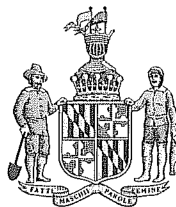
DOUGLAS F. GANSLER
Attorney General
jschwartz@oag.state.md.us
E-Mail
(410) 576-7036
FACSIMILE NO.



KATHERINE WINFREE
Chief Deputy Attorney Genera
JOHN B. HOWARD, JR.
Deputy Attorney General
(410) 576-6327
WRITER'S DIRECT DIAL NO.

STATE OF MARYLAND
OFFICE OF THE ATTORNEY GENERAL

May 28, 2008

Harold B. Bob, M.D.
Suite 200
25 Main Street
Reisterstown, Maryland 21136

Dear ~~Dr. Bob~~ Harold:

You have requested advice on two questions about the Instructions on Current Life-Sustaining Treatment (LST Options) form. One concerns the effect, if surgery is indicated, of an instruction by a patient rejecting cardiopulmonary resuscitation and ventilator use. The other concerns an instruction by a surrogate that a patient not be hospitalized.

I

DNR/DNI Status and Anesthesia During Surgery

Your first question posits an LST Options form completed by a patient with capacity. In Part C, concerning code status, the patient initialed "No, do not attempt CPR; allow death to occur naturally"; in Part D, concerning artificial ventilation, the patient initialed "No artificial ventilation." The patient later lost capacity, so health care decisions are now made by a proxy (health care agent or surrogate). The patient falls and sustains a hip fracture. Despite the patient's overall poor prognosis, surgery to stabilize the bone is medically indicated, primarily to relieve pain. Yet, if the patient's prior instruction must be honored by the proxy, the surgery will be impossible, because the necessary anesthesia might well call for resuscitation measures and temporary ventilator use. No anesthesiologist will participate unless the DNR/DNI order is suspended intraoperatively.

In my view, the proxy may consent to the suspension of the DNR/DNI order as an aspect of consenting to the surgery. The patient's instructions on the LST Options form are not controlling.

Generally speaking, a competent patient may use an LST Options form to decline CPR and associated intubation. In other words, the LST Options form can serve as a vehicle for an ethically and legally valid exercise of a patient's common law right to refuse life-sustaining treatments.[1] Although the form is not a medical order and hence cannot itself directly determine care, ordinarily a DNR/DNI order should be entered promptly after the patient's informed refusal of CPR and intubation.

Furthermore, a refusal of these interventions, as reflected on an LST Options form, is to be seriously considered by a proxy charged with making health care decisions after the patient's loss of capacity, for if possible the proxy is to base decisions "on the wishes of the patient." Health-General § 5-605(c)(1).[2] A proxy is to consider, among other factors, the patient's "expressed preferences regarding the provision of, or the withholding or withdrawal of, the specific treatment at issue or of similar treatments." Health-General § 5-605(c)(2)(ii).

Nevertheless, the patient's refusal must be understood in context. As the LST Options form says, the refusal of attempted CPR is in furtherance of allowing death to occur naturally. It is most unlikely that, in rejecting interventions that many people see as merely prolonging the dying process, the patient also intended to reject temporary use of these interventions for a quite different purpose. (I would say the same thing about similar language in a living will.) As the leading treatise on end-of-life legal issues observes:

> [The] contemplation of surgery for a patient with a preexisting DNR order ought to provide the occasion for renewed discussion of the purpose and value of CPR for this particular patient. CPR in the surgical context is, in effect, a different treatment from CPR outside the surgical context. Just as one should not infer from a patient's decision to decline kidney transplantation that hemodialysis ought to be forgone (or vice versa), one should not infer from a

---

[1] "Under Maryland common law, a competent adult has the right to refuse medical treatment and to withdraw consent to medical treatment once begun." *Wright v. Johns Hopkins Health Sys. Corp.*, 353 Md. 568, 572 (1999).

[2] The patient's loss of capacity should trigger a review of the LST Options form. Health-General § 5-608.1(c)(8).

> DNR order that the patient is not to be resuscitated in the course of, or recovery from, surgery.

Alan Meisel and Kathy Cerminara, *The Right to Die: The Law of End-of-Life Decisionmaking* § 6.02[E], at 6-54 to 6-55 (2004, 2008 Supp.)

In deciding whether to consent to the surgery, which entails suspension of the DNR/DNI order, the proxy may conclude that the patient's prior instruction reflects no relevant wish. Consequently, if the proxy knows of no other evidence of the patient's wishes, the decision should be based on the patient's best interest.

