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Advance Medical Directives and the Authority to Compel Medical Treatment

by Martha L. Ridgway

Continuing legal education classes for elder law attorneys frequently cover the different forms of advance medical directives available in Colorado. Discussions have arisen among elder law attorneys regarding how much time should be spent, and can be billed, in assisting clients to draft meaningful and workable advance medical directives and facilitating communication between principals and agents under medical powers of attorney. How attorneys view their roles and implement them can have a real impact when family members and agents are faced with difficult end-of-life decisions.

This article explores how advance medical directives are used and construed and provides an analysis of the Colorado Patient Autonomy Act[1] ("Patient Autonomy Act") and how it is impacted by the Colorado Medical Practice Act[2] ("Medical Practice Act"). This discussion focuses on whether, under the Patient Autonomy Act, an agent under a medical power of attorney, or a court, can compel a treating physician to continue medical treatment that the physician finds to be medically inappropriate or unwarranted. The article is presented in the context of a fact situation taken from an actual case, with the names changed. As the fact situation evolves, the readers can consider how the drafting attorney might have assisted the client initially to construct a more effective advance medical directive.

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The Facts

Ann Smith was 85 years old and resided in a skilled nursing facility. She suffered from end-stage renal disease, including renal failure, diabetes, congestive heart failure, blindness, and dementia. She was incapacitated to the point that she could no longer direct her medical care. Ann Smith was married and had four adult children. Her husband, John Smith, suffered from mild dementia and lived in an assisted living facility. Three of the children lived out of state; the fourth, a daughter, Mary Smith, was local. Ann Smith had a power of attorney for health care in which she named Mary Smith and another daughter as co-agents to act jointly. The power of attorney contained no directions to the co-agents, even though Ann Smith was diagnosed with many of the conditions listed above when she signed the power of attorney.

Due to Ann Smith's rapidly declining health and overall medical condition, her physicians approached John Smith and Mary Smith about ceasing all life-sustaining procedures, including dialysis, and entering a do-not-resuscitate ("DNR") order. John Smith and Mary Smith were vehemently opposed to this suggestion and wanted all life-sustaining procedures administered. The other co-agent, as well as the other two children, were in favor of letting their mother die naturally. Due to the dispute between the co-agents, the probate court was asked to determine what, if any, life-sustaining procedures should be administered.

Several hearings were held in which contradictory evidence was presented concerning what Ann Smith would have wanted. Several inconsistent form advance directives that Ann Smith had signed when she was admitted to the hospital complicated matters. After considering the evidence, the court determined that if Ann Smith were able to express her wishes, she would want to receive dialysis and other life-sustaining treatment. Important to the court's determination was the fact that Ann Smith did not have a living will.[3] The court found that this fact did not represent an oversight on her part because Ann Smith had executed a medical power of attorney. Therefore, the court ordered that all life-sustaining procedures, including dialysis, continue to be administered to Ann Smith.

Despite the administration of dialysis, antibiotics, and other aggressive medical treatment, Ann Smith's condition continued to decline significantly. She went back and forth between the hospital and nursing home numerous times. Of the four dialysis providers in the area, three discontinued treating Ann Smith based on their determination that dialysis constituted futile and unethical treatment. The fourth group finally gave four weeks' notice, stating that it too would discontinue treating her, based on the physician's belief that continued dialysis constituted futile and unethical treatment.

John Smith and Mary Smith disagreed with the doctor's conclusion and requested that the court order the doctor to continue providing dialysis. The other three Smith children supported the doctor's po-

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sition. At a hearing before the district court, the nephrologist testified concerning Ann Smith's medical condition and explained why she believed dialysis constituted futile and unethical treatment. According to the physician, dialysis is not appropriate when the patient has no reasonable expectation of recovery and no quality of life. The doctor testified that dialysis was never intended to be provided solely to keep an otherwise dying person alive, and noted that Ann Smith's health continued to decline. The doctor testified that Ann Smith was lying in a near-fetal position, was unresponsive to any medical personnel and unaware of her environment, could not express her wishes, and suffered from several serious and painful decubitus ulcers.

At the conclusion of the hearing, the court instructed all counsel to brief the issue of whether the court could order a nonparty physician to provide medical treatment the physician believed to be futile and unethical. After the hearing, but before the briefs were due, a hospital ethics committee meeting was held in which the family, court, counsel, and many of Ann Smith's current medical providers participated. The ethics committee issued a written opinion that supported the position of the treating nephrologist, finding the treatment to be medically inappropriate. Mary Smith and John Smith were not persuaded by the ethics committee to change their position.

The Court's Decision

In rendering its decision, the court analyzed both the Patient Autonomy Act and the Medical Practice Act, and considered what was in the Smiths' best interest.

The Patient Autonomy Act and The Medical Practice Act

The court first found that neither an agent appointed in a medical durable power of attorney nor the court can compel treatment that is medically inappropriate or unwarranted. In this case, dialysis was not medically appropriate because Ann Smith had no reasonable expectation of recovery and no quality of life. Therefore, continuing the dialysis constituted a futile effort. This medical opinion was unanimous and uncontroverted.

