

LAW, INSOUCIANCE, AND DEATH IN THE EMERGENCY ROOM

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During the 2009 health care debate, rumors of government-sponsored “death panels” filled headlines, and advanced care planning became the center of these discussions. The dissension, however, fails to consider the situation where advance directives are needed most, yet often do not apply: the emergency room. When a patient presents for treatment at an emergency room, the patient’s consent for resuscitation is implied, even if that patient previously executed an advance directive explicitly forgoing resuscitation. This Note discusses the legal status of advance directives as they pertain to the emergency room setting. The Note provides a brief history of end-of-life decision making in the United States and discusses the difficulty of honoring patient autonomy in the emergency room. The Note then addresses the end-of-life decision-making concerns specific to the emergency room setting and analyzes the current state of advance directives. Ms. Webley proposes a regime for end-of-life planning that considers the uniqueness of the emergency room setting and incorporates multiple goals of end-of-life policy and jurisprudence.

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I. Introduction

Rumors of government-sponsored “death panels” plagued the 2009 health care debate.¹ A key aspect of the controversy revolved around a pending House bill that would require Medicare to reimburse physicians for the time they spend counseling Medicare enrollees about end-of-life planning.² Although this provision was not included as part of the recently enacted Patient Protection and Affordable Care Act,³ commonly referred to as ObamaCare, the debate over who should pay for advance care planning continues today.⁴ This dissension, however, has little relevance in the current health care regime, because advance directives generally do not matter in the situation where patients most frequently need them—the emergency room.⁵

When an incapacitated patient arrives for treatment at an emergency room, the patient’s consent for resuscitation may be implied, even if that patient previously executed an advance directive explicitly forgoing resuscitation.⁶ The intersection of emergency medicine and end-of-life planning is especially apropos when considered in the context of elder law. Literature reveals that most elderly patients do

1. Jim Rutenberg & Jackie Calmes, *Getting to the Source of the Death Panel Rumor*, N.Y. TIMES, Aug. 14, 2009, at A1.

2. America’s Affordable Health Choices Act of 2009, H.R. 3200, 111th Cong. § 1233 (2009). Sarah Palin referred to the bill as “downright evil,” claiming that the elderly would be brought before a “death panel so [President Obama’s] bureaucrats [could] decide . . . whether they are worthy of health care.” Kate Snow, *Health Care ‘Death Panels’ a Myth*, ABC NEWS, Aug. 10, 2009, <http://abcnews.go.com/Politics/story?id=8298267&page=1>. The bill, however, did not create “panels,” but rather called for a “consultation between the individual and a practitioner,” at which the parties would discuss end-of-life options and the physician could assist the patient in preparing an advance directive. *Id.*

3. See Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 (2010).

4. A portion of ObamaCare, the CLASS Act, is a self-funded program aiming to assist Americans in paying for long-term care services. See Patient Protection and Affordable Care Act, 124 Stat. 828. Although CLASS Act benefits are not part of Medicare, one may use the benefits to pay for end-of-life counseling or legal fees to create an advance directive. 42 U.S.C. § 3205(c)(1)(B) (final sentence); Richard L. Kaplan, *Analyzing the Impact of ObamaCare on Older Americans*, 18 ELDER L.J. 213, 214 (2011).

5. EILEEN E. MORRISON, HEALTH CARE ETHICS: CRITICAL ISSUES FOR THE 21ST CENTURY 133 (2d ed. 2009).

6. Kathleen E. Wherthey, *Cause of Action to Recover Damages for Health Care Provider’s Failure to Comply with Advance Directive*, in 16 CAUSES OF ACTION 2D 83 § 16 (2009) (“A patient’s consent may be implied where the patient is in a physical or mental condition rendering him unable to consent, while an emergency requires immediate action to preserve his life or health.”).

not want to receive cardiopulmonary resuscitation (CPR) after learning of their low probability of surviving until hospital discharge.⁷ Nevertheless, these patients may end up in the emergency room because a family member calls 911 out of panic or in a final effort to do everything possible to save the patient's life.⁸

As an illustration, consider the case of Jane Doe, a seventy-six-year-old woman afflicted with a chronic disease.⁹ After her primary care physician informs her that she is unlikely to survive until hospital discharge if she requires resuscitation after cardiac arrest, Ms. Doe executes a living will specifying her wish not to be resuscitated. The living will is placed in her medical record. One month later, at her home, Ms. Doe becomes short of breath, and her family calls 911. Upon arrival, the emergency medical technicians (EMTs) note that Ms. Doe is in respiratory distress and put her in an ambulance for transport to the nearest emergency room. En route, Ms. Doe's blood pressure drops to zero and she loses her pulse, prompting the EMTs to begin chest compressions. In the emergency room, doctors immediately defibrillate, intubate, and place Ms. Doe on a ventilator while continuing their resuscitative efforts.

