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Legal Guardians’ Authority to Consent to Do-Not-Resuscitate Orders

With longer life spans comes the concern of maintaining medically compromised people indefinitely, with a questionable quality of life. Hard questions need to be asked: When should older, frailer people be resuscitated? Who should determine when not to resuscitate, and how? This article examines the legal, ethical, and social ramifications of our professional and personal choices.

By Robert J. Best

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This article will examine do-not-resuscitate (DNR) orders as applied to the older adult population. We will look at recent statutory and case law related to the authority of surrogate decision makers, particularly guardians, with regard to withholding cardiopulmonary resuscitation from an older person who is not able to give informed consent. From this background, we will offer a framework in which guardians can make this determination consistent with current legal, ethical, and social considerations.

Background

In recent years, a great deal of attention has been given to the topic of life-sustaining treatment. Three significant developments in the delivery of health care have contributed to this heightened awareness: (1) the increase in the number and types of life-sustaining technologies, (2) changing perceptions of the role of the patient in treatment decisions, and (3) an expanded view of the responsibilities of health care facilities. In addition, the advances in medical technology and health practices have contributed to longer life spans and a resultant dramatic increase in the number of people over 65 years of age, particularly in the over-85 age group. It sometimes seems that very frail, medically compromised persons can be maintained indefinitely, with a questionable quality of life. Many people, professionals and lay people alike, have begun to question when the use of life-sustaining treatment is appropriate and who should make that decision.

Cardiopulmonary resuscitation (CPR) is unique among life-sustaining technologies. In order to be effective, it requires rapid initiation. Consequently,
there is no time to discuss treatment options with the patient, responsible parties, or the professional team. The introduction of mouth-to-mouth ventilation and external cardiac massage in the late 1950s revolutionized the provision of emergency care in instances of sudden death. Health care facilities adapted and developed elaborate procedures and equipment to enable this new emergency medical technique. Organizations like the American Heart Association and the American Red Cross initiated efforts to mobilize citizens to learn and provide CPR. The overwhelming support for this form of life support, and the unique urgency mentioned above, led to a National Conference proposal that CPR be initiated without a formal order from the attending physician. This presumption in favor of CPR became widely accepted. CPR has been very effective, in many cases, in maintaining life after a sudden-death incident and enabling individuals to return to their previous lifestyle. Without CPR, many of these people would have died prematurely.

Should CPR be administered to every patient who experiences cessation of heartbeat, breathing, or both? Mark Siegler provides strong commentary on this point: “This approach—equal CPR for all regardless of medical condition or patient preference—is indefensible, counterintuitive, and unethical, and would signal the ultimate transformation of medicine from an art based upon clinical discretion into an unthinking, unfeeling bureaucratic system.”

CPR was originally intended as a means to resuscitate otherwise healthy people whose heartbeat and/or breathing had failed. But, as noted above, the presumption in favor of CPR has been, to some extent, viewed as a universal principle. Only more recently have certain questions begun to arise about CPR, particularly as it relates to a frail elderly population. A study of the outcomes of CPR initiated on persons over 65 was conducted by the Department of Medicine at Johns Hopkins University. The study reviewed outcomes for both residents and nonresidents of nursing homes. According to the authors:

This study demonstrates that for patients in whom CPR was initiated in a nursing home, the benefits were extremely limited. Of 115 patients undergoing CPR, 102 were pronounced dead in the emergency room and two more died within 24 hours of admission to the hospital. Nine were admitted for an average stay of five days before dying at the hospital. . . . Two residents returned to the nursing home: one for two weeks and one, in a very debilitated state, for eight months.

The study found better outcomes for older people who were not residents of nursing homes (and presumably less frail and perhaps somewhat younger). Nevertheless, it raises significant questions about the benefits of CPR for older people.

Who Should Decide?

While it is clear that CPR can be beneficial for many people, it is also clear that in some instances it only serves to prolong dying and perhaps suffering. As suggested above, the presumption in favor of CPR made standing orders for CPR a general rule in health care facilities and in emergency medical response. Consequently, it became necessary to develop do-not-resuscitate (DNR) orders for patients who are not to receive CPR. Again, because of the urgency of CPR treatment, these orders must be provided in advance of the need for treatment. But who should decide whether or not CPR should be performed? The consensus paper of the 1974 National Conference on Cardiopulmonary Resuscitation indicates that “the physician has an obligation to initiate CPR in any situation where it is medically indicated.” The paper goes on to say that in the absence of medical indications, the physician should judiciously see that CPR is not given. This statement seems to give a great deal of authority to the physician. It would seem that the physician is most qualified and in the best position to make a determination of the efficacy of CPR for a particular patient. However, this view of medically indicated CPR does not give reference to patients’ preferences. There is a great deal of evidence to indicate that physicians frequently make critical life-support decisions, particularly those relating to resuscitation, without adequate participation from patients.

