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George J. Annas

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Decision-Making and the Critically Ill Patient: Some Legal Aspects of a Patient Classification Scheme

George J. Annas, J.D., M.P.H.

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Some physicians and hospital administrators view the law as obstructing medical progress and destroying the doctor-patient relationship.¹ This perception is fostered by civil medical malpractice litigation which is viewed by many as unfair.² Less frequently a significant criminal case against a physician, such as the 1975 Boston case in which a physician was tried for manslaughter for failing to attempt to preserve the "life" of a fetus during a legal abortion, will arouse both resentment and fear in the medical community.³ These attitudes toward the law

and lawyers are both unfortunate and unnecessary. The legal system is nothing more (or less) than a system for resolving conflicts and making difficult decisions, and the major aim of legal counseling is usually preventive. It is to predict major problems that might arise from a given course of action, and suggest ways that such problems might be either avoided or lessened.

In an area as complex as intensive care for the critically ill, the prudent physician and hospital administrator will seek legal advice before introducing novel approaches to decision-making concerning treatment or termination of treatment. While the law cannot, and should not presume to, answer the question of what does or does not constitute proper medical care in the ICU, the law can be extremely helpful to the physician by identifying those aspects of the decision-making process that affect the patient's legal rights.

The "patient rights movement" in this country, if one can be said to truly exist, is of relatively recent origin and exists as an offshoot of the consumer movement

Dr. Annas is Director of the Center for Law and Health Sciences of Boston University School of Law, and Lecturer in Legal Medicine at Boston College Law School. He is a graduate of Harvard College, Law School, and School of Public Health. He is Editor-in-Chief of Medicolegal News, and writes a monthly column on legal medicine for Orthopaedic Review. He has recently written a book on The Rights of Hospital Patients, published by Avon during March of 1975.

in our society. The movement is founded on two fundamental propositions: (1) the American medical consumer possesses certain interests, many of which may be properly described as legal rights, that he does not automatically forfeit by entering into a relationship with a physician or health care facility; and (2) most physicians and health care facilities fail to recognize the existence of these rights and interests, fail to provide for their protection or assertion, and frequently limit their exercise without recourse for the patient.^{4,5}

Because a sick person's first concern is to regain his health, he is usually willing to give up rights that otherwise would be vigorously asserted. The sicker a person is, the more willing he is to permit others unlimited control over his body. The intensive care unit may be the place in the hospital where the patient is most easily denied any participation in decision-making about his future. Because the dangers of loss of autonomy and privacy are greatest in this setting, the obligations of the physician and staff of the unit to preserve the patient's legal and human rights are perhaps more compelling than in any other hospital setting.

From the patient's perspective, his first wish is usually either to recover, or, if that is impossible, to continue to live with the least pain, disfigurement and disability possible. The price of continued life, in terms of economics, pain,

disability, probability of recovery, or any other criteria relevant to the patient, may, however, be too high for an individual. In such cases discontinuance of active treatment may be sought by the patient or his family. It is my view that the wishes of the mentally competent adult patient should always be honored by the hospital staff, provided that he has discussed the implications of his wishes with his physician. If a classification system, such as one discussed elsewhere in this issue (in which patients are grouped into four categories, each of which calls for degrees of medical effort ranging from "maximal" to "discontinuance of all life support assistance and therapy"), serves both to enhance the patient's role in decision-making about his treatment, and improve or at least not downgrade the quality of medical care he receives, then its introduction is a step in the right direction. If, on the other hand, such a system deprives the patient of what little voice he now has in medical decision-making, its introduction should be strenuously opposed.

Without having directly participated in the types of decisions necessitated by a "triage" classification scheme in the intensive care unit, my initial judgment is that such a scheme contains both the potential for great good and the potential for great abuse. Rather than minutely dissecting all the potential legal issues raised by such a system, I will

deal with the four which strike me as the most important in implementing such a system of patient care classification in an intensive care unit: proper authority, proper documentation, adequate prediction criteria, and adequate representation of the patient's desires and interests in the decision-making process.