Second, contrary to the arguments of John Smith and Mary Smith, the Patient Autonomy Act does not mean that the last treating physician is "stuck" with the patient if no other doctor is willing to provide the treatment the agent requests.[4] The Patient Autonomy Act specifically provides that nothing in this part 5 or in a medical durable power of attorney shall be construed to compel or authorize a health care provider or health care facility to administer medical treatment that is otherwise illegal, medically inappropriate, or contrary to any federal or state law."[5]

> "Clients are best served if their attorneys, social workers, geriatric care managers, and medical providers can work together in an informed manner."

Moreover, although the Patient Autonomy Act provides protocols on how to handle the situation in which physicians differ on treatment options, the section does not address the question of what to do when no physician is willing to accept the patient under the condition of providing the care the agent requests.[6] Again, the statute does *not* state that the last physician treating the patient is "stuck" with the patient when neither the treating physician nor any other health care provider is willing to provide the treatment the agent requests.

Third, the court cannot order the treating physician to violate medical ethics or the Medical Practice Act.[7] Engaging in "... the administration, without clinical justification, of treatment which is demonstrably unnecessary ... or ordering or performing, without clinical justification, any service, x-ray, or treatment which is contrary to recognized standards of the practice of medicine as interpreted by the board [of medical examiners]" is a violation of this act.[8] Moreover, engaging in "[a]ny act or omission which fails to meet generally accepted standards of medical practice" is also "unprofessional conduct" and therefore a violation of the Medical Practice Act.[9]

While no published Colorado cases on point exist,[10] case law from other jurisdictions supported the physician's decision to withdraw dialysis. One case in particular, *Barber v. Superior Court of California*,[11] was instructive. *Barber* involved the criminal prosecution of a physician whose patient suffered severe brain damage that left him in a vegetative state. The physician had withdrawn life support equipment and intravenous tubes pursuant to the directions of the patient's family members.

The court distinguished between life-sustaining and life-prolonging treatment, noting that "[t]he question presented by this modern technology is, once undertaken, at what point does it cease to perform its intended function and who should have the authority to decide that any further prolongation of the dying process is of no benefit to either the patient or his family?"[12] The court held that "[a] physician has no duty to continue treatment, once it has proved to be ineffective. Although there may be a duty to provide life-sustaining machinery in the *immediate* aftermath of a cardio-respiratory arrest, there is no duty to continue its use once it has become futile in the opinion of qualified medical personnel."[13] (*Emphasis in the original.*)

In its decision, the *Barber* court also relied on medical literature and noted that:

> [a] physician is authorized under the standards of medical practice to discontinue a form of therapy which in his medical judgment is useless.... If the treating physicians have determined that continued use of a respirator is useless, then they may decide to discontinue it without fear of civil or criminal liability. By useless is meant that the continued use of the therapy cannot and does not improve the prognosis of recovery.[14]

The *Barber* court struggled with how decisions should be made to determine whether a treatment should be used, because this determination was essentially a medical one and was unique in every case.[15] The court decided that:

> [a] more rational approach involves the determination of whether the proposed treatment is proportionate or disproportionate in terms of the benefits to be gained versus the burden caused.
>
> Under this approach, proportionate treatment is that which, in the view of the patient, has at least a reasonable chance of providing benefits to the patient, which benefits outweigh the burdens attendant to the treatment. Thus, even if a proposed course of treatment might be extremely painful or intrusive, it would still be proportionate treatment if the prognosis was for complete cure or significant improvement in the patient's condition. On the other hand, a treatment course which is only minimally painful or intrusive may nonetheless be considered disproportionate to the potential benefits if the prognosis is virtually hopeless of any significant improvement in condition.[16]

Based on the foregoing analysis, the court held that, by his actions, the physician did

not unlawfully fail to perform a legal duty, and therefore upheld the order dismissing the complaint against him.

In Ann Smith's case, the medical literature also supported the physician's position. An article written for *JAMA* stated, "The moral basis of the physician/patient relationship is the obligation of the physician to attempt to do the patient some good. Actions that do not contribute to this end are not morally required."[17]

The American Thoracic Society set forth the following position in one of its publications:

> [b]ased on the ethical principles of beneficence and nonmaleficence that underlie the practice of medicine and define its goals, the purpose of a life-sustaining intervention should be to restore or maintain a patient's well-being and it should not have as its sole goal the unqualified prolongation of a patient's biological life.[18]

The Society opined that there is "no value" of life for a permanently unconscious person.[19]

An article in *Critical Care Medicine* stated, "[t]herapy is not required if it causes more harm than benefit, as with painful, invasive, or risky surgical procedures that are unlikely to improve outcome. . . . Physicians do not have a responsibility to provide futile or unreasonable care even if a patient or family member insists."[20] In another journal article, the authors state: "Futility is a professional judgment that takes precedence over patient autonomy and permits physicians to withhold or withdraw care deemed to be inappropriate without subjecting such a decision to patient approval."[21] Finally, an article for the *New England Journal of Medicine* notes, if a patient is severely and irreversibly demented, "it is ethically permissible for the physician to withhold treatment that would serve mainly to prolong the dying process."[22]

The Smiths' Best Interest

The court considered the following factors in determining what was in Ann Smith and John Smith's best interest. The medical evidence showed that Ann Smith's condition was irreversible, her death was imminent, and the dialysis would have had no impact on her well-being. Discontinuing dialysis would permit Ann Smith to die a painless, natural, peaceful, and dignified death. Additionally, discontinuing treatment would permit Ann Smith's transfer to a hospice, which could have provided comfort care for her and emotional and spiritual assistance to her family. Finally, John Smith's financial security might have been undermined by the cost of prolonged dialysis because Medicare and supplemental insurance will likely refuse to pay for treatment that is deemed futile and unnecessary.