The paternalistic view of medicine suggests that patients lack the knowledge and expertise to make sound decisions regarding CPR. At the same time, the patient’s right to refuse medical care, such as CPR, is widely acknowledged. In his comparison of the In re Quinlan and Belchertown State School v. Saikewicz cases, George Annas states: “Both courts enunciate a constitutional right to refuse life-sustaining treatment, based on the right to privacy.” The
implementation of the Patient Self-Determination Act in 1991 seemed to strengthen the case for the right of patients to decide for themselves.

It is possible to reconcile the decision-making authority of the patient and physician. As Mark Seigler puts it: “It is the physician’s responsibility to decide which patients can possibly be treated with which medical techniques, and it is the joint responsibility of the physician and the patient to decide which should be so treated.” He continues by offering two “ethical grounds” for making a decision not to resuscitate a patient: (1) based on sound medical judgment that the patient’s death from primary disease is imminent and that further treatment for the primary disease is futile, or (2) following the stated preference of an “autonomous, self-determining, competent adult.”

There seems to be strong ethical, legal, and societal support for the idea that a competent adult, in consultation with his or her physician, has the right to decide to withhold CPR.

Patients Without the Capacity to Make Health Care Decisions

The issue of DNR orders becomes significantly more complicated when applied to persons who are incompetent or incapacitated. The capacity to make informed decisions is a critical and disputed concept with regard to planning for the elective use of life-sustaining treatment. According to Wisconsin statutes,

“Incompetent” means a person adjudged by a court of record to be substantially incapable of managing his or her property or caring for himself or herself by reason of infirmities of aging, developmental disabilities, or other like incapacities.

“Incapacity” means the inability to receive and evaluate information effectively or to communicate decisions to such an extent that the individual lacks the capacity to manage his or her health care decisions.

When people are incompetent or incapacitated, do they forfeit the right to refuse life-sustaining treatment? Citing the decision of the courts with regard to Quinlan and Saikewicz, George Annas suggests that they do not: “Incompetents should be afforded the opportunity to exercise this right [to refuse life-sustaining treatment].” But how does one exercise this right when he or she lacks competence and/or capacity?

In the recent past, the decision was often made by the physician. Physicians frequently take it upon themselves to be surrogate decision makers for incompetent patients, even when family members are available and qualified to play that role. One physician argues that when an incompetent patient has not already expressed his wishes, the physician should assume the responsibility for the decision and then explain to family members why resuscitation will not be attempted, rather than to ask them whether or not it should be attempted.

This idea is contrary to the concept of patient self-determination. An alternative would be to seek the advice of family members and close friends. Input from family and significant others may be ethically important for two reasons:

First, they may (but not necessarily) reflect the personal preferences of the patient who is unable to express them. Second, the common practice of turning to family members acknowledges that we exist in communities of concern and that those who care most about us ought to have a special moral authority to assist in making decisions about us when we are no longer able to do so for ourselves.

Ethical issues notwithstanding, “family members [and friends] have no legal authority to make decisions on behalf of patients unable to make decisions for themselves, unless they have been granted such powers by a judge or a legislative statute.” For this reason, health care professionals are increasingly expected to look to legally authorized surrogate decision makers, namely the holders of powers of attorney for health care or legal guardians. Most health care facility protocols require the use of legally appointed surrogates for decisions to forgo life-sustaining treatment, especially when family members are not available or are divided about the course of action.

Surrogate Decision Making with Respect to Forgoing Life-Sustaining Treatment

The authority of surrogate decision makers with regard to life-sustaining treatment has been the subject of several court decisions in recent years. Three significant developments have been influential in this regard:
1) There is a growing recognition of the right of an appropriate surrogate to refuse life-sustaining treatment or care for an incompetent, even in the absence of an advance directive authorizing refusal.

2) Courts are rejecting the view that forgoing the use of sophisticated life-sustaining devices such as respirators is sometimes permissible but that withholding other procedures such as artificial feeding is never permissible. They seem to be moving toward acceptance of the fact that any sort of life support may sometimes justifiably be withheld or withdrawn.

