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Memorandum

TO: Senator Fred Dyson
FROM: Chuck Burnham, Legislative Analyst
DATE: January 19, 2012
RE: State Laws: Assuring Healthcare Provider Compliance with Advance Health Directives
LRS Report 12.142

You asked about states' laws on "do not resuscitate orders" (DNRs). Specifically, you asked how other states prevent healthcare providers from using their patient care management authority to issue DNRs against the will of patients who have terminal conditions.

Background

As you likely know, all states have laws codifying patients' control, to varying degrees, over the medical care they receive in their final days of life.[1] Such legal mechanisms are commonly known as "advanced health directives," and may include "do not resuscitate orders" (DNRs). Typically, DNRs are used by elderly individuals or those with terminal illnesses to direct healthcare providers to suspend treatment should the patient experience a medical event that, in the absence of intervention, is likely to bring about death. In the absence of a DNR, medical ethics and standards of practice generally compel physicians to attempt life-saving measures; however, this requirement is limited when, in the judgment of the attending physician, such care would not ultimately prove beneficial to the patient. This concept is embodied in the Code of Ethics of the American Medical Association (AMA), which includes the following language in AMA Opinion 2.035:

> 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. Denial of treatment should be justified by reliance on openly stated ethical principles and acceptable standards of care, as defined in Opinion 2.03, "Allocation of Limited Medical Resources," and Opinion 2.095, "The Provision of Adequate Health Care," not on the concept of "futility," which cannot be meaningfully defined.

Recognizing the emotional and trying atmosphere that surrounds end-of-life care, the AMA provides in Opinion 2.037 a framework of considerations and actions to be taken by healthcare providers in circumstances where their prescribed treatment differs from the wishes of terminal patients. That Opinion frames the issue as follows:

> 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. However, there are necessary value judgments involved in coming to the assessment of futility. These judgments must give consideration to patient or proxy assessments of worthwhile outcome. They should also take into account the physician or other provider's perception of intent in treatment, which should not be to prolong the dying process without benefit to the patient or to others with legitimate interests. They may also take into account community and institutional standards, which in turn may have used physiological or functional outcome measures. Nevertheless, conflicts between the parties may persist in determining what is futility in the particular instance.[2]

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[1] Alaska's laws on advanced healthcare directives are codified at AS 13.52. For the purposes of this report, the term "patient" generally includes individuals receiving care, their families, and other proxies that may be involved in end-of-life decisions should the patient become incapacitated.

[2] The AMA Code of Medical Ethics is available online at *http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page?*.

The AMA recommends that healthcare institutions adopt policies that use a due process approach in determining medical futility. Opinion 2.037 outlines a seven-step approach that emphasizes fostering understanding and cooperation between patient and physician, involvement of institutional bodies such as ethics committees where disagreements remain, and the swift and orderly transfer of patients to other institutions when agreement cannot be reached.

Patient Protections in State Laws

Although the policies of the AMA generally appear to strike a reasonable balance between the wishes of patients and the medical judgment of physicians, those policies do not carry the weight of law. The concern that you contemplate—that physicians may order a DNR over the wishes of the patient at a point too early in the end-of-life process—is clearly shared by policymakers in a number of other jurisdictions.

For example, the Uniform Law Commission (ULC) includes protection against physicians superseding the wishes of patients in its Uniform Healthcare Decisions Act.[3] Section 7 of the Act, "Obligations of Healthcare Provider," includes the following:

> (d) Except as provided in subsections (e) and (f), a health-care provider or institution providing care to a patient shall:
>
> > (1) comply with an individual instruction of the patient and with a reasonable interpretation of that instruction made by a person then authorized to make health-care decisions for the patient; and
> >
> > (2) comply with a health-care decision for the patient made by a person then authorized to make health-care decisions for the patient to the same extent as if the decision had been made by the patient while having capacity.

The Act then allows that should a healthcare provider decline to comply with the instructions of a patient for reasons of conscience, policy, or conflict with generally accepted healthcare standards, the patient should be promptly informed and treatment should continue until transfer to another facility can be arranged.[4] The Act, in part or in total, has been adopted by a number of states including Alaska and, for example, Mississippi and New Mexico.

Although the policies of the AMA and the Uniform Act have clearly influenced policymakers' approaches to protecting patients' wishes in end-of-life circumstances, states nonetheless vary considerably in their laws on the topic. For instance, in California and Hawaii, physicians may issue orders specifying withholding end-of-life treatment, but only with the signature of a patient or legally recognized proxy. Similar orders may be issued by physicians in Tennessee and Virginia only with the "consent" of the affected patient. Medical doctors in Ohio may issue a "DNR Identification" order, but state law makes clear that the legal "declaration" of a patient regarding treatment preferences supersedes the physician's DNR.[5]

It is important to note that although the states we have mentioned, and others, have taken steps to protect patients from becoming subject to a DNR order against their will, determinations on when to discontinue efforts at life-saving interventions such as cardio pulmonary resuscitation (CPR) fall to the purview of physicians, the policies of the institutions in which they practice, and the accepted standards of medical practice. Therefore, patients' authority under the laws we've discussed necessarily extend only to whether they desire or refuse medical intervention through an advanced directive at the end of life rather than to the duration or timing of the cessation of those measures.

We hope this is helpful. If you have questions or need additional information, please let us know.

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[3] Established in 1892, the ULC, also known as the National Conference of Commissioners on Uniform State Laws, seeks to provide states with "non-partisan, well-conceived and well-drafted legislation that brings clarity and stability to critical areas of state statutory law." The ULC is comprised of lawyers, judges, legislators, and academics who have been appointed by state governments. More information is available on the Commission's website at *http://www.nccusl.org/Default.aspx*.

[4] Full text of the Act is available online at *http://www.nccusl.org/Default.aspx*.

[5] We include, as attachments, examples of relevant statutes of California, Delaware, Florida, Georgia, Hawaii, Mississippi, New Mexico, Ohio, Tennessee, and Virginia.