Proper Authority

A number of court cases during the past decade have enunciated a doctrine of corporate liability in the hospital field. This doctrine is essentially that the hospital may be held liable in a malpractice suit for the actions not only of its employees but also of the physicians it permits to practice medicine within its walls.⁶ The basis of this finding is that the board of directors of the hospital has both the authority and the duty to supervise medical practice within the hospital. Therefore if a patient is injured because an unqualified or consistently careless physician is permitted to treat him, both the physician and the hospital are responsible to the patient. In one notorious case a hospital failed to revoke a physician's staff privileges even though it could have discovered, had it performed a proper review of patient records, that the physician was performing unnecessary laminectomies that were resulting in permanent disabilities to a number of his patients.⁷

Because the ultimate legal responsibility rests with the board of directors of the hospital, it is

essential that this body formally approve any systematic deviance from what would otherwise be "standard" medical treatment. Because medical expertise rests with the medical staff, approval of the executive board of the medical staff should also be required. Since the success of any such system demands complete cooperation and concurrence of those in charge of the ICU, the approval of those in charge of this unit should also be sought. In providing for these formal approvals, the Tagge proposal is to be commended. Even with these "policy" approvals, however, it might be appropriate for the protocol to be reviewed and approved by the hospital's human studies committee.

Proper Documentation

The importance of good data keeping in any study is elementary. If good data is not kept the ethics of conducting the study are immediately called into question, and the probability of attaining significant and convincing results is diminished. These observations apply to the ICU classification scheme.

Legally, there is no excuse for not entering important treatment decisions and orders in the patient's permanent record. The AMA unequivocally recommends that an order not to provide cardiopulmonary resuscitation be entered directly in the patient's progress notes and *also* indicated "on the physician's order sheet for the benefit of nurses and other personnel who may be called

upon to initiate or participate in cardiopulmonary resuscitation."⁸ In striking contrast, the policy on classification at the Massachusetts General Hospital is that "such orders as 'Do Not Resuscitate (DNR)', etc., should be communicated directly verbally to the nursing and house staff, and should be registered in the nursing notes, but *not written into the regular order sheet or permanent record.*" (emphasis supplied)⁹ At this particular hospital such nursing notes are routinely destroyed following the patient's death or discharge (a procedure permitted under Massachusetts law) so that the only purpose of such a policy seems to be to destroy any evidence that the doctor ever gave such an order or that the hospital would ever approve such an order. As a policy, this covert method of medical practice may be counterproductive (i.e., some nurses or house staff members may not learn of the verbal order and so attempt resuscitation). Moreover, it indicates that those implementing the classification system do not really believe that what they are doing is right or legal, or that they have been given the proper authority to do it. Such a policy thus calls the entire classification method into serious question. Nor is it an effective way to avoid any legal consequences that might be feared, since the nursing and house staff can be compelled to appear as witnesses in both civil and criminal cases, and can testify to the verbal order. Also, if

the system is functioning properly, the order will not be kept secret from the surviving family, since they should have had (with the competent patient's consent) a part in making this decision themselves!

Adequate Prediction Criteria

The law is very skeptical about man's ability to predict death. In one recent case involving estate taxes, for example, the tax tables had put a 75 year-old woman's life expectancy at 6 years. The IRS attempted, with medical testimony, to prove that her "actual" life expectancy was less than a year since she was suffering from cancer of the colon which had metastasized to the liver, a disease all agreed was both fatal and incurable. A number of physicians testified at the trial concerning the woman's actual life expectancy. One cancer expert said "I do not believe you can place a time span on her expected length of life . . . [I] had at least one case who has lived six years now with liver metastasis."

