# Liability for the Health Care Provider: Non-Implementation of Patients' Advanced Directives

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**KEY WORDS**
Advanced Directives, Death and Dying, End-of-Life Care

*Death and dying, once taboo subjects, have risen to a level of increased sensitivity and awareness for both the public and health care providers alike. Many health care professionals have not been educated in end-of-life care issues, yet are facing more exposure and challenges in how to deal with end-of-life care wishes of their patients both orally and in writing—through advanced directives. When health care providers fail to implement their patients' advanced directives, they may be faced with liability claims for medical battery, negligence, and malpractice. The intent of this educational article is to provide the legal nurse consultant (LNC) with relevant information and guidelines that the LNC may use when evaluating a medical battery case for merit which alleges a breach in the standard of care relating to advanced directives. This information is not intended to be a substitute for contacting an attorney when questions may arise during the medical review process.*

In today's health care delivery system, attitudes toward end-of-life care have taken on new dimensions, with death and dying having risen to a level of increased sensitivity and awareness for both the public and health care professionals alike. Health care providers often have feelings of discomfort and guilt when faced with patients who are dying, despite the health care provider's efforts to cure (Stanley, Blair, & Beare, 2005). Very often, the advances in medical technology can merely neutralize the effects of certain diseases without healing. An individual can be placed into a sort of human limbo—kept from dying but deprived of quality of living. Individuals facing death are concerned with losing autonomy, having medical decisions made by strangers, pain, becoming a burden, dependency on others, unwanted intrusion of futile treatment, the emotional and financial impact upon them and their family, and having their religious concerns denied or not being honored.

The information presented in this educational article may be used by the LNC when evaluating a medical battery case for merit which alleges a breach in the standard of care relating to advanced directives. Included are federal and state laws on advanced directives; types of advanced directives and do-not-resuscitate orders; common causes of action against health care providers for non-implementation of patients' advanced directives; and relevant guidelines for health care providers to implement when dealing with end-of-life care patient issues to reduce potential liability. The article introduces guidelines that the LNC can use to evaluate a medical record and associated documents for a case alleging damages caused by a health care provider's failure to implement a patient's advanced directive.

## Federal and State Laws on Advanced Directives

In today's health care delivery system, informed consent is a fundamental right of patient autonomy. The doctrine of informed consent is based upon the fundamental right of self-determination and the fiduciary nature of the health care provider-patient relationship. Under traditional tort law, a health care provider who performed medical treatments or procedures beyond the scope of the patient's consent was sued under the intentional tort theory of battery (Croke, 2003).

As far back as 1891, the United States Supreme Court recognized the fundamental right of self-determination. In speaking for the Court's majority, Justice Horace Gray stated, "No right is held more sacred, or is more carefully guarded, by common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law" (Union Pacific Railway Co. v. Botsford, 1891, at 251). An application of this fundamental right was rendered in 1914 by Justice Benjamin Cardozo. He cited the reason for consent in protecting patient autonomy by stating, "Every human being of adult years and sound mind has a right to determine what shall be done with his own body, and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages" (Schloendorf v. Society of New York Hospitals, 1914, at 93). Consent is not contingent on a request for clarification of information by the patient, but on a person's right to control what is done to his or her body—and on prevention of battery (Guido, 2001).

End-of-life care issues, such as living wills, patient competency/incompetency, substituted judgment, institutional rights and beliefs, and withdrawal of medical

care came to the forefront of both the public eye and legal arena in the 1970s. In 1975, Joseph Quinlan, Karen Quinlan's father, was the first to challenge the guardian issue of withdrawing medical care based upon his daughter's incompetent state. Mr. Quinlan sought a court order to have his daughter, Karen, removed from a respirator, as she had long been in a persistent vegetative state. The New Jersey Supreme Court found that "the state's interest…weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the progress dims. Ultimately there comes a point at which the individual's rights overcome the State interest" (In re Quinlan, 1976, at. 647)…"The only practical way to prevent destruction of [individual's right to privacy] is to permit the guardian of Karen to render their very best judgment…as to whether she would exercise it in these circumstances" (at 664).