The resuscitation saves Ms. Doe's life, but the procedure leaves her brain damaged and ventilator dependent, with broken ribs, several intravenous lines to give medications, and a Foley catheter to drain her bladder. Ms. Doe is admitted to the hospital where she requires mechanical and invasive support to remain alive. Only after the emergency passes is a note discovered on the EMTs' chart stating "family reported patient was [do not resuscitate] at home, but they didn't have the paperwork."¹⁰ As her primary care physician pre-

7. Jessica P. Hwang et al., *Challenges in Outpatient End-of-Life Care: Wishes to Avoid Resuscitation*, 22 J. CLINICAL ONCOLOGY 4643, 4643 (2004). The success rate (defined as being discharged alive from the hospital) for elderly patients receiving CPR is 3.8%. Donald J. Murphy et al., *Outcomes of Cardiopulmonary Resuscitation in the Elderly*, 111 ANNALS INTERNAL MED. 199, 203 (1989).

8. See Hwang et al., *supra* note 7, at 4644.

9. This story loosely follows the story set forth in *Challenges in Outpatient End-of-Life Care: Wishes to Avoid Resuscitation*, written by Jessica P. Hwang, Martin L. Smith, and Anne L. Flamm for the Journal of Clinical Oncology. *Id.* The author consulted with Dr. Daniel Gadzinski when adding the medical details necessary to tailor the story to the emergency context. Telephone interview with Dr. Daniel Gadzinski, Attending Emergency Room Physician, Oakwood Health Sys. (Oct. 10, 2009) [hereinafter Gadzinski Interview].

10. Hwang et al., *supra* note 7, at 4643.

dicted, Ms. Doe never makes it out of the hospital alive—succumbing after a three-week hospital stay.

This scenario illustrates how, even though a patient consults with his or her primary care physician, makes an informed decision regarding end-of-life treatment preferences, and puts the preferences into his or her medical record, the patient may still receive the precise treatment he or she wishes to avoid. This may happen for several reasons. First, unless made aware of the patient's end-of-life treatment preferences, family members may call an ambulance when the patient enters the active phase of dying that requires an immediate treatment decision.¹¹ Even if aware of the patient's preferences, family members may call an ambulance due to confusion and panic.¹² The EMTs that arrive on the scene have a legal and ethical obligation to stabilize the patient and transport him or her to the nearest emergency room unless they receive concrete proof of the patient's wishes.¹³ In the above illustration, family members orally informed the EMTs of Ms. Doe's wish not to be resuscitated; however, because no one could produce the legal document, Ms. Doe was resuscitated against her wishes.

Another issue arises if the emergency physician lacks access to the patient's medical record. This could occur, for example, if the medical record is located at a different hospital. Furthermore, regardless of whether the hospital has the patient's medical record on file, there likely will not be enough time in an emergency situation to access it.¹⁴

A difficult dilemma faced by emergency physicians may occur when the legal document is produced (so the emergency physician knows of the patient's treatment preferences), but a family member present at the scene requests that the physician save the patient regardless.¹⁵ What is a reasonable emergency physician to do in such a circumstance?

11. Charles P. Sabatino, *Survey of State EMS-DNR Laws and Protocols*, 27 J.L. MED. & ETHICS 297, 297 (1999). "Living wills . . . have proved particularly unhelpful in situations where a dying patient residing outside a hospital suffers a medical crisis and a family member or caretaker dials 911 for help." *Id.*

12. Hwang et al., *supra* note 7, at 4644.

13. Sabatino, *supra* note 11, at 297.

14. Gadzinski Interview, *supra* note 9.

15. Evan Thomas, *The Case for Killing Granny, Rethinking End-of-Life Care*, NEWSWEEK, Sept. 21, 2009, at 34.

This Note discusses the legal status of advance directives as they pertain to the emergency room setting. Part II presents a brief history of end-of-life decision making in the United States and discusses the fact that the hallmark of death and dying jurisprudence—honoring patient autonomy—is often prohibitively difficult in the emergency room. Part III elucidates end-of-life decision-making issues unique to the emergency room setting and analyzes the current state of advance directives in the United States. Part IV recommends a regime for end-of-life planning that takes the emergency room setting into account.

II. Background

Proliferation of sophisticated, life-sustaining medical technology means that Americans live longer with greater attention paid to end-of-life care.¹⁶ Older Americans and their families face increasingly complex decisions concerning initiating, withholding, and terminating medical treatments.¹⁷ The capability of medical science to substantially prolong the dying process troubles many people, causing them to seek “death with dignity.”¹⁸ Once a dying patient’s suffering becomes unbearable, the patient may seek to control the manner and timing of his or her death.¹⁹

Judicial consideration of these issues came to the forefront in 1976 with the landmark New Jersey case, *In re Quinlan*.²⁰ At only twenty-one years of age, Karen Ann Quinlan entered a persistent vegetative state after suffering severe brain damage from a mixture of drugs and alcohol.²¹ Although the primitive portions of Karen Ann’s brain, which controlled such basic functions as body temperature regulation, chewing, and swallowing, still functioned, she remained un-

16. Faith P. Hopp, *Preferences for Surrogate Decision Makers, Informal Communication, and Advance Directives Among Community-Dwelling Elders: Results from a National Study*, 40 GERONTOLOGIST 449, 449 (2000).

17. *Id.*

18. Norman L. Cantor, *Twenty-Five Years After Quinlan: A Review of the Jurisprudence of Death and Dying*, 29 J.L. MED. & ETHICS 182, 182 (2001).