II

Do Not Hospitalize Orders

Your second question requires analysis of a surrogate's authority to request issuance of a "Do Not Hospitalize" (DNH) order on behalf of a nursing home resident who lacks decision-making capacity. The possibility of DNH status is explicitly presented in Part E of the LST Options form. You ask how a surrogate's preference for DNH status and the attending physician's entry of a DNH order relate to certification of condition under Health-General § 5-606(b).

To illustrate the issue, you present the following case: A resident has a progressive dementia that has left her without capacity to make health care decisions. She also has cardiovascular and other problems, making her susceptible to a variety of life-threatening events, but her condition is not yet terminal or end-stage. She has no advance directive. Her daughter, as surrogate, believes that, when a life-threatening situation arises, her mother would prefer to remain in her familiar surroundings rather than be treated in the disorienting and probably frightening environment of a hospital. Hence, the surrogate opts for "Do Not Hospitalize" status in Part E of the LST Options form. In furtherance of this decision, the patient's attending physician enters a DNH order on her chart. This means that, when a life-threatening situation arises, the patient will receive only treatments available in the nursing home.[3] The patient will not be transferred to a hospital even if the treatments available there might increase the chances of prolonging her life.

---

[3] The exact wording is: "Do not transfer; treat with options available outside the hospital."

The common understanding is that a surrogate decision maker lacks authority under the Health Care Decisions Act to withhold or withdraw a life-sustaining procedure unless the patient has been certified to be in one of three conditions: terminal condition, end-stage condition, or persistent vegetative state. This is a good working formulation, but the statutory restriction is actually addressed to health care providers, not surrogates: "A health care provider may not withhold or withdraw life-sustaining procedures ... on the basis of the authorization of a surrogate, unless ... the patient's attending physician and a second physician have certified that the patient is in a terminal condition or has an end-stage condition." Health-General § 5-606(b)(1).[4]

This wording has one important implication about use of the LST Options form: Certification of condition is *not* a prerequisite to a surrogate's expression of a preference against the use of a life-sustaining procedure, even if certification *is* a prerequisite to the carrying out of the surrogate's preference. This point is discussed in my advice letter to you dated November 8, 2005.[5]

Is certification required under Health-General § 5-606(b) prior to the physician's entry of a DNH order to carry out the surrogate's decision? Yes, but only to the extent that a DNH order amounts to the withholding of life-sustaining procedures.[6] Establishing whether that is the practical effect of a DNH order will often be a matter of medical judgment.

Suppose, for example, that the patient in the case that began this discussion develops an infection that, left untreated, would be life-threatening but for which antibiotic therapy is available. Suppose, further, that two antibiotics are labeled for treating this type of infection.

---

[4] The same limitation applies if life-sustaining procedures are to be forgone on the basis of a "living will" type of advance directive – instructions without appointment of a health care agent. Certification of PVS is another possibility, covered in § 5-606(b)(2). A physician or other health care provider who withholds or withdraws a life-sustaining procedure on the basis of a surrogate's authorization *without* the requisite certification loses the legal immunity otherwise broadly available for actions taken in accordance with the Health Care Decisions Act. § 5-609(a). However, the Act does not itself impose any sanctions for this action. Whether the action would result in liability depends on its consistency with the applicable standard of care, which might be affected by the Health Care Decisions Act provisions but is not determined by them.

[5] The letter is available at this link: http://www.oag.state.md.us/Healthpol/bobnov20052.pdf

[6] To the extent that a DNH order precludes hospital transfer for conditions not involving vital functions, the order may be applied without regard to certification of condition. See Health-General § 5-601(m) (definition of "life-sustaining procedure").

One is an oral antibiotic, which can be used in the nursing home. The other is an intravenously administered antibiotic, which requires special monitoring and so can only be used in a hospital. If the physician believes that using the oral antibiotic is consistent with the standard of care for treating the patient's condition, the DNH order may be applied. This action is not the withholding of life-sustaining procedures on the basis of the surrogate's authorization; rather, it is the carrying out of the surrogate's choice *between* two life-sustaining procedures. By contrast, to pursue this example further, suppose the infection does not respond to the oral antibiotic administered at the nursing home. If the physician believes that the only way to try to prevent the patient's death from the infection is by means of the hospital-based treatment, then to give effect to the DNH order would amount to the withholding of what, under the circumstances, is the only life-sustaining procedure available for the patient. Then, the Act requires certification of terminal or end-stage condition as grounds for maintaining the DNH order.

I hope that this letter of advice, although not to be cited as an Opinion of the Attorney General, is fully responsive to your inquiry. Please let me know if I may be of further assistance.

Very truly yours,

Jack Schwartz
Assistant Attorney General
Director, Health Policy Development