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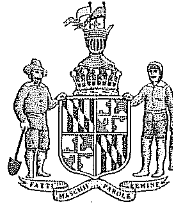

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OFFICE OF THE ATTORNEY GENERAL

November 20, 2007

Virginia Hierholzer, Esq.
Staff Counsel
Baltimore City Department of Social Services
Bank of America Building, 15th Floor
100 South Charles Street
Baltimore, Maryland 21201

Dear Ms. Hierholzer:

I am writing in response to your memorandum of November 7, 2007, in which you described a situation involving an adult ward of the Baltimore City Department of Social Services ("BCDSS") that prompted concern about the effect of a hospital-based physician's Emergency Medical Services/Do Not Resuscitate ("EMS/DNR") order, issued on the grounds of medical ineffectiveness, after a patient's transfer to a nursing home.

For the reasons stated below, in my view current law provides adequate means to ensure that a ward's code status is consistent with his or her current medical condition.

I

Background

When a 63 year-old ward of the BCDSS was hospitalized in April 2007, two physicians determined that CPR and intubation would constitute medically ineffective treatment for her. After the necessary certifications were made, the attending physician informed the Adult Protective Services ("APS") case manager of the finding and provided copies of the certifications. However, unknown to any APS personnel, the attending hospital physician also completed an EMS/DNR order. Upon the patient's discharge from the hospital, the EMS/DNR order accompanied her to a local nursing home and became a part of her medical record there.

Recently, nursing home staff questioned the APS case manager about the code status for this ward. Confusion then arose because the APS social worker responded by saying that the patient was "full code," while nursing home staff, aware of the EMS/DNR order, relied on this document to consider the patient a "DNR/DNI." This particular case was readily resolved in a conference call with the nursing home's medical director, for it turned out that the hospital attending physician had completed the form incorrectly (stating that "no CPR" status was established with the consent of the guardian, which was not the case). The EMS/DNR order was rescinded, and the patient was made a full code.

Although this case has been resolved, you view it as raising concerns about the "portability" of an EMS/DNR order established on a finding of "medically ineffective treatment" and therefore without consent by a guardian or other surrogate.[1] Nothing on the form indicates that the physician must give notice of the order to the surrogate. Moreover, you are concerned that a nursing home to which the patient is transferred might believe that the code status documented in the order must be subsequently followed without regard to the current medical status of the patient. Most wards of the BCDSS are relatively young. Their medical conditions can improve dramatically. In the case that resulted in this inquiry, for example, sufficient improvement occurred to cause the nursing home's medical director to conclude that the ward was appropriate for full-code status. You suggest that guardians might be better able to carry out their obligations to wards if the Health Care Decisions Act were amended to require (1) a physician to give notice that an EMS/DNR order had been completed and (2) in the case of an EMS/DNR order based on "medically ineffective treatment," periodic review of the physical condition of the patient.

II

Medically Ineffective CPR

A. Hospital Physician's Initial DNR Order

For some patients, CPR meets the definition of "medically ineffective treatment" in § 5-601(n), because cardiac arrest "represents the start of an inexorable dying process that cannot be prevented by CPR." 79 Op. Att'y Gen. 218, 235 (1994). The attending physician

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[1] Given the facts of the case resulting in your inquiry, typical of cases in which a certification of medical ineffectiveness is made, I shall take as a premise that the patient lacks capacity. I shall also assume that no health care agent was named or is available. Hence, this letter will refer only to a surrogate and particularly to a guardian of the person, the surrogate with the highest statutory priority. Health-General § 5-605(a)(2). All statutory references in this letter are to the Health-General Article, Maryland Code.

need not offer medically ineffective CPR. § 5-611(b)(1). *See* advice letter to Janicemarie Vinicky (December 16, 1999).[2]

Given the nearly universal practice that CPR is attempted unless an order to the contrary is on the chart, certification of medically ineffective CPR should result in the simultaneous issuance of a DNR order. The form of this order – whether specific to the hospital or a standard EMS/DNR order[3] – depends on hospital policy or procedures.

Neither a certification that CPR is medically ineffective nor the implementing DNR order, in whatever format, is immutable. If a patient's condition improves to the point that a cardiac arrest would no longer signal the start of an inexorable dying process, the certification will have become invalid, and the attending physician is responsible for voiding it. Just as any other medical order is to be revisited if the patient's condition changes in a material way, so the initial DNR order is to be reviewed. Under these changed circumstances, the attending physician is responsible for conducting an informed consent process about the use of CPR. The patient might remain a "no code," but only as a result of the surrogate's decision, applying the criteria in §§ 5-605(c) and 5-606(b) and, if the surrogate is a guardian, with appropriate court authorization.

