The divergence of medical ethics and state laws regarding life sustaining treatment

OAKLAND UNIVERSITY WILLIAM BEAUMONT

Hannah VanDusen[1], Jason Adam Wasserman, Ph.D., HEC-C[2,3]

[1]MD Candidate, Oakland University William Beaumont School of Medicine
[2]Department of Foundational Medical Studies, Oakland University William Beaumont School of Medicine
[3]Department of Pediatrics, Oakland University William Beaumont School of Medicine

Introduction

Cardiopulmonary resuscitation (CPR) is a potentially life-saving procedure which involves chest compressions, respirations, medications, and in some cases, defibrillation. While many factors contribute to the likelihood of successful resuscitation, research reveals that CPR rarely leads to prolonged survival in patients with chronic illnesses in whom death is expected in the relatively near-term.[1,2] CPR also is not a benign procedure, with risks including fractured ribs and sternum, pneumothorax, hypoxic brain injury. In many of these cases, CPR does not provide a reasonable medical chance of achieving the desired outcome-meaningful recovery. Thus, there is strong ethical consensus favoring a physician's right to refuse to provide CPR when it is physiologically futile or medically inappropriate.[3]

The legal statutes that govern medically ineffective treatment, however, sometimes diverge from the ethical consensus. It is common for a patient or surrogate to request from medical providers treatments, medications, or procedures which are either non-beneficial, inappropriate, or futile.[4] It is the goal of these encounters that through education and communication, the patient and provider can agree on an evidence-based plan moving forward. However, when an agreement cannot be reached, physicians and surrogates often seek relief in the courts. The state laws which predicate the authority of physicians and surrogates in these situations are diverse and often ambiguous. Many statutes leave physicians afraid or unable to refuse to offer medically inappropriate life sustaining procedures out of fear of litigation.[5]

This study examines laws related to life sustaining treatment, analyzing both physician and surrogate authority in decision making about resuscitation orders. We conclude by situating Michigan law in the national context.

Aims and Objectives

1. Review state laws regarding advance directives and develop a coding strategy

2. Report the scope of decisional authority of physicians and surrogates in each state

3. Examine whether each law includes conscience protections for physicians with objections to the patient/surrogates wishes

4. Situate Michigan law within the national context of legal statutes which govern physician and patient/surrogate authority for end of life interventions

Methods

Relevant state laws were extracted from an online database or directly from state government websites. These were coded to assess physician authority and surrogate authority, for their relative ambiguity, and for whether and how each enabled exceptions for reasons of conscience. The coding algorithm is shown below in Figure 1.

