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Dear Jan:

Following up on the interesting meeting a few weeks ago at Harbor Hospital, you asked me to summarize how the Health Care Decisions Act applies to a physician=s order that cardiopulmonary resuscitation not be attempted in the event of cardiac arrest (here called a ADNAR order@).

I
DNAR Orders B Carrying Out Another=s Decision or Independently Issued

Often, a physician enters a DNAR order because someone else with legal authority to make decisions about end-of-life care B the patient or a legally authorized proxy[1] B has decided against attempted CPR. Unquestionably, a physician may issue

[1] In this advice letter, I use the term Aauthorized proxy@ to encompass a health care agent, surrogate decision maker, or guardian.

medical orders, including a DNAR order, so as to implement a plan for end-of-life care that is legally valid under the Act or Maryland common law. You are not asking about this situation, so I will omit a discussion of many of the Act=s requirements and restrictions (for example, that an order to forgo life-sustaining treatments based on a decisional advance directive or a surrogate=s decision must be accompanied by a certification that the patient is in one of three qualifying conditions).[2]

Rather, you have asked that I address a different issue of legal authority: If there is neither an advance directive to implement nor consent from the patient or authorized proxy, under what circumstances may the attending physician enter a DNAR order? Moreover, are there circumstances in which the attending physician may enter a DNAR order despite the objection of the patient or an authorized proxy?

II
Legal Framework for Physician=s Independent Decision-making

A. Physician=s Independent Authority

Although most of the Health Care Decisions Act concerns advance directives and decision-making by authorized proxies, the Act also sets out two circumstances in which a physician may decline Ato prescribe or render medical treatment to a patient.@ One is when a physician determines the treatment A to be ethically inappropriate.@'5-611(a) of the Health-General (AHG@) Article; the term Aethically inappropriate@ is not defined.

The other is when a physician determines the treatment Ato [be] medically ineffective.@ HG '5-611(b)(1). A Amedically ineffective treatment@ is one that, Ato a reasonable degree of medical certainty,@ will neither A prevent or reduce the deterioration of the health of an individual@ nor Aprevent the impending death of an individual.@ HG '5-601(n). If a medical procedure would improve or maintain the

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[2] An explanation of the relevant law may be found in *Wright v. Johns Hopkins Health Sys. Corp.*, 353 Md. 568 (1999), and 79 *Opinions of the Attorney General* ___ (1994) [Opinion No. 94-023 (May 3, 1994)].

patient=s quality of life or avert a dying process, it should not be deemed Amedically ineffective.@[3]

[3] In the case of A a treatment that under generally accepted medical practices is life-sustaining in nature,@ and except in an emergency department with only one available physician, a second physician must concur with the attending physician=s judgment that the procedure is Amedically ineffective.@ '5-611(b)(2).

B. Clinical Judgment

The Amedically ineffective treatment@ provision in the Health Care Decisions Act calls on physicians to make predictive clinical judgments with legal consequences: whether, Ato a reasonable degree of medical certainty,@ a treatment will not prevent A impending@ death. Doubtless many physicians would be comforted if the law itself answered key questions like the exact degree of probability required or the precise time frame within which death may be characterized as Aimpending.@ For better or worse, however, the law does not do so.

The phrase Ato a reasonable degree of medical certainty@ is used by legislators and courts to signify that the physician=s assessment of probability should be objectively based, not a mere hunch, and that the probability of an outcome should be markedly greater than the probability of any other outcome.[4] While there is no basis in current law for my settling on an exact numerical equivalent of Areasonable certainty,@ I can say that the probability of an event need not be 100 percent to meet the test; the fact that very long-odds events sometimes occur would be paralyzing if it were not immaterial.

With regard to the term Aimpending,@ neither the case law nor the dictionary allows any explication other than equally imprecise synonyms, like Aabout to take place.@ The Legislature has given physicians the privilege and burden of discretion in deciding when death is so near as to be called A impending.@ The Legislature=s judgment would be subverted if subsequent legal guidance, like this letter, purported to limit that discretion to some arbitrarily chosen number of hours or days.[5] Therefore, I cannot do so.