19. *Id.* Some patients seek “the disconnection of life-sustaining medical interventions, such as respirators and dialysis machines.” *Id.* Others seek “access to pain relief medication—even in dosages posing some risk. . . of hastening death.” *Id.* Some patients “voluntarily refuse[] to eat or drink or to accept artificial nutrition and hydration.” *Id.* Lastly, some dying patients seek “the more expeditious route of assisted suicide (via a prescription of lethal medication) or even active euthanasia (via a lethal injection at a physician’s hand).” *Id.*

20. *In re Quinlan*, 355 A.2d 647 (N.J. 1976).

21. Cantor, *supra* note 18, at 183.

conscious and unaware of her surroundings.²² Karen Ann relied on a respirator and artificial nutrition and hydration to stay alive.²³ In essence, everything that made Karen Ann human—her capacity to talk, think, and feel—was gone.²⁴ Karen Ann's father sought judicial appointment to be named her guardian with the authority to remove her respirator.²⁵ Amidst allegations that removing the respirator would constitute murder, the New Jersey Supreme Court ruled that Karen Ann, if competent, would have had the right to resist continued life support.²⁶ In light of her incapacity, the court held that her right could be exercised by a conscientious guardian—her father.²⁷

The United States Supreme Court recognized the constitutional basis for the right to refuse treatment in the 1990 case, *Cruzan v. Director, Missouri Department of Health*.²⁸ By the time the United States Supreme Court heard the case, thirty-two-year-old Nancy Beth Cruzan had been in a persistent vegetative state for seven years, requiring artificial nutrition and hydration for her continued survival.²⁹ Nancy Beth's parents wanted the artificial nutrition and hydration procedures terminated.³⁰ The United States Supreme Court found that the Fourteenth Amendment, providing that no state shall "deprive any person of life, liberty, or property, without due process of law," included a liberty interest in refusing heroic medical measures.³¹ At the heart of these types of cases lies the fear felt by many that they or those they love will be kept alive in the face of a dismal prognosis and a dreadful quality of life.³²

The hallmark of death and dying jurisprudence is patient autonomy.³³ The emphasis placed on patient autonomy has led to the in-

22. MICHAEL S. LIEF & H. MITCHELL CALDWELL, AND THE WALLS CAME TUMBLING DOWN: CLOSING ARGUMENTS THAT CHANGED THE WAY WE LIVE—FROM PROTECTING FREE SPEECH TO WINNING WOMEN'S SUFFRAGE TO DEFENDING THE RIGHT TO DIE 7 (2004).

23. Cantor, *supra* note 18, at 183.

24. LIEF & CALDWELL, *supra* note 22, at 7.

25. Cantor, *supra* note 18, at 183.

26. *Id.*

27. *Id.*

28. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990).

29. *Id.* at 265–67.

30. *Id.* at 265.

31. *Id.* at 278.

32. Angela Fagerlin et al., *The Use of Advance Directives in End-of-Life Decision Making: Problems and Possibilities*, 46 AM. BEHAV. SCIENTIST 268, 269 (2002).

33. Cantor, *supra* note 18, at 183.

creased promotion of advance directives, documents that allow individuals to designate their preferences for medical care in the event they cannot communicate these wishes at a future time.³⁴ Advance directives come in two basic forms—the living will and the durable power of attorney for health care.³⁵

The living will allows individuals to specify in writing their preferences for the type of medical care they wish to receive.³⁶ An effective living will should specify the exact circumstances under which it will apply, such as when the patient becomes terminally ill or enters a persistent vegetative state.³⁷ Additionally, the patient should list the treatments to be administered or rejected.³⁸ Finally, the patient should state his or her awareness that the refusal of care could result in death and that the patient's "intent in refusing treatment is not to die but, rather, is to avoid a long, painful death."³⁹

The durable power of attorney for health care is a legal document allowing a person to designate a surrogate decision-maker, who will have the authority to make medical decisions on his or her behalf upon incapacitation.⁴⁰ When executing this document, one should explain the exact powers granted to the surrogate decision-maker.⁴¹

34. Jaklin Elliott & Ian Olver, *Autonomy and the Family as (In)Appropriate Surrogates for DNR Decisions: A Qualitative Analysis of Dying Cancer Patients' Talk*, 18 J. CLINICAL ETHICS 206, 206 (2007).

35. Hopp, *supra* note 16, at 449.

36. *Id.*

37. Catherine J. Jones, *Decisionmaking at the End of Life*, 63 AM. JUR. TRIALS 1 § 31 (2009).

38. *Id.* Treatments that may appear in a living will include mechanical ventilation, artificial nutrition and hydration, medication, blood products, surgery, kidney dialysis, cardiopulmonary resuscitation (CPR), diagnostic tests, and comfort care. *Id.*

39. *Id.* The latter part of this statement is necessary to counter the argument that refusal of treatment is equivalent to suicide and, therefore, "contrary to the state's compelling interest in preventing suicide." *Id.*

40. Hopp, *supra* note 16, at 449.

41. Jones, *supra* note 37, at § 32. Examples of the powers often granted to surrogate decision-makers are communicating the patient's wishes concerning the administration or withholding of certain types of medical treatment to the attending physician, consenting to or refusing medical treatment on behalf of the patient, consenting to or refusing comfort care, requesting, employing or discharging health care providers, and endeavoring to ensure that the patient's wishes are carried out. *Id.*