In 1976, California became the first state to legalize living wills, known as the California Natural Death Act. All remaining states followed suit passing legislation legalizing living wills, though not without public concerns. This question of an individual's right to die was thereafter examined by various state courts using such standards as the clear and convincing evidence standard (e.g. using substituted judgment). Clear and convincing standards were developed as "litigation safeguards" for individuals in vegetative states. Missouri and New Jersey used this standard as a "safeguard to ensure that feeding tubes could not be removed without 'clear and convincing' evidence that the person would have wanted feedings removed if in a 'vegetative' state. This was about more than just the 'vegetative' state. It allowed the 'right to die' position to morph from one where the issue was allowing dying people a natural death to one where choice and legalities were the primary issues, whatever the patient's condition" (Valko, 2001, p. 3).

In 1990, the first right-to-die case brought before the United States Supreme Court was *Cruzan v. Director, Missouri Department of Health*. The Court upheld Missouri's clear and convincing evidence standard. The Court ruled that "the common law doctrine of informed consent is viewed as generally encompassing the right of a competent individual to refuse medical treatment" (at 241). There was a strong implication that an appointed surrogate decision maker, or agent, would have the same right. The Supreme Court sent the case back to the trial court, which found that Nancy Cruzan's statements made to friends years before her accident "about not wanting to live in a vegetative state" met the clear and convincing standard—once her tubes were legally removed Nancy Cruzan died 12 days later, after being in a vegetative state for 7 years. The Supreme Court made explicit that right-to-die case issues would be decided by each state with limited interference from the U.S. government (constitutional law) as to what each state could decide to do (Guido, 2001).

In response to the Cruzan case, the U.S. Congress introduced in 1990 the Patient Self-Determination Act (PSDA), as part of the Omnibus Budget Reconciliation Act, and in 1991 enacted it into federal law. This law underscored the widespread public concern regarding patients' rights and decisions on life-sustaining treatment. The law does not "create any new rights for patients nor does it change state law" (Guido, 2001, p. 157). The PSDA requires all health care facilities receiving Medicare or Medicaid funding to implement the following regulations:

- Ask the patient on admission to the facility about the existence of an advanced directive;
- Provide written information to all patients on admission to their facility about their rights to accept or refuse medical or surgical treatment/procedures under state law;
- Patients must be given the right to complete an advanced directive, though the law does not mandate that the patient execute an advanced directive;
- Health care providers must document advanced directives in each of the patient's records;
- Health care facility/providers must provide education to staff, caregivers and patients on advanced directives;
- Health care facility/provider must not discriminate in care for or against patients with an advanced directive;
- Every health care facility must have in place and communicate to staff, caregivers, and patients a policy about implementing advanced directives;
- The health care facility must include a clear and precise explanation of any conscious objection a provider, facility, or provider's agent may have to follow an individual's advanced directive. Only the conscious objections permitted under state law may be included in the facility policy (Painlaw, 2004).

## State-Specific Stipulations

Advanced directives (living wills to durable power of attorney for health care) are based upon common law and authorized by state law, (exceptions noted in New York and Massachusetts), and allow competent adults, 18 years of age and older, to direct the medical treatments or procedures he or she would want or not want if they are later incapacitated by illness (Painlaw, 2004). In New York, the Living Will is authorized by law created by New York courts, not through legislative enactments. As a result, there are no specific requirements guiding its use. Similarly, Massachusetts does not have a statute governing the use of Living Wills (Partnership in Caring, 2004). Some states honor oral advance directives. For example, in California, Maryland, and Virginia, only a physician may accept a patient's oral advance directive (Frederick Memorial Healthcare System, 2002; University of Virginia Health System, 2004).

