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E-MAIL

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Evan G. DeRenzo, Ph.D.
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Dear Evan:

You have requested my advice about the application of Maryland's law on health care decisionmaking to the facts of a case in a Maryland hospital. You are especially interested in whether, given these facts, the entry of a "do not resuscitate/do not intubate" order ("DNR/DNI order") was legally prohibited. I conclude that, although the DNR/DNI order was not authorized by the Health Care Decisions Act, the physician who gave the order is not subject to liability under the Act. Moreover, I consider it highly unlikely that the physician would be subject to tort liability for the action.

A. The Case

The essential facts of the case, as you outline them, are as follows: The patient was an 87 year old man who had been declining over a period of several months. For the last six weeks, he had been bed-bound with lumbar compression fractures. Over a two-week period, his use of opioid analgesics had increased markedly to treat unremitting back pain. He was admitted to the intensive care unit with hypotension (abnormally low blood pressure), hypoxemia (inadequate oxygen in the blood), and septicemia (toxic microorganisms in the blood stream), all against the background of long-standing and severe coronary artery disease. Although the patient was not acutely terminal, the attending ICU physician believed that he was in an end-stage condition.

The patient was stuporous and lacked capacity to make his own decisions, and there was no reasonable expectation that he would regain capacity. The physician discussed the patient's condition with his wife and adult daughter. Both the wife and daughter believed that the patient would not want to prolong his life by any form of artificial life support, even if aggressive intervention might allow him to survive this episode, because he would likely be more deteriorated than he was at present. Consequently, the attending ICU physician wrote a DNR/DNI order.

When the ICU attending conveyed this information to the community attending physician, the ICU attending was told that he could not write such an order on the basis of his conversation with the wife and daughter, because it was "illegal." Presumably, the community attending's comment was based on the recognition that entry of the DNR/DNI order had not been preceded by the two-physician certification called for under the Health Care Decisions Act.

B. General Observations

The community attending's comment – that the DNR/DNI order was "illegal" – illustrates a common misunderstanding. As clinicians have become increasingly familiar with the Health Care Decisions Act, some have come to assume that the Act is the legal alpha and omega on decisionmaking near the end of life. This assumption is incorrect. While the Act is surely the primary source for the legal ground rules that apply to this kind of decisionmaking, the Act itself, in § 5-616(a) of the Health-General Article, recognizes that it is not necessarily the last word:

> The provisions of this subtitle are cumulative with existing law regarding an individual's right to consent or refuse to consent to medical treatment and do not impair any existing rights or responsibilities which a health care provider, a patient, including a minor or incompetent patient, or a patient's family may have in regard to the provision, withholding, or withdrawal of life-sustaining procedures under the common law or statutes of the State.

One of the "responsibilities" of a health care provider under the common law is to conform to the applicable standard of care. A failure to do so is malpractice. At least with respect to issues of consent, a physician's compliance with all elements of the Health Care Decisions Act is conclusive proof of conformity to the standard of care. Indeed, compliance with the Act gives the physician the protection of immunity. The converse does not follow, however: Noncompliance with the Health Care Decisions Act is *not* conclusive proof of a breach of the standard of care. As in this case, withholding or withdrawing life-sustaining procedures after a failure to meet the Act's documentation requirements, while inevitably leading to the loss of the immunity afforded under the Act, is not necessarily malpractice.

C. Specific Analysis

I shall assume that the patient in the case met the *substantive* standards of the Health Care Decisions Act, set out in § 5-601(i), for a finding of "end-stage condition." That is, the patient had an advanced, progressive, and irreversible condition. Any treatment of the underlying condition would have been medically ineffective. Moreover, the condition had progressed to the point of causing severe and permanent deterioration, marked by the patient's incapacity and inability to perform activities of daily living independently.[1]

As the case is presented, however, the Act's *procedural* requirements were not met for certifying the patient to be in an end-stage condition. Certification of condition requires not only the assessment of the attending physician, which occurred here, but also the concurrence of a consulting physician, which did not. § 5-606(b). Consequently, because the patient was not certified to be in end-stage (or terminal) condition, the health care provider "may not withhold or withdraw life-sustaining procedures ... on the basis of the authorization of a surrogate ...." § 5-606(b). A surrogate is someone identified in § 5-605 of the Act who "may make decisions about health care for a person who has been certified to be incapable of making an informed decision and who has not appointed a health care agent ...." There is no indication from the facts that the patient's incapacity, albeit clinically evident, was certified.[2]

In short, entry of the DNR/DNI order was outside the scope of the Act. With the Act's certification left undone, the withholding of life-sustaining procedures was not accomplished "on the basis of the authorization of a surrogate." The health care provider may not lay claim to the immunity from suit afforded by § 5-609(a) of the Act, for the withholding was not "under authorization obtained in accordance with this subtitle."

The loss of immunity, however, is not tantamount to liability. The Act itself imposes no liability on a provider who, despite the lack of certification, carries out a spouse's decision against CPR and intubation for a gravely ill patient.[3] If liability were to exist, the basis for it would be a breach of the standard of care.

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[1]The criteria for "end-stage condition" are discussed in detail in 78 Op. Att'y Gen. 208 (1993). This letter does not address potential liability issues if a physician were to carry out a surrogate's instruction to forgo life-sustaining medical treatment when a patient is deemed by the attending physician *not* to be in an end-stage or terminal condition or in a persistent vegetative state. See note 3 below.

[2]The Act contains a separate, two-physician certification requirement for the patient's incapacity. § 5-606(a). Because the definition of "end-stage condition" itself incorporates the element of incapacity, however, a patient who is certified to be in an end-stage condition need not have a separate certification of incapacity.

[3]If a decision by a health care agent or surrogate to forgo life-sustaining procedures is believed by the provider to be "inconsistent with generally accepted standards of patient care," the provider must either

A hypothetical plaintiff (surely not the family members on the scene, who sought the DNR/DNI order) would have to prove that the patient was harmed by the failure to attempt CPR or to intubate and that the harm was caused by the physician's negligence – in other words, that the standard of care for a patient in this condition, and with close family members seeking a palliative care approach, is nevertheless to attempt CPR and to intubate. It is difficult to imagine how, under these circumstances, a plaintiff could prevail.

D. Conclusion

Health care providers involved in decisions about the use of life-sustaining procedures should adhere to both the substantive standards and the procedural safeguards of the Health Care Decisions Act. This is so, primarily, because the Act reflects the community's view, adopted by their elected representatives, about appropriate standards and safeguards. Providers also benefit from the immunity afforded by the Act to those who comply with it in good faith. Health care facilities should examine their systems to make it as easy as possible for the required documentation to be done.

If a decision is carried out outside the Act, however, the decision is not perforce illegal. Whether such a decision could lead to tort liability (or, in some circumstances, sanctions from a licensing board) depends on the applicable liability standards, actual harm to the patient, and other factors. The fact of noncompliance with the Health Care Decisions Act, although ordinarily admissible in evidence, is not itself controlling.

I hope that this letter of advice, although not to be considered 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

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petition the facility's patient care advisory committee for its advice or bring the matter to court. § 5-612. Plainly, the attending physician had no such belief about the wife's decision in this case.