Theoretically, allowing a patient to dictate in advance his or her end-of-life preferences would serve the goal of patient autonomy.⁴² Patients would be able to influence their medical treatment decisions even after becoming incapacitated by conveying specific preferences while they still have capacity.⁴³ If decision-makers exactly follow patients' wishes, advance directives would allow patients to control their medical treatment, even after losing the capacity to make medical decisions.⁴⁴ Often, however, this ideal remains unrealized, because it may be difficult for patients to predict their own future treatment preferences when executing the advance directive.⁴⁵ Furthermore, even if treatment preferences can be predicted accurately, no document can provide for the limitless possibilities of future medical issues a patient may encounter.⁴⁶

A common issue with the durable power of attorney for health care arises when the surrogate decision-makers find themselves unable to convert patients' documented treatment preferences into specific treatment decisions.⁴⁷ An underlying problem with living wills is that patients may not want to impose this specific level of control over their end-of-life medical decisions, preferring loved ones to select the course of medical treatment.⁴⁸ A substantial body of research suggests that a gap exists between the autonomy-centered foundation at the heart of current advance care standards and the actual desires of many patients.⁴⁹

In 1990, Congress passed the Patient Self-Determination Act (PSDA), which requires all federally funded facilities to ask incoming patients whether they have an advance directive and inform those who do not about their decision-making rights.⁵⁰ The PSDA spurred tremendous support for advance directives in both the general public and prevalent organizations, such as the American Medical Associa-

42. Nikki Ayers Hawkins et al., *Micromanaging Death: Process Preferences, Values, and Goals in End-of-Life Medical Decision Making*, 45 GERONTOLOGIST 107, 107 (2005).

43. *Id.*

44. *Id.* at 107.

45. *Id.* at 107-08.

46. *Id.* at 108.

47. *Id.*

48. *Id.*

49. *Id.*

50. Federal Patient Self Determination Act, 42 U.S.C. § 1395cc(f)(1)(A) (2006).

tion and the American Association of Retired Persons.⁵¹ The PSDA, however, does not actually impose a standard of care on physicians or treatment centers. It simply requires the facility to maintain written policies and procedures concerning advance directives and to provide certain information to the patient, in writing, regarding the patient's right to make decisions concerning his or her medical care.⁵² Furthermore, the PSDA does not require emergency departments to provide the patient with information regarding advance directives because "the individual's admission [to the hospital] as an inpatient," triggers the facility's requirement to provide such information,⁵³ but the emergency room is a pre-hospital setting.⁵⁴

Not only are emergency departments not required to provide incoming patients with information regarding advance directives,⁵⁵ but emergency physicians might not even honor advance directives.⁵⁶ In the emergency department setting, the standard of practice, depending on the urgency of the case, is "to treat first and ask questions later."⁵⁷ As Dr. Gregory Luke Larkin notes:

The initial impulse to save a life is considered by most commentators to be the right impulse For example, if [an emergency physician has] someone who is losing blood pressure and their

51. Fagerlin et al., *supra* note 32, at 269.

52. Federal Patient Self Determination Act, 42 U.S.C. § 1395cc(f)(1). The PSDA requires the facility to do the following:

[M]aintain written policies and procedures with respect to all adult individuals receiving medical care . . . (A) to provide written information to each individual concerning (i) an individual's rights under State law . . . to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives . . . , and (ii) the written policies of the provider or organization respecting the implementation of such rights; (B) to document in prominent part of the individual's current medical record whether or not the individual has executed an advance directive; (C) not to condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive; (D) to ensure compliance with requirements of State law . . . respecting advance directives . . . ; and (E) to provide . . . for education for staff and community on issues concerning advance directives.

Federal Patient Self Determination Act, 42 U.S.C. § 1395cc(f)(1).

53. 42 U.S.C. § 1395cc(f)(2)(A).

54. Gadzinski Interview, *supra* note 9.

55. See *supra* notes 53–54 and accompanying text.

56. MORRISON, *supra* note 5, at 133.

57. Gregory Luke Larkin & Tammie E. Quest, *End-of-Life Decisions Can Be Complex, Even When Patients Have a DNR*, 17 EMERGENCY DEPARTMENT MGMT. 49, 49 (2005).

heart is fibrillating, [the physician should not even] get a history until [the physician shocks the heart]. That's the very nature of emergency medicine.

When a patient requires life support measures and time is of the essence, the implementation of advance directives may be prohibitively difficult.⁵⁹ Most emergency physicians do not consider the emergency room to be the proper time and place to make critical judgment calls.⁶⁰ These physicians recognize that they could either "spend time making a written determination of patient incapacity, validate the integrity of the written advance directive, verify the identity of the authorized agent, and engage in the required informed consent procedures with the agent *or* treat the patient."⁶¹ The consensus is to treat the patient.⁶²

When a patient presents for treatment at an emergency department, physicians presume that the patient wants treatment.⁶³ Theoretically, if a physician treats a patient without his or her consent, the physician may be liable for battery, even if the procedure is harmless or beneficial.⁶⁴ However, in an action for failure to comply with an advance directive, the fact that the disputed health care decision took place in an emergency context with a patient incapable of making his or her own medical decisions serves as a complete defense against a battery theory.⁶⁵ "A patient's consent may be implied where the patient is in a physical or mental condition rendering him unable to consent, while an emergency requires immediate action to preserve his life or health."⁶⁶ In *Estate of Leach v. Shapiro*, the Court of Appeals of

58. *Id.* at 49-50. Dr. Gregory Luke Larkin is a professor of surgery, emergency medicine, and public health at University of Texas Southwestern Medical Center. *Id.* at 49.