In July 2000, California's Natural Death Act and the Durable Powers of Attorney Health Care laws were replaced by the Health Care Decisions Law (AB 891). Even with the

new law, California law permits "Patients with existing Durable Powers of Attorney for Health Care NEED NOT execute new ones. They remain valid even if executed on or after July 1, 2000. All properly executed Natural Death Act declarations remain valid. Also valid Emergency Medical Services Pre-Hospital Do Not Resuscitate (DNR) forms remain in effect" (Drake & Groszkruger, 2002, p.1). The Federal Health Care Privacy Law—Health Insurance Portability and Accountability Act (HIPAA at 45 CFR 164.524) (2003) does not require any language changes in advanced directives and a person (proxy, surrogate, agent) authorized under his or her state advanced directive law to make health care decisions on behalf of a patient may still receive medical information on that patient. There are restrictions and limitations to personal representatives if a health care provider suspects "domestic violence, abuse, neglect, or endangerment" by the personal representative against the best interests of the patient (Partnership in Caring, 2004).

Laws pertaining to advanced directives may vary from state to state. Health care providers need to be cognizant of federal advanced directive laws as well as their state advanced directive laws to help decrease liability when dealing with end-of-life care issues. State-by-state laws pertaining to advanced directives, as well as state-approved advanced directive forms, are available at pfc@partnershipforcaring.org.

## Types of Advanced Directives and Do-Not-Resuscitate Orders

Formats of advanced directives vary by state law. Advanced directives inform health care providers what type of care the individual would like to have or not have if the individual becomes unable to make health care decisions. Two types of advanced directives are the durable power of attorney for health care (DPAHC) and living wills.

The durable power of attorney for health care allows an individual (patient) to appoint someone (agent, proxy, surrogate) to make health care decisions for him or her. It becomes effective (active) when the patient becomes unconscious, loses the ability to make decisions, or is incapable of communicating his or her wishes. The health care agent is responsible for carrying out the patient's wishes as they are expressed in the advanced directive or in discussions with the agent. The health care agent may not change the patient's wishes expressed in the DPAHC.

Living wills (e.g. 5 Wishes) only come into effect when the patient is terminally ill, usually defined as less than 6 months to live. The living will provides specific instructions to health care providers about the particular types of treatment or procedures the patient would want or would not want to prolong life. Not every individual wishes to think about the possibility of developing a dementing disease such as Alzheimers, but this form of advanced directive can also be tailored to include the individual's own personal philosophy about the potential loss of capacity in the future. Oral advanced directives are allowed in some states if there is "clear and convincing" evidence of the patient's wishes. Advanced directives can be revoked at any time by the patient—verbally or in writing. A physician's order in a patient's medical record is required to execute the end-of-life care issues expressed by the patient in the advanced directive.

A Do-Not- Resuscitate (DNR) order (or "no code order") is another type of advanced directive. The DNR allows a patient to declare that he or she does not want certain resuscitative measures (e.g. cardiopulmonary resuscitation—CPR) performed. DNR orders require specific written orders from a physician (some health care facilities require two physicians to implement a DNR order). Documentation must be noted in the patient's medical record of the factual discussion between the patient and physician (and family members, if present). If the patient is in a nursing home or is at home, a DNR order alerts health care professionals and emergency medical personnel (EMS) not to perform emergency resuscitative measures and not to transfer the patient to a health care facility for CPR. Depending on state DNR statutes, a patient's DNR order is not appropriate for use by EMS providers, as most state laws require EMS personnel to attempt resuscitation. A patient may complete a valid Emergency Medical Services Pre-Hospital DNR form and should also wear a bracelet alerting EMS personnel to a DNR order. If a med alert bracelet is worn, it must include the patient's name and address, as well as the name and telephone number of the patient's attending physician. All health care providers must know their state's DNR law and their health care facility's policy and procedures for implementation of DNR orders (Medi-Smart, 2004).