3) Courts are showing an increasing awareness that substituted judgment is an . . . appropriate guidance principle for incompetents who previously were competent, not for all incompetents.23

These developments paved the way for numerous state statutes related to the authority of a surrogate to consent to a DNR order. Georgia, Illinois, Montana, New Jersey, and New York are among the first states to enact such legislation. Statutes vary somewhat from state to state; however, the general provisions are similar. Each statute provides that an appropriately authorized person may consent to a DNR order for an adult candidate for nonresuscitation.21 Each state may have slightly different definitions of an “appropriately authorized individual.” They also define the circumstances under which a surrogate could authorize the issuance of a DNR order. Below are the circumstances as defined in New York statutes. The language in other state statutes varies somewhat, but the intent is essentially the same:

1. The patient is in a terminal condition (reasonably expected to cause death within one year).
2. The patient is permanently unconscious.
3. Resuscitation would be medically futile.
4. Resuscitation would impose an extraordinary burden on the patient in light of the patient’s medical condition and the expected outcome of resuscitation on the patient.24

These statutes were followed by a proliferation of health care proxy statutes. Like the Wisconsin power of attorney for health care statutes, these health care proxies are appointed by patients before they become incapacitated. The health care proxy is given the same authority with respect to DNR orders as the patient would have if the patient were capable to act. Consequently, the agent is given “broader authority than the surrogate appointed pursuant to the DNR statutes who . . . may only consent to a DNR order under certain circumstances.”25

Most states now allow for the appointment of a legally authorized surrogate decision maker. This person, called a health care agent, power of attorney, proxy, surrogate, or some other title, is chosen by the patient while capacitated. This surrogate is authorized to make health care decisions on behalf of the patient when the patient is no longer able to do so, based on the previously expressed wishes of the patient. However, if the patient has not previously designated a health care surrogate, that person is not able to do so after he or she becomes incapacitated. It then becomes necessary to petition for a court-appointed guardian (of the person) to consent to health care treatment.

The Authority of Guardians

Like a health care proxy, a guardian of the person is considered to have the power to consent to medical treatment for the benefit of the ward. “The guardian does not have the authority, however, to consent to medical care that does not serve the ward’s interest.”26 So, does a guardian have authority to consent to a DNR order for a ward? To determine the answer, we need to look at the issue from several different angles. The first issue has to do with a distinction between previously competent and never-competent persons.

A previously competent patient may have indicated preferences regarding CPR before becoming incapacitated. “If these ward’s wishes are known, it is considered to be in the ward’s best interest that these wishes be followed, and the guardian has the authority to follow those wishes if they are clear.”27 This is consistent with the standard of “best interest.” The Supreme Court in regard to the Cruzan v. Missouri Dept. of Health case concluded that states may require clear and convincing evidence of a ward’s previously expressed wishes before allowing a guardian to authorize removal of artificial nutrition or hydration.28 It then becomes an issue of what constitutes “clear and convincing” evidence. If the ward had not previously made expressions related specifically to CPR, it may still be possible for the guardian to use substituted judgment “if the
ward's wishes can be reasonably inferred from his or her past conduct."

The guardian should consider the ward's past behavior and/or lifestyle, the ward's history, and other contexts that may reflect the ward's values. In *Quinlan*, the court approved the substituted judgment test, but found it unnecessary because it believed that almost everyone with the patient's prognosis would refuse treatment if they could. Nevertheless, *Quinlan*’s primary significance is its affirmation of the right of a legal guardian to refuse life-prolonging treatment through the exercise of substituted judgment, in the absence of a formal advance directive.

In *Severns v. Wilmington Medical Center*, both the Chancery Court and the Delaware Supreme Court "affirmed that an appropriate surrogate can refuse life-sustaining treatment through an exercise of substituted judgment."

The Delaware Supreme Court interpreted "medical supportive measures" as including the use of respirators, antibiotics, and feeding tubes. The court also stated that no order requiring CPR could be written for a patient.

A case before the Wisconsin Supreme Court has, once again, considered the standard by which the courts will judge the authority of a guardian to consent to withdrawing or withholding life-sustaining treatment from a ward. In *In the Matter of the Guardianship and Protective Placement of Edna M.F. v. Eisenberg*, the court concluded that the guardian could not consent to removal of a feeding tube because the ward was not in a persistent vegetative state and had not provided an advance directive regarding tube feedings. The court held that:

"If that person is not in a persistent vegetative state, this court has determined that, as a matter of law, it is not in the best interests of the ward to withdraw life-sustaining treatment, including a feeding tube, unless the ward has executed an advance directive or other statement clearly indicating his or her desires."