59. Robert A. Partridge et al., *Field Experience with Prehospital Advance Directives*, 32 ANNALS OF EMERGENCY MED. 589, 590 (1998) ("In the prehospital setting, where extraordinary life support measures are frequently necessary, the implementation of [advance directives] is often difficult. Patients may be unable to communicate their wishes, documentation of [advance directives] may not be immediately available, and relatives or bystanders may be ignorant of a patient's wishes or express equivocal requests.").

60. MORRISON, *supra* note 5, at 134.

61. *Id.* (emphasis added).

62. *Id.*

63. Gadzinski Interview, *supra* note 9.

64. *Estate of Leach v. Shapiro*, 469 N.E.2d 1047, 1051 (Ohio Ct. App. 1984).

65. Wherthey, *supra* note 6, at 108.

66. *Id.* at 107.

Ohio recognized that “doctors must be free to exercise their best medical judgment in treating a life-threatening emergency.”⁶⁷

These heroic measures may be unwanted, especially in the elderly population. As a person ages, it is increasingly likely that he or she will be chronically or terminally ill when suffering from cardiac arrest, which decreases the probability of a successful resuscitation.⁶⁸ “Surveys show that almost all patients would not want to be resuscitated to a state of severe neurologic impairment, yet this can be the result of resuscitative efforts, especially in the chronically ill.”⁶⁹ The emergency medical setting creates major challenges in striking a balance between indiscriminant resuscitation, which may lead to unwanted or unnecessary invasive medical procedures, and rigidly following advance directives, which may preclude instances where meaningful survival could have resulted.⁷⁰

In 2005, the case of Terri Schiavo brought advance directives and other end-of-life issues to the forefront of the public’s attention.⁷¹ Terri Schiavo suffered cardiac arrest on February 25, 1990, which temporarily stopped her heart and caused severe brain damage.⁷² At only twenty-six years old, Terri never regained consciousness.⁷³ The following June, Terri’s husband, Michael Schiavo, was appointed her guardian.⁷⁴ In May 1998, Michael filed a petition to the district court for the removal of Terri’s feeding tube, but Terri’s parents strongly objected.⁷⁵ No one knew Terri’s wishes because she did not have a living will, and this left the courts in the position of resolving the bitter contention between Terri’s husband—her legal guardian—and Terri’s parents.⁷⁶ Michael testified at trial that Terri, while still able to do so,

67. Estate of Leach, 469 N.E.2d at 1054.

68. Corita R. Grudzen et al., *Potential Impact of a Verbal Prehospital DNR Policy*, 13 PREHOSPITAL EMERGENCY CARE 169, 169 (2009).

69. *Id.*

70. *Id.*

71. Larkin & Quest, *supra* note 57, at 49; see generally Schiavo *ex rel.* Schindler v. Schiavo, 403 F.3d 1289 (11th Cir. 2005).

72. Kathy Cerminara & Kenneth Goodman, *Key Events in the Case of Theresa Marie Schiavo*, U. OF MIAMI, http://www.miami.edu/ethics/schiavo/schiavo_timeline.html (last updated June 15, 2009).

73. LOIS SHEPHERD, IF THAT EVER HAPPENS TO ME: MAKING LIFE AND DEATH DECISIONS AFTER TERRI SCHIAVO 15 (2009).

74. Cerminara & Goodman, *supra* note 72.

75. *Id.*

76. *In re* The Guardianship of Schiavo, No. 90-2908GD-003, 2000 WL 34546715, at *3 (Fla. Cir. Ct. Feb. 11, 2000).

had indicated that she would not want to live her life in such a state.⁷⁷ The court determined that Terri was in a persistent vegetative state and, if competent to make her own medical decisions, would choose to remove her feeding tube.⁷⁸ Fifteen years after Terri Schiavo's heart attack, doctors removed her feeding tube, and she was allowed to die.⁷⁹

Terri Schiavo's story captivated the American public and brought end-of-life decision making to the foreground of popular debate. This helped to shape the current legal climate, which focuses primarily on patient autonomy.⁸⁰ Most people believe that if one executes an advance directive, one has the ability to direct end-of-life care in every situation.⁸¹ This belief, however, is inaccurate because advance directives have little relevance in the emergency room, where patients often present for care when they are near death.⁸²

III. Analysis

Near the end of life, when patients often make important decisions about medical treatments, they likely face mental or physical incapacitation and, thus, cannot make treatment decisions for themselves.⁸³ Anticipating this dilemma, some choose to influence their future treatment by executing an advance directive, which either specifies the treatment desired or designates a surrogate decision-maker to make treatment choices when the time comes.⁸⁴ The patient autonomy framework that underlies the American death and dying legal

77. *Id.* at *4.

78. *Id.* at *5, *7.