## Common Causes of Action Claims for Non-Implementation

Unlike consent forms, advanced directives "are not used to inform people about risks and benefits before treatment in a particular situation. Instead, they are used to cover refusal of treatment in an unknown future situation, which can lead to unintended consequences" (Valko, 2001, p. 5). Medical battery constitutes an intentional tort—due to the health care provider's unauthorized treatment (without informed consent) to the patient—and as such, courts may compensate the patient by awarding him or her damages for injuries and other expenses. Punitive damages may also be a plaintiff request. Besides intent, a successful plaintiff must prove the following elements: harmful/offensive contact, lack of consent, causation, and damages. Medical battery must be distinguished from a cause of action claim of "wrongful living." Wrongful living is a new cause of action claim based upon a health care provider's intentional or negligent interference with an individual's right to refuse medical treatments or procedures (Painlaw, 2004).

In most states, health care providers who follow (compliance) an advanced directive in good faith (immunity) are not subject to criminal or civil liability or discipline for unprofessional conduct. Failure to follow an advanced directive may result in the health care provider's liability for damages and for liability claims of battery, negligence, and malpractice.

In *Leach v. Shapiro* (1984), Mr. Leach, acting as his wife's agent, brought a cause of action suit against the hospital and physician for wrongfully placing and maintaining his wife on life-support systems, contrary to the expressed wishes of his wife and without obtaining his informed consent. Mr. Leach sought damages for the time his wife was on life support; sought to recover damages for defendants' alleged conduct that invaded Mrs. Leach's right to privacy; sought to recover pain, suffering, and mental anguish for Mrs. Leach and family; and sought to recover punitive damages. The trial court awarded summary judgment to the defendants, ruling that Mr. Leach had failed to meet a cause of action claim under Ohio law. An Ohio appellate court ruled that there had been harmful contact when Mrs. Leach was placed on life support without her consent (while in a vegetative state) and reversed the trial court's rulings. The cause of action claim was remanded for further proceedings. The Court also ruled that a patient has the right to refuse treatment and that such refusal cannot be overcome by implied consent (at 397). The lower court ruling allowed only the claim for battery.

In *Anderson v. St. Francis-St. George Hospital, Inc.* (1996), plaintiff Mr. Winter brought suit against the hospital for damages resulting from the hospital's failure to follow his "no code blue" order. Mr. Winter had a known history of cardiac problems. He was resuscitated by a nurse (battery) and later suffered a stroke. The Supreme Court of Ohio determined that Mr. Winter's "wrongful life" cause of action claim was not satisfied—there was no evidence linking Mr. Winter's stroke with the resuscitative measures performed by the nurse. In its analysis, the court found the that "…the 'harm' that was proximately caused by medical professional's breach of duty in a prolongation of life case was the 'benefit of life,' a harm which courts have repeatedly refused to allow compensation" (at 85).

*In Duarte v. Chino Community Hospital* (1999), the California Court of Appeals found no civil liability for a physician who had refused to withdraw life-sustaining treatment against the Duarte's family wishes and in the absence of an advanced directive. No award for money damages was made for the refusal to comply with the family's instructions, as they found that their sole remedy was to request the court for an order forcing compliance.

Martin (1999) identified the following various causes of action claims for which patients may recover monetary damages:

- An action for battery if a health care facility or provider fails to comply with the requirements set forth in the PSDA;
- An action for battery if the patient's refusal of treatment or procedure is ignored;
- An action for pain, suffering, and mental anguish for both the patient and family if treatments or procedures are administered without consent and if the treatment or procedure caused discomfort beyond which the patient would have otherwise suffered.