The Ruling

The district court denied the request to order the doctor to continue providing dialysis services. A request for a show cause [illegible]

porary restraining order prohibiting the doctor from discharging Ann Smith as a patient were also denied.[23] The court ordered that, once dialysis was discontinued, Ann Smith was to be transferred to hospice care. The court's decision was appealed unsuccessfully. Ironically, Ann Smith died shortly thereafter from causes other than the discontinuance of dialysis. Litigation of these issues resulted in legal bills of almost $100,000 to the Smith[illegible]

Drafting Considerations

As attorneys working in this area have experienced, for some families, no amount of work on advance medical directives will smooth the end-of-life decision-making process. However, this client would have been better served if the attorney drafting the medical power of attorney had raised the issues of whether the co-agents worked well together and shared similar values.

Further, the drafting attorney could have: (1) drafted provisions in the document for a dispute resolution mechanism in case the agents could not reach agreement; (2) mentioned the client's chronic medical conditions and asked whether the client wanted to include any direction to the agents on aggressive treatments for those conditions; (3) encouraged the client to discuss her wishes with the agents and her entire family; and (4) stated in the medical power of attorney that the client specifically refused to sign a living will and wanted all measures to be continued.

Conclusion

Clients are best served if their attorneys, social workers, geriatric care managers, and medical providers can work together in an informed manner. Experiencing a case such as the one described in this article may make doctors less willing to accept a patient for fear they will be involved as the treating physician and will not be able to find another physician to provide the treatment the agent and family demand. Finally, the Colorado Rules of Professional Conduct provide insufficient guidance and direction to attorneys representing clients in end-of-life decision-making cases that require a consideration of broader ethical principles.

NOTES

1. CRS §§ 15-14-503 to -509.
2. CRS § 12-36-101 *et seq.*
3. Also known as a "Declaration as to Medical or Surgical Treatment." *See* CRS § 15-18-104.
4. CRS § 15-14-507(5).
5. CRS § 15-14-506(5)(b).
6. CRS § 15-14-507.
7. CRS § 12-36-101 *et seq.*
8. CRS § 12-36-117(1)(bb)(I).
9. CRS § 12-36-117(1)(p).
10. For the actual case, *see In Re Lois Warp*, Boulder District Court (Case No. 98PR231) (March 11, 1999).
11. *Barber v. Superior Court of California*, 195 Cal.Rptr. 484 (Cal.App. 2 Dist. 1983).
12. *Id.* at 489.
13. *Id.* at 490-1.
14. *Id.* at 491; *see also* Horan, "Euthanasia and Brain Death: Ethical and Legal Considerations," 315 *Annals N.Y. Acad. Sci.* 363, 367 (1978), *as quoted in* President's Commission Report for the Study of Ethical Problems in Medicine and Biomedical Behavioral Research, *Deciding to Forego Life-Sustaining Treatment: A Report on the Ethical Medical and Legal Issues in Treatment Decisions* (*hereafter, President's Commission Report*)(Wash., D.C.: GPO 1983) at 44.
15. *Supra*, note 11 at 491.
16. *Id.*; *see also President's Commission Report, supra,* note 14 at 82-90.
17. Tomlinson and Brody, "Futility and the Ethics of Resuscitation," 264 (10) *JAMA* 1264-1272, 1277 (Sept. 12, 1990).
18. American Thoracic Society, "Withholding and Withdrawing Life-Sustaining Therapy," *The American Review of Respiratory Disease*, 144: 726-731 (Sept. 1991).
19. *Id.*
20. Luce, "Physicians Do Not Have a Responsibility to Provide Futile or Unreasonable Care if a Patient or Family Insists," *Critical Care Medicine*, 23:760-766 (April 1995).
21. Schneiderman, Jecker, and Jonsen, "Medical Futility: Its Meaning and Ethical Implications," 112(12) *Annals Internal Med.* 949, 953 (1990).
22. Wanzer, *et al.*, "The Physician's Responsibility Toward Hopelessly Ill Patients," *New England Journal of Medicine*, 310:955 (1984).
23. This was the decision of the Boulder District Court in *In Re Lois Warp*, *supra*, note 5. The decision was appealed to the Colorado Supreme Court under a Petition for Rule to Show Cause Pursuant to CAR 21. The court refused to grant the petition (99-SA-103, March 19, 1999). ■