When patients are in a vegetative state, doctors believe they cannot experience life in any way—that they are completely unconscious. When the condition is properly diagnosed as permanent, there is no evidence that the patient can ever regain any consciousness; . . . the chance of recovery, even slight recovery, is most accurately described as zero.

SHEPHERD, *supra* note 73, at 1.

79. KANT PATEL & MARK RUSHEFSKY, *HEALTH CARE POLITICS AND POLICY IN AMERICA* 354 (3d ed. 2006).

80. Cantor, *supra* note 18, at 183.

81. MORRISON, *supra* note 5, at 134.

82. Gadzinski Interview, *supra* note 9.

83. Hawkins et al., *supra* note 42, at 107 (“In order to maintain a patient’s ‘voice’ in these decisions, great efforts have been made to develop policy and law to both entitle and encourage patients to document their preferences for treatments before incapacitating illness occurs.”).

84. Hopp, *supra* note 16, at 449–50.

regime may lead the public to believe that their advance directives always are honored.⁸⁵ In actuality, if a patient presents for treatment in the emergency room, even if the patient possesses a valid advance directive, the patient implicitly consents to medical care.⁸⁶

A. End-of-Life Decision-Making Issues Unique to the Emergency Setting

Refusal of care represents one of the most common ethical dilemmas faced by an emergency physician, pitting the duty to help patients against the duty to respect patient autonomy.⁸⁷ End-of-life decision making in the emergency room presents unique dilemmas that may not exist in the inpatient setting.⁸⁸ First, when a patient presents for treatment in the emergency room, the emergency physician may not know whether the patient has a valid advance directive.⁸⁹ For example, the patient's medical record may be located at a different hospital, and the emergency physician may not have enough time to access the record.⁹⁰ Even if a family member states that the patient has a valid advance directive, if the paperwork cannot be produced, the patient still might be resuscitated.⁹¹

Another common dilemma arises when family members disagree as to appropriate end-of-life care.⁹² An advance directive might be rendered useless if a family member present in the emergency room demands alternative treatment.⁹³ Even if a valid advance directive is produced, the family members may dispute or reject it and in the emergency setting, the patient may be resuscitated.⁹⁴

85. Cantor, *supra* note 18, at 194.

86. Wherthey, *supra* note 6, at 107.

87. Jeremy R. Simon, *Refusal of Care: The Physician-Patient Relationship and Decisionmaking Capacity*, 50 ANNALS OF EMERGENCY MED. 456, 456 (2007).

88. Larkin & Quest, *supra* note 57, at 49 (providing examples of the unique circumstances present in emergency departments).

89. *Id.* at 49.

90. Gadzinski Interview, *supra* note 9.

91. Grudzen et al., *supra* note 68, at 171. A 2006–2007 study conducted in Los Angeles County surveyed 897 patients, with a mean age of 67.7 years, who suffered from a nontraumatic cardiac arrest. *Id.* at 170. Of the patients studied, fifty-five had a DNR order, and of those fifty-five, ten were resuscitated anyway. *Id.* at 171. For nine of the ten patients, a family member at the scene noted that the patient had a DNR order but could not produce it for the emergency personnel. *Id.*

92. Gadzinski Interview, *supra* note 9.

93. Thomas, *supra* note 15, at 40.

94. Grudzen et al., *supra* note 68, at 171.

B. Who Makes Treatment Decisions for an Incapacitated Patient in the Emergency Setting?

If a patient remains conscious and competent, then the patient acts as the proper decision-maker regarding his or her end-of-life medical care.⁹⁵ A patient with capacity to consent who refuses medical care should be discharged against medical advice.⁹⁶ Patients presenting for emergency care, however, frequently are not in a position to make medical treatment decisions.⁹⁷ In these cases, who does the current legal regime call upon to make treatment choices for the incapacitated patient?

1. IF THE INCAPACITATED PATIENT LEGALLY DESIGNATED A SURROGATE DECISION-MAKER, THE SURROGATE SHOULD GUIDE MEDICAL CARE

Some literature states that the first responsibility (if time permits) of an emergency physician, when deciding how to treat an incapacitated patient, is to assess whether the patient designated a surrogate decision-maker.⁹⁸ If so, the surrogate must be allowed to guide medical care, regardless of what the physician thinks may be best for the patient.⁹⁹ "Durable powers of attorney allow principals to designate agents to make decisions for them when they are no longer able to do so, and the law requires that agents be treated like principals."¹⁰⁰ Proponents of this view argue that even if the foregone treatment likely will benefit the patient, it is inappropriate for a physician to second-guess the patient's duly designated agent, because physicians are not allowed to second-guess competent patients.¹⁰¹

Some of the literature that recognizes the importance of respecting the patient's authority to designate a surrogate decision-maker

95. Jones, *supra* note 37, at § 18. The reasoning for respecting a patient's choices if the patient is competent to make his or her own choices is twofold. Simon, *supra* note 87, at 458. First, society assumes that people generally know what is best for them, so respecting their choices maximizes patient good. *Id.* Second, there remains an inherent value in respecting patient autonomy, regardless of the benefit a particular decision may produce. *Id.*

96. Simon, *supra* note 87, at 456.

97. Gadzinski Interview, *supra* note 9.

98. Simon, *supra* note 87, at 460.

99. *Id.*

100. David Hyman, *Case Discussion: Comments from a Health Law Professor*, MID-ATLANTIC ETHICS COMM. NEWSLETTER (Institutional Ethics Comm. Res. Network, Balt. Md.), Fall 1995, at 8.