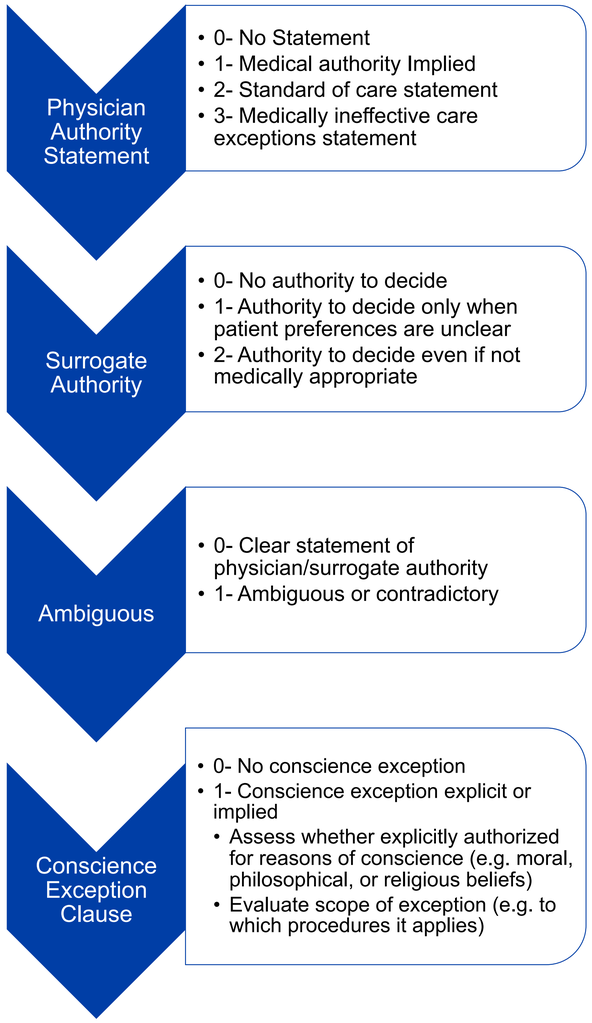

Figure 1. Coding Algorithm

Results

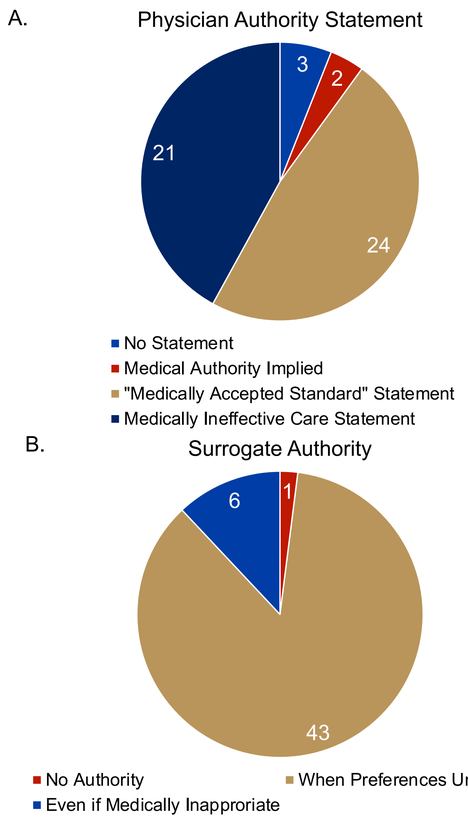

Figure 2. Physician (A.) and Surrogate (B.) coded authority results.

- 42% of states have laws that specifically protect physicians from the need to perform medically ineffective/inappropriate procedures, while another 48% more generally demand practice "within the accepted medical standards," and 4% provide weaker implied protections for physician medical authority
- Michigan, Florida, and Arizona statutes explicitly undermine medical authority and its role in limiting ineffective or inappropriate treatments.
- 12% of states have laws that imply or explicitly state the surrogate may demand life sustaining procedures, including CPR, even when medically inappropriate
- Nearly all states (94%) included provisions allowing individual physician refusal to adhere to a patient's advance directive or surrogate's requests for end-of-life care, of which 55% specifically indicate such refusals as matters of conscience. Five states specifically allow physicians to refuse to comply with a DNR order, while only Alaska specifies that a physician may not refuse to honor a patient's DNR order.
- 60% of state laws are ambiguous related to conflict between physician and surrogate surrounding decision of life sustaining treatments

Conclusions

There is a broad range of ways in which state law protects medical authority and the power of a surrogate, with varying degrees of clarity. Despite ambiguities, Figure 2a shows that 94% of states either explicitly or imply medical decision making authority. Michigan, Florida, and Arizona represent markedly poor protections for medical decision making and provide no protection for physicians who refuse to offer medically inappropriate CPR.

Michigan, for example, specifies that physician should be consulted by a court appointed guardian, but does not contain any statute addressing ineffective care nor a law requiring practice within "medically accepted standards." The only phrase limiting surrogate power in Michigan Law is "A patient advocate shall act in accordance with the standards of care applicable to fiduciaries in exercising his or her powers."

Oklahoma provides a robust example of a statute which provides clarity in medical decision making authority: "Nothing in the Oklahoma DNR Act shall require a physician, health care provider, or health care agency to begin or continue the administration of cardiopulmonary resuscitation when in reasonable medical judgement, it would not prevent the imminent death of the patient." This statement, amongst many others, offers a template for those states lacking protections from the divergence of law and ethics.

Additionally, conscience laws surrounding life sustaining treatment often are problematic where they allow physicians to "refuse to withhold" life sustaining treatment for reasons of conscience effectively sanctioning the performance of unwanted procedures on patients who have indicated they do not want them, at least until such a time as the patient can be transferred. These laws are deeply concerning and future work will explore more fully the implications of such refusals, and work to pursue clarity or revision of such statements

References

1. Rubulotta, F., & Rubulotta, G. (2013). Cardiopulmonary resuscitation and ethics. *Revista Brasileira de terapia intensiva*, *25*(4), 265–269.

2. Sehatzadeh S. (2014). Cardiopulmonary Resuscitation in Patients With Terminal Illness: An Evidence-Based Analysis. *Ontario health technology assessment series*, *14*(15), 1–38.

3. Guidelines for the Appropriate Use of Do-Not-Resuscitate Orders. *JAMA.* 1991;265(14):1868–1871. doi:10.1001/jama.1991.03460140096034

4. Firn, J., Marks, A., Vercler, C., Shuman, A., Goldman, E., & Kamil, L. H. (2016, November). UMHHC Policy 03-07-009 Withdrawal and Withholding of Medical Treatments (Non-beneficial Treatment/Intervention). In *University of Michigan Policies*.

5. Marco CA. (2005).Ethical issues of resuscitation: an American perspective. *Postgraduate Medical Journal* 2005;**81**:608-612.