Another cancer expert, this one called by the IRS, testified that the deceased "could have lived for a year," but added "in medicine you can't be too didactic, because someone always surprises you." A third physician, an internist, put her life expectancy at one to six months. The court found that on the basis of this testimony the range of predictable life was between one month and at least six years (absent clinical signs of imminent death), and that determination of actual

life expectancy, even by experts, would be "little better than a guess."¹⁰

Not only are courts unlikely to accept non-unanimous medical views of imminent death, they are also likely to place a high value on even very slim chances of survival. Courts have required ship owners to make reasonable searches for persons who have fallen overboard, even where chances of recovery are negligible. In one case a seaman was not discovered missing until five and one half hours after he had last been seen. The captain refused to reverse course and search, arguing that there was almost no chance he was still alive. The court found against the captain saying "Once the evidence sustains a reasonable possibility of rescue, ample or narrow, according to the circumstances, total disregard of the duty, refusal to make even a try, as was the case here, imposes liability."¹¹ As one commentator approvingly noted, "it is ancient learning that 'a drowning man cannot pull himself out by his own hair,' and a 2% chance of rescue as opposed to a 98% chance of survival is proportionately that much more precious."¹²

A recent New York malpractice case approved a similar finding by a jury against a physician and a hospital. The physician had ordered a drug, Naturetin, which was necessary to reduce the patient's blood pressure so that she could undergo surgery. For some reason the drug was not admin-

istered, the operation could not be performed, and the patient died. There was testimony that, even without the surgery, the administration of the drug as prescribed would have given the woman a 2% chance of survival. The jury specifically did not find negligence in the failure to perform the surgery, but based its award of \$70,000 solely on the negligent denial of a 2% chance of survival.¹³

The lesson of these cases is clear. No decision should be made to terminate treatment of a patient without the patient's competent, understanding and voluntary consent unless there is *no* chance of survival. If there is any measureable chance of survival, even as little as one or two percent, the legal duty of the staff of the intensive care unit would seem to be to exercise all of their skills to give their patient the full benefit of that chance. Reversing nature's processes and saving the previously unsaveable is, after all, what intensive care treatment is all about. By operating such a unit the hospital takes upon itself a higher duty of medical care for the critically ill than it would have without such a unit.

Adequate Patient Representation

In life and death decision-making about individual patients it is essential that the patient's interests be adequately represented. It should be readily apparent that no patient in an ICU can properly represent his own position — either for vigorous continued treatment or for cessation

of treatment. Nor are members of his immediate family usually in a position to knowledgeably and effectively champion the rights and desires of the critically ill patient.

In a court proceeding, where decisions will be made about a person who is unable to represent his own interests (e.g., for reasons of age, mental incompetency), the court will appoint a "guardian." The guardian's job is to represent the interests of the minor or incompetent in the legal proceedings. I suggest that any time categorization decisions are going to be made in staff rounds or recommended by an advisory group, the patient be represented in all such deliberations by a person whom I term a "patient rights advocate."¹⁴ The advocate's duty is to make those arguments that the patient would were he physically or mentally able to represent his own interests. The advocate should be named by the patient, but could also be a member of the advisory group specifically designated for such a role. The advocate's only loyalty, however, must be to the patient and the advocate's only duty must be to represent the patient's interests as best he or she can. As an example, the advocate should ensure that decisions are only based on relevant criteria, and never on such considerations as race or ability to pay.

In the event that the patient is comatose and has not indicated a prior wish against heroics (e.g.,

through a living will) the advocate should be required to assume that the patient wants all reasonable medical steps taken to preserve his life, and argue for the position accordingly. Only with such strong presentation of the arguments in favor of continuing treatment can the treating physician, the ICU staff, or the advisory committee to the ICU, have any confidence that they have considered all the reasonable arguments in favor of the patient's desires. If treatment is terminated without providing the patient with the benefit of such an advocate, the patient effectively loses any independent voice in the decision-making process about his future. The entire proposed classification scheme then becomes little better than if decisions were left to the individual attending physician.

Summary

The law and legal analysis of decision-making processes can play a positive role in promoting patient rights without retarding potential medical advances. To achieve both of these goals any system of patient classification that determines treatment or non-treatment in an Intensive Care Unit should make provisions for proper authority, proper documentation, adequate prediction criteria, and adequate patient representation. If any of these elements is missing, the rights of critically ill patients may be compromised rather than enhanced.

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Paul Marx, O.S.B., Director
The Human Life Center
Saint John's University
Collegeville, Minnesota 56321