101. *Id.* at 8-9.

notes caveats that occur in the emergency setting.¹⁰² For example, some argue that even when a surrogate decision-maker is present and directs a course of treatment for the patient, the emergency physician may still consider family input.¹⁰³ The emergency physician should be sensitive to the fact that the treatment decision made for the patient will affect the family.¹⁰⁴ Furthermore, the family may have knowledge of the patient's wishes and values, which may guide the surrogate and physician in deciding on a course of treatment.¹⁰⁵

Allowing a single, designated surrogate to make the final treatment decision may resolve a case in which several relatives disagree as to the proper course of treatment.¹⁰⁶ For the elderly, however, this approach presents the risk that the designated surrogate, usually the spouse, is also incapacitated, due to the prevalence of dementia and other chronic diseases in the elder population.¹⁰⁷ The approach's inability to provide guidance to the emergency physician if the designated surrogate cannot be located represents another disadvantage.¹⁰⁸

2. IF THE INCAPACITATED PATIENT DID NOT DESIGNATE A SURROGATE DECISION-MAKER OR THE SURROGATE IS UNAVAILABLE, THE EMERGENCY PHYSICIAN MAY SEEK GUIDANCE FROM A VARIETY OF SOURCES WHEN MAKING TREATMENT DECISIONS

Despite efforts to encourage the creation of advance directives, few people actually complete such a document.¹⁰⁹ Although few people complete advance directives, greater numbers share treatment

102. Simon, *supra* note 87, at 460.

103. *Id.*

104. *Id.*

105. *Id.*

106. Ann Alpers & Bernard Lo, *Avoiding Family Feuds: Responding to Surrogate Demands for Life-Sustaining Interventions*, 27 J.L. MED. & ETHICS 74, 74 (1999). In some states, such as New York, there is no ambiguity as to who has authority to make decisions for the patient since only the legally appointed surrogate, designated in writing, can assume the role of decision-maker. Simon, *supra* note 87, at 460.

107. Gadzinski Interview, *supra* note 9.

108. *Id.*

109. Hopp, *supra* note 16, at 449. "[W]hereas approximately 80% of Americans report having an estate will, only about 18% have drafted any type of advance directive. Although individuals with chronic or terminal illnesses complete living wills at rates that exceed those of nonpatients, completion rates are still low Moreover, completion rates are particularly low for some ethnic groups. European Americans, for example, have been found to be more inclined to complete advance directives than African Americans" Fagerlin et al., *supra* note 32, at 271.

preferences with loved ones through informal conversation.¹¹⁰ In fact, a key reason given by patients for not completing an advance directive is that they confidently feel they can rely on loved ones to make their health care decisions if they cannot do so.¹¹¹

a. The Emergency Physician May Seek Guidance from State Default Surrogacy Laws If the incapacitated patient requiring emergency care does not have a designated surrogate decision-maker, the emergency physician may look to state default surrogacy laws to help protect the wishes of the patient.¹¹² The statutory systems in a substantial majority of states provide a “priority list,” designating who may serve as a surrogate in the absence of an advance directive.¹¹³ This “priority list” approach corresponds with the Uniform Health Care Decisions Act, which states:

[I]f an individual has not designated a surrogate—or if the designated surrogate is not “reasonably available”—a health care provider can obtain consent (or refusal of consent) from: “[A]ny member of the following classes of the patient’s family who is reasonably available, in descending order of priority . . . : (1) the spouse, unless legally separated; (2) an adult child; (3) a parent; or (4) an adult brother or sister.” If no such persons are reasonably available, any other adult “who has exhibited special care and concern for the patient, who is familiar with the patient’s personal values, and who is reasonably available” may serve as the incapacitated patient’s surrogate. In the event that more than one member of a class assumes surrogate decision making authority, the supervising health care provider is to comply with the will of the majority of the members of the class.¹¹⁴

110. Hopp, *supra* note 16, at 449.

111. *Id.* at 449–50. “Older persons, faced with the prospect of complex medical decisions, usually expect that family members will make medical decisions for them if they are unable to do so.” *Id.*

112. Nina A. Kohn & Jeremy A. Blumenthal, *Designating Health Care Decision-makers for Patients Without Advance Directives: A Psychological Critique*, 42 GA. L. REV. 979, 983 (2008).

113. *Id.* at 984.

114. *Id.* at 985–86. In addition to the rigid priorities designated by the Uniform Health Care Decisions Act, “some states make allowances for non-traditional families by including domestic partners or close friends.” *Id.* at 984–85. “A number of states also allow physicians to make decisions where no surrogate is available. Other states give physicians a role in selecting the surrogate. States generally obligate health care providers to rigidly adhere to the state’s priority list when identifying a default surrogate decisionmaker for an incapacitated patient.” *Id.* at 985.

