedure, the patient has the authority to decline to have it administered to him or her. The proposed changes turn this right to decline recommended medical care into a demand that the physician provide medical care regardless of the physician's best medical judgment.

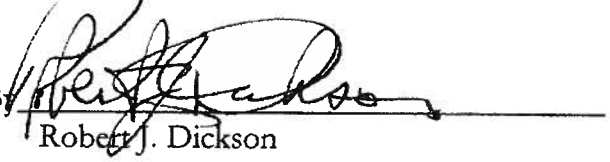
Finally, we note the Division of Legal and Research Services Memorandum dated December 30, 2011, to Senator Dyson, which apparently formed the basis for the CSSB 172, had a number of errors. That memo indicated that the selection of life-sustaining procedures was not sufficiently addressed in the statutory form. Although the term "life-sustaining procedures" is not set out in the form, the form provides for "choice to prolong life" which is understood by all concerned to include a request to use appropriate life-sustaining procedures "within the limits of generally accepted health care standards." The form goes on to address specifically artificial nutrition and hydration and relief from pain. But the initial choice would already call for the application of life-sustaining procedures. The memorandum also suggests that the term "individual instruction" appears to cover a DNR order. As indicated above, it does not. The same sentence misquotes the definition of "health care decision" and mis-cites to the wrong section of the statute. See text of that memorandum on p.2 at fn. 5 and 6. The correct cite is to AS 13.52.390(20). The memorandum then goes on to state that "AS 13.52.065(f) clearly allowed DNR orders to be made ineffective if a patient who is able to make the decision requests this. . . ." As explained above, that is not the case. Finally, in the final paragraph the memorandum states that "it seems that a patient with capacity has the right to make a DNR order ineffective." But that is inconsistent with the language of AS 13.52.062(f), as discussed above.

Consequently, CSSB 172 does not merely "clarify" what was the intent in the original enactment, it is diametrically opposed to the carefully crafted statutory scheme that complied with the uniform law on the subject and with national medical ethical codes. In the last analysis, the changes are unnecessary because the problem attempted to be solved is already addressed within the existing terms of the statute by permitting a patient to transfer to another physician or facility.

We hope the foregoing is helpful. Please let us know if there is further clarification or explanation needed.

Very truly yours,

ATKINSON, CONWAY & GAGNON

By 
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