Various reasons for health care providers not implementing their patient's advanced directives include:

- Fear of a lawsuit when a patient's advanced directive is opposed or disagreed with by family members;
- Patient's wishes were in opposition to the health care provider's own clinical judgment (health care provider's belief in using their judgment as the best for their patient, a type of for-your-own- good reasoning);
- The health care provider may not believe in patient autonomy;
- Health care provider's uncertainty about the meaning and application of the advanced directive;
- Emergency circumstances (Weiler, Eland, & Buckwater, 1999).

| Relevant Guidelines for Health Care Providers to Implement When Dealing With End-of-life Care Patient Issues—Reducing Potential Liability |
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| Know federal and state laws on advanced directives and ensure advance directive compliance. |
| Know policy and procedures relating to advanced directives at their health care facility. |
| Health care providers must remember, that, as their patient's advocate, they have an obligation to be knowledgeable about their patient's "moral and legal rights" and must work to protect and support these rights. |
| Health care providers must be aware of the absence or existence of an advanced directive of their patients. Documentation must be recorded in the medical record whether or not the patient has executed an advanced directive. |
| The advanced directive must be placed in the patient's medical record, and all health care providers must be made aware of its existence. |
| Health care providers must be cognizant of their patient's end-of-life care wishes. |
| Health care providers should review the advanced directive with the patient or agent to make sure the advanced directive is understood exactly as the patient wishes. |
| Health care providers must not discriminate against a patient based on whether the patient has executed an advanced directive.<br>Advanced directives should be discussed in the patient's preferred language. If an interpreter is used, the interpreter must sign the medical document |
| Health care facilities and providers must provide staff, patient, family, and caregivers information on advanced directives. |
| Some states mandate that advanced directives be notarized, and state law and forms must be followed. |
| If the health care provider in unsure whether the advanced directive meets the state's requirement, the hospital's legal department should be asked to review the document (Weiler, Eland & Buckwater, 1999). |

| Guidelines for Use by an LNC When Evaluating a Medical Record and Associated Documents for a Case Alleging Damages Caused by a Health Care Provider's Failure to Implement a Patient's Advanced Directive. |
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| 1. Know federal laws on advanced directives as well as state advanced directive laws where the alleged breach in the standard of care occurred. Does the health care facility receive Medicare or Medicaid funding? |
| 2. Review policy and procedures of health care institution relating to advanced directives. Knowing about a health care facility's policy and procedures relating to advanced directives may assist the LNC in investigating if documentational evidence indicates that the health care facility followed its own P&P. If advanced directives are violated, the LNC may be able to show that the health care facility breached the standard of care relating to advanced directives. |
| 3. Know the alleged cause of action claim (s). Patient or personal representative may have co-existing claims of medical battery, negligence or malpractice. |
| 4. What was the type of advanced directive executed by the patient? |
| 5. Was the advanced directive document readily visible in the patient's medical record? |
| 6. Was there documentation in the patient's medical record that the physician reviewed the contents of the advanced directive with the patient, family, caregiver, or agent? |
| 7. Was the advanced directive in the patient's preferred language and, if an interpreter was used, was it signed by the interpreter? |
| 8. Was there any type of patient discrimination noted in the medical record documentation? |
| 9. Were there any medications taken by the patient that might alter his or her competency status? |
| 10. What were the patient's medical diagnoses? Are there any known medical diagnoses that may alter his or her state of competency? |

## Summary

End-of-life care issues are among the most difficult subjects for health care providers, patients, family, and caregivers to openly discuss. Advanced directives are open to varying interpretations based upon the ambiguity of the advanced directive terminology, state law requirements, and the health care provider's willingness to make subjective value judgments concerning quality of life (Trevor, Barbour, & Schwartz, 2003). To decrease the potential liability for failure to implement advanced directives, it is important for health care providers to know the existence of their patient's advanced directive, review the document with the patient and family/surrogate for clarity of the patient's desired end-of-life care wishes, be willing to implement the advanced directive and—if unable or unwilling—transfer the patient to another health care provider willing to implement the advanced directive, and know federal and state advanced directive laws.

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