With its requirement that a guardian demonstrate "by a preponderance of evidence a clear statement of [the ward's] desires," the court seems to be seriously limiting the use of substituted judgment in such cases. Consequently, it may no longer be viable for a guardian to call upon this standard, unless the guardian can produce a significant amount of evidence of the ward's previous wishes. Does this mean that a guardian will not be able to consent to a DNR order for a ward who has not given an advance directive and is not in a persistent vegetative state?

In *Edna*, the supreme court held that it was not in the ward's best interest to withdraw a feeding tube because she was not in a persistent vegetative state and "could, therefore, likely feel the pain and discomfort of starving to death." The decision was based largely on the conclusion that the ward's best interest (to be relatively free of pain) were better served by maintaining the feeding tube. Given the volumes of literature regarding the potential negative outcomes of CPR for older people, it is likely that a guardian could make a strong case for not administering CPR. It would not be in the best interest of the ward to put him or her through the pain and discomfort of CPR. In other words, the guardian would have to depend upon a best-interest standard to consent to a DNR order.

For the patient who was never competent, substituted judgment is even less meaningful. In *Saikewicz*, the court adopted the test of substituted judgment to be applied by a probate court after an adjudicatory hearing. This was a case involving forgoing chemotherapy for a never-competent person. The court suggested that substituted judgment can only be exercised by the courts in such cases. The appropriate standard for the patient who has never been competent is the patient's best interest. Subsequent court rulings have suggested that a best-interest standard be applied in cases involving never-competent individuals. In *In re Conroy*, the New Jersey Supreme Court argued convincingly that where the patient's wishes are not or cannot be known, the appropriate question is whether life-support measures provide the patient with a balance of benefits over burdens.

Conroy and *In re Storar* both acknowledge that substituted judgment is only applicable to individuals who previously were competent. Conroy proposes a best-interest standard for cases in which a decision cannot be based on the individual's previous values and preferences. In *Storar*, the New York Supreme Court held that "the question of what the individual would choose if competent has no sense when applied to a lifelong incompetent."

How does one determine the best interest for a person who is incompetent? In virtually every case,
it is suggested that persons with disabilities will benefit from a strong presumption that their interests are essentially the same as the interests of other people. As indicated earlier, when the patient’s previous wishes are known, it is presumed to be in his or her best interest to follow those wishes. If the patient’s previous wishes are not known, or if the patient was never competent, one would normally assume that the preservation of life is in the patient’s best interest. However, there may be exceptions to this rule. According to a handbook on advising older clients for Wisconsin attorneys:

If there is no way to know what the ward would have wanted, a guardian may still consent to the withholding or withdrawal of life-sustaining treatment if the ward is in a persistent vegetative state and the guardian determines in good faith that withholding treatment is in the ward’s best interests.

This position is affirmed in In the Matter of Guardianship of L. W. The court concluded:

Where . . . there is little or no evidence of a patient’s wishes, the guardian must determine what is presently in the patient’s best interest. Unlike a substituted judgment, which necessarily involves considerations of the patient’s past wishes, values, feelings and beliefs, the best interests standard focuses solely on what is currently in the patient’s best interests.

The court provided 12 criteria to guide the guardian’s best-interest determination:

2. The wishes of the family.
3. An independent medical opinion.
4. The recommendation, if any, of a bioethics committee.
5. The chances of physical recovery.
6. The chances of mental recovery.
7. The likelihood of physical, psychological, or emotional injury as a result of providing or not providing treatment.
8. The likelihood and duration of survival without treatment.
11. The motives of those supporting withdrawal.
12. Any other factors bearing on the best interests of the ward.

The court examined the interests of the state with regard to life-sustaining treatment. These interests, as identified in Saikewicz, include: (1) preserving life, (2) safeguarding the integrity of the medical profession, (3) preventing suicide, and (4) protecting innocent third parties. The L. W. court determined that the state’s interest in preserving life “weakens as the degree of bodily intrusion increases and the chance of recovery wanes.” Similarly, the Saikewicz court found that no state interest in the continuation of life can overcome the constitutional right “to decline medical treatment in a situation of incurable illness.” In L. W., the court determined that the state’s interest in protecting the integrity of the medical profession was not implicated, because the physicians supported the decision to withdraw life support. With regard to the suggestion of suicide, the court referred to Section 154.11(1) of the Wisconsin Statutes, which states specifically: “The withholding or withdrawing of life-sustaining procedures . . . from a qualified patient under this chapter does not, for any purpose constitute suicide.”