C. Absence of Consent, Objection

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[4] This phrasing is drawn from a recent medical malpractice case in the District of Columbia and is consistent with other cases. *Robinson v. Group Health Ass=n, Inc.*, 691 A.2d 1147, 1150 (D.C. 1997).

[5] The Medicare hospice regulation, widely deemed to be overly rigid and insensitive to many patients= needs because of its requirement of a prognosis of death within six months, illustrates the unhappy results when the law requires physicians to make unrealistically precise prognostic judgments.

A physician=s determination that a procedure is not to be performed, because to perform it would be Aethically inappropriate@ or Amedically ineffective,@does not require consent. In fact, asking consent to refrain from performing an ethically inappropriate or medically ineffective procedure seems antithetical to the physician=s own moral agency and professional standing.

It is foreseeable, however, that in some situations a patient or authorized proxy will insist on a procedure that the physician has judged to be ethically inappropriate or medically ineffective. The Act does not require the physician to provide the procedure simply because of another=s insistence. Rather, in this or any other situation in which Aa health care provider intends not to comply with@ a patient=s or authorized proxy=s instruction, the provider is to inform the person giving the instruction of the refusal and make the person aware of the opportunity to Arequest a transfer to another health care provider.@ HG '5-613(a). Pending a requested transfer, the health care provider is legally required to comply with the instruction only Aif a failure to comply with the instruction would likely result in the death of the individual.@

III
Life-Sustaining Procedures and the Trajectory of Fatal Illness

CPR is expressly included within the Act=s definition of Alife-sustaining procedures.@ HG '5-601(m)(2). Therefore, a physician may certify it to be Amedically ineffective@ for a patient only if that conclusion is warranted by the patient=s clinical situation **B** in particular, only if, as to that patient, CPR would not prevent the patient=s impending death. HG '5-601(n)(2).[6] While I recognize that a patient=s clinical situation might defy easy categorization, the analysis of when CPR may be considered Amedically ineffective@ can be linked to two distinct phases in the trajectory of chronic disease:

$ *living despite a fatal illness*, in which the patient has an illness that will

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[6] CPR is not a procedure related to quality of life; hence, the first part of the definition of Amedically ineffective treatment@ is irrelevant.

predictably cause the patient=s death but for which interventions can be still offered with a meaningful chance of prolonging the patient=s life, as contrasted with

$ *actively dying*, in which interventions cannot reverse a decline that will soon end in death (for a hospitalized patient, for example, during the current hospital stay).

In either situation, of course, therapies that improve or maintain the patient=s quality of life are not Amedically ineffective@; I am referring here only to interventions intended to stop a dying process.

When a patient is in the phase that I have termed Aliving despite a fatal illness,@ decisions about the balance between efforts at prolonging life and palliation B how much burden the patient is to bear for a chance at postponing death B are for the patient or authorized proxy. Although these decisions can be crucially affected by the physician=s assessment of prognosis, they are ultimately based on the patient=s values and priorities. In this situation, neither the Health Care Decisions Act nor common law authorizes the physician to act as an independent decision maker. If the patient has not crossed the threshold from gravely ill to actively dying B that is, death is not yet A impending@ B then life-sustaining procedures are not medically ineffective.

The physician can and should play a key role in the decision-making process: by explaining the situation in a way that is meaningful to the decision maker and by clarifying the choices that are medically reasonable. Indeed, the physician can often help lift a heavy psychological burden from a weary patient or family member by making a recommendation about a plan of care. Nevertheless, in this situation, medical interventions aimed at prolonging life are not A medically ineffective,@ even if the physician deems them unwise.[7]

When the patient is in the phase that I have termed Aactively dying,@ the course of the disease has foreclosed the goal of seeking to prevent impending death. If,

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[7] The same conclusion applies to a patient in a persistent vegetative state, although this condition does not really fit within the chronic disease model set out in the text.

because of multiple organ system failure or other situation beyond medical management, impending death most likely cannot be prevented, then any procedure with the purpose of preventing death can properly be regarded as A medically ineffective.@

IV
DNAR Orders and the Physician=s Authority

A. Physician Entry of DNAR Orders

The preceding analysis of the legal and clinical background leads me to the following conclusions about DNAR orders in facilities that, as a matter of policy, require CPR to be attempted unless a DNAR order is on a patient=s chart:[8]

1. Consent should always be obtained for a DNAR order if the patient is living despite a fatal illness *and* CPR has a meaningful chance of restoring the patient to that situation B that is, successful CPR would leave the patient once again living despite a fatal illness. CPR could not properly be certified as medically ineffective.