B. Surrogate's Awareness of Initial DNR Order

An attending physician who has certified attempted CPR as medically ineffective must inform the surrogate "of the physician's decision." § 5-611(b)(2). In my view, "the physician's decision" includes not only notification about the certification itself but also the steps that the physician will take in consequence of the certification – what will and will not be done. In this way, the surrogate will learn about the DNR order and have an opportunity to ask questions or to see the order itself.

If the surrogate is a guardian, moreover, current law obliges the guardian to request a copy of both the certification and the DNR order. As explained by Attorney General Curran, the responsibility of a guardian to the court means that the guardian (for BCDSS, the Director acting through the APS case manager) should provide the court with a copy of both.

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[2] This advice letter elaborates on the criteria for certification that attempted CPR is medically ineffective. Except in an emergency department staffed by only one physician, the concurrence of a second physician is required. The letter is available at the following URL: http://www.oag.state.md.us/Healthpol/dnrauth.pdf

[3] By "standard EMS/DNR order," I mean one that conforms to the requirements adopted by the Maryland Institute for Emergency Medical Services Systems pursuant to § 5-608(a).

79 Op. Att'y Gen. at 236-37. Therefore, if the attending physician has written an EMS/DNR order to implement the certification of medical ineffectiveness, the guardian will become aware of it.

C. EMS/DNR Order on Transfer

Your inquiry focuses on a patient who, based on a determination of CPR's medical ineffectiveness, was a "no code" during a hospital stay and who was transferred to a nursing home with the hospital physician's EMS/DNR order. In general, this practice is entirely proper. If, after assessing the patient's condition prior to discharge, the physician views the prior certification as still valid – that is, attempted CPR is still deemed medically ineffective – having an EMS/DNR order in place effectively communicates the physician's judgment. On the other hand, suppose that the physician does not consider whether, given the patient's current condition, attempted CPR remains medically ineffective. Instead, the physician signs the EMS/DNR hurriedly as one in a sheaf of discharge papers. It is unlikely that the surrogate, even a guardian, will know of such a last-minute EMS/DNR order. This latter scenario is, unfortunately, realistic and, if there were no further check, could result in a serious medical error.

As you point out, under an amendment effective October 1, 2007, an EMS/DNR order has a direct impact across care sites. A health care provider who sees an apparently valid EMS/DNR order "*shall*, after a patient's cardiac or respiratory arrest, withhold or withdraw treatment in accordance with" the order. § 5-608(a)(3)(ii). You are concerned that this provision might have the effect of extending indefinitely an ill-considered EMS/DNR order.

In my view, however, several safeguards protect against a nursing home's rote compliance with an outmoded EMS/DNR order. The EMS/DNR order statute itself requires compliance only if the EMS/DNR order has not been "superseded by a subsequent physician's order." § 5-608(a)(3). This provision dovetails with regulatory provisions aimed at ensuring timely, skillful assessment of a newly admitted nursing home resident. These regulations in part require analysis of "a resident's current status, recent history, and medications and treatments, to enable safe, effective continuing care and appropriate regulatory compliance" and "admission orders in a timely manner ... to enable the nursing facility to provide safe, appropriate, and timely care." COMAR 10.07.02.10A. *See also* COMAR 10.07.02.10H(1) (timely medical orders by attending physician). Regulatory compliance should lead to prompt identification of a discrepancy between the patient's improved condition and an EMS/DNR order based on medical ineffectiveness (or, for that matter, an EMS/DNR order based on the surrogate's prior consent but now needing review because of the patient's improvement). If the EMS/DNR order is outmoded, the attending

physician should issue a new order related to code status. That would immediately supersede the prior order.

In addition, compliance with the Act's provision on a form about current life-sustaining treatment issues should bring such a discrepancy quickly to light. Under § 19-344(f)(5)(i), a nursing home must "offer a resident, upon admission, the opportunity for the preparation of an 'Instructions on Current Life-Sustaining Treatment Options' form."[4] This "opportunity" is to be offered to a surrogate on behalf of an incapacitated resident. Because attempted CPR is always one of the treatments to be discussed, current law provides a mechanism by which the guardian or other surrogate will promptly find out about any EMS/DNR order in place and, if the patient's changed condition warrants it, reexamine the patient's code status.

III

Conclusion

In my view, if current law is carried out properly, a surrogate will be informed of the entry of a DNR order related to a certification that CPR is medically ineffective; a guardian, including a public guardian, will obtain a copy of the order; the attending physician will take steps to change the order if the patient's condition improves materially; and an EMS/DNR order will be reviewed soon after a patient's admission to a nursing home, as part of both the assessment process and discussion with the surrogate about current life-sustaining treatment issues. Given these safeguards, I do not see the need for a change in the law.

Sincerely yours,

Jack Schwartz
Assistant Attorney General and
Director, Health Policy Development

cc: Jeffrey Dier, Esq.

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[4] Until a 2007 amendment, this form was termed the "Patient's Plan of Care" form. The old forms remain in use until the Attorney General's Office completes the rulemaking process required by the Administrative Procedure Act.