The fourth state interest, that of protecting innocent third parties, was also determined to be inapplicable, as there were no third parties involved. The Saikewicz court recognized that the right to refuse life-sustaining treatment was a constitutional right that can only be interfered with if the state can demonstrate a compelling interest. According to Frolik and Barnes, “[w]hen the state’s interests are balanced against those of the individual . . . the state almost never prevails.”

As noted earlier with regard to the L. W. case, the guidelines for deciding whether or not treatment is in the best interest of the ward include considering the likelihood of physical, psychological, or emotional injury as a result of providing or not providing treatment. This seems to be an acknowl-
edgment that the trauma caused by treatment may not be in the ward's best interest, if the probability of recovery and continued life is relatively low. In support of the decision not to require Saikewicz to undergo chemotherapy, the court stated: "He . . . would experience fear without the understanding from which other patients draw strength. The inability to anticipate and prepare for the severe side effects of the drugs leaves room only for confusion and disorientation." 56

With regard to CPR in an elderly patient, the potential injury is significant. Most elderly people suffer broken bones and internal organ damage as a result of CPR. And, as discussed earlier, the likelihood of survival, let alone recovery, may in some cases not be very good.

Conclusions

In conclusion, it would seem that the guardian of the person has authority to consent to a do-not-resuscitate order for the incompetent ward in most circumstances within appropriate guidelines. If the ward is a previously competent individual and had explicitly indicated his or her wishes regarding CPR, the guardian can and should follow those wishes. If the ward did not provide specific information regarding his or her wishes with respect to CPR, the guardian may call upon a substituted judgment standard, if the guardian can provide sufficient evidence of the ward's values and preferences as expressed clearly through his or her previous lifestyle and behavior. If the ward was never competent or if his or her previous wishes cannot be determined, the guardian should determine, using the criteria outlined in the L. W. case, whether or not CPR is in the best interest of the ward. These determinations should be made in dialogue with the physician and other health care professionals. James Childress offers a simple lexical ordering of decision makers for situations in which the patient's current or previous preferences cannot be ascertained: family (or legally authorized surrogate), physicians and other health professionals, hospital committees, and the courts. The process works like this:

The family [or guardian] can make the decision only in consultation with the physician and other health professionals, but the physician remains a moral agent and should appeal to another decision-maker if he or she believes that the family's [or guardian's] decision is not in the patient's best interest. The court's involvement may be indispensable when it is necessary to adjudicate a conflict between the family's [or guardian's] interests and the patient's interests. 57

Decisions regarding life-support measures, including CPR, are very personal and profound. As George Annas states: "No one wants a system in which all treatment decisions for incompetents are made by judges, or one in which they are all made by physicians. Nor does anyone want a system where the rights of the weakest members of our society are not fully protected." 58

Properly appointed guardians, acting in good faith, in consultation with medical professionals, trying to the extent possible to ascertain the wishes of the ward, are in the best position to consent to treatment for the ward, including the withholding of CPR.

Endnotes

2. See id.
3. See id.


11. CASES IN BIOETHICS, supra note 4, at 106.

12. Id.

13. See Miles, supra note 1, at 67.

14. Wis. Stat. § 880.01(4).

15. Wis. Stat. § 155.01(8).


17. See Buchanan, supra note 8, at 290.


19. CASES IN BIOETHICS, supra note 4, at 106.

20. Id.

21. See Miles, supra note 1, at 69.


23. See Schlesinger, supra note 9, at 346.

24. Id. at 348.

25. Id. at 349.


29. See Viney, supra note 26, at § 6.6.

30. See Childress, supra note 18, at 172.

31. See Annas, supra note 10, at 382.

32. Buchanan, supra note 8, at 293.

33. Id.

34. See id.


36. Id.

37. Id. at 490.

38. Id.

39. See Saikewicz, 370 N.E.2d at 420.

40. See Childress, supra note 18, at 173.

41. See Buchanan, supra note 8, at 294.

42. See id.

43. See id.


45. Viney, supra note 26, at § 6.6.

46. In the Matter of Guardianship of L.W., 482 N.W.2d 60, 70 (Wis. 1992).

47. Id. at 64.


49. In the Matter of Guardianship of L.W., 482 N.W.2d at 74.

50. Annas, supra note 10, at 374.

51. In the Matter of Guardianship of L.W., 482 N.W.2d at 75.

52. See id.

53. See id.

54. Annas, supra note 10, at 374.
55. Frolik, supra note 28, at 1014.
56. Annas, supra note 10, at 376.
57. Childress, supra note 18, at 174.
58. Annas, supra note 10, at 394.