2. Consent need not be obtained for a DNAR order if the patient is living despite a fatal illness *but*, if the patient suffered cardiac arrest, CPR would have no meaningful chance of restoring the patient to that situation B that is, even successful CPR would leave the patient actively dying. In other words, if, in the clinical judgment of the attending physician (with another physician=s concurrence), cardiac arrest would signal the start of active dying, then CPR could be certified as medically ineffective. Therefore, the attending physician may enter a DNAR order on his or her own authority.

3. Consent need not be obtained for a DNAR order if the patient is already actively dying. CPR, even if it temporarily restored circulation, would not change that fact and, hence, could be certified by the attending physician (with another physician=s

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[8] This kind of institutional policy, while certainly commonplace, is not mandated by the Health Care Decisions Act. A discussion of alternative policies, however, is beyond the scope of this letter.

concurrence) as medically ineffective. Therefore, the attending physician may enter a DNAR order on his or her own authority.

B. Insistence on Attempted CPR

What is the legal situation if the attending physician has entered a DNAR order but the patient or authorized proxy insists that CPR be attempted in the event of cardiac arrest? In my view, if the DNAR order is entered in the first scenario sketched above, the order must be withdrawn and CPR attempted. If, however, the DNAR order is entered in the second or third scenario, the order need not be withdrawn. My reasons are as follows:

As discussed in Part II above, in only one circumstance must a health care provider who has declined to comply with a patient=s or authorized proxy=s instruction nevertheless comply with the instruction: pending transfer, Aif a failure to comply ... would likely result in the death of the individual.@ '5-613(a)(3). This provision calls for an assessment of the relationship of the instruction to the dying process: the failure to comply with an instruction could result in the death of the patient only if following the instruction would present a reasonable chance of prolonging the life of the patient.

In the first scenario sketched above, in which the patient is living with a fatal illness and therefore CPR is not medically ineffective, suppose the attending physician decided, for some personal reason, that to perform CPR would be A ethically inappropriate@ and entered a DNAR order over the objection of the patient or authorized proxy. In this situation, by hypothesis, if the patient suffered a cardiac arrest, CPR would stand a reasonable chance of restoring circulation, averting impending death, and returning the patient to the prior status. Consequently, the refusal to comply with an instruction to perform CPR, should the patient arrest, would likely result in the patient=s death. Pending transfer, CPR must be attempted if the patient were to suffer an arrest.[9]

In the second and third scenarios, however, the attending physician=s failure to

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[9] The analysis and conclusion would be the same if the patient were in a persistent vegetative state. For a discussion of this aspect of the issue, see Opinion No. 94-023, at 14.

comply with an instruction that CPR be attempted would *not* Alikely result in the death of the individual.@ By hypothesis, the post-arrest patient is actively dying and remains so whether or not CPR is attempted. It is the inevitable end of the disease process, rather than the physician=s decision not to comply with an instruction that medically ineffective CPR be attempted, which will result in the death of the patient.[10] Therefore, the Act does not require CPR to be attempted despite the physician=s DNAR order.

This discussion of the physician=s authority ends with a legal conclusion, not a clinical or ethical one, and therefore does not address all aspects of a most sensitive and challenging problem: how providers might best respond to an anguished family=s insistence on medically ineffective CPR. Nevertheless, I hope that this letter is a helpful response to your request. Please let me know if I may be of further assistance.

Very truly yours,

Jack Schwartz
Assistant Attorney General
Director, Health Policy Development

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[10] The patient or authorized proxy is free to replace the attending physician if another can be found who takes a different view about the relationship between CPR and the dying process.