Proponents of state default surrogacy laws argue that such laws help protect the wishes of the incapacitated patient.¹¹⁵ Furthermore, they argue that default surrogacy laws create an efficient mechanism for determining decision-making authority.¹¹⁶ Despite these perceived benefits, some literature questions the ability of default surrogacy statutes to effectuate patients' wishes, noting that default surrogacy statutes may not adequately account for "non-traditional" families.¹¹⁷ "Non-traditional families" may refer to same-sex couples and to "those who are estranged from their biological families or whose family units do not adhere to the traditional Western nuclear family design."¹¹⁸ Furthermore, individuals appointed under default surrogacy statutes, like health care surrogates in general, may not make the treatment choices patients would make for themselves.¹¹⁹

b. The Emergency Physician May Look to Family Members Present at the Scene The common law presumes that family members have a right to be consulted when a patient lacks capacity to make his or her own medical decisions, "with appropriate explanation and justification required if they are not [consulted]."¹²⁰ In the event of a patient's incapacitation, allowing family members present at the scene to make treatment decisions has many advantages. First, family members presumably know the patient's wishes.¹²¹ Additionally, they have the potential to fill the communication gap that exists between the patient and the treating physician, as they may be familiar with the patient's medical history.¹²² Furthermore, family members likely helped shape and share the values that would underlie the patient's decision.¹²³ Finally, patients most often choose family members as surrogates, indicating the preferred status usually held by family members.¹²⁴

Although allowing family members to make treatment decisions for an incapacitated patient provides many advantages, disadvantag-

115. *Id.* at 983.

116. *Id.* at 988.

117. *Id.* at 992.

118. *Id.*

119. *Id.* at 996.

120. Elliott & Olver, *supra* note 34, at 211.

121. *Id.* at 207.

122. Grudzen et al., *supra* note 68, at 171.

123. Elliott & Olver, *supra* note 34, at 207.

124. *Id.*

es also exist, which sometimes may disqualify family members from acting as surrogate decision-makers.¹²⁵ First, family members may have difficulty coming to terms with the imminent death of the patient, resulting in some form of denial.¹²⁶ This denial may result in the inability of family members to carry out the patient's wishes.¹²⁷ Family members may shy away from discussing the sensitive topic of end-of-life decision making with the patient while the patient is still competent and, thus, lack a strong sense of the patient's preferences.¹²⁸

Furthermore, an emergency situation likely will be frightening and unfamiliar to family members, resulting in a strong emotional response that "can be deemed to interfere with the desired rational process. [T]he very conditions that constitute family members as appropriate decision makers can function to identify them as inappropriate surrogate decision makers."¹²⁹ Finally, it may be unclear to the physician to whom "family" refers.¹³⁰ The family is "composed of individual members in different relationships to the patient . . . , who have different sets of values, experiences, and needs."¹³¹ A physician may have a tendency to consider the "family" a "homogenous superpersonality that thinks and acts as one."¹³² If the family is not a "homogeneous superpersonality," then which family members should be allowed to function as surrogate decision-makers for an incapacitated patient?

The hierarchical compensatory model suggests that older people prefer support and assistance in their daily lives first from spouses, next from children or other relatives, and finally, when familiar sources of support are unavailable, from neighbors and friends.¹³³ A

125. *Id.* James L. Nelson and Hilde Lindemann argue, in their response to Elliott and Olver's assertion that family members are not the ideal decision-makers that the problems with allowing family members to make end-of-life medical decisions are true for *all* potential decision-makers. James L. Nelson & Hilde Lindemann, *What Families Say About Surrogacy: A Response to "Autonomy and the Family as (In)appropriate Surrogates for DNR Decisions"*, 18 J. CLINICAL ETHICS 219, 224 (2007).

126. Elliott & Olver, *supra* note 34, at 212.

127. *Id.*

128. *Id.* at 213 ("If family members and patients can justifiably avoid these discussions as liable to have a negative effect on their (emotional) well-being, the extent to which family members can know and represent the patient's wishes will be compromised.").

129. *Id.*

130. *Id.* at 211.

131. *Id.*

132. *Id.*

133. Hopp, *supra* note 16, at 450, 454.

study conducted in 2000 by Faith P. Hopp posits that the hierarchical compensatory model applies only in part to the preferences of older persons for health care decision-makers.¹³⁴ The difference lies in the fact that elderly persons surveyed who had both spouses and living children indicated a preference for children to act as surrogate decision-makers over spouses.¹³⁵ An explanation for this discrepancy may be the anticipation by elderly patients that their spouse may be deceased or incapacitated when they need health care decisions made and that members of the younger generation will better be able to fulfill the task of communicating health care preferences to physicians.¹³⁶ This study suggests that, rather than give priority to a spouse, as many surrogacy statutes suggest, health care providers should recognize and respect the important role played by the younger generation in making medical decisions for older persons.¹³⁷

c. *The Emergency Physician May Be Required to Make the Final Decision* Dictating a course of treatment for a family member, especially in an emergency setting, can be a daunting and unwelcome task. In situations where emotions overcome family members and they cannot fulfill the responsibilities of surrogacy, the physician may step in as the family's preferred, dispassionate decision-maker.¹³⁸ The physician should be able to "rationally and independently weigh[] up objective facts" and then reach a decision.¹³⁹

The relatively recent focus on patient autonomy represents a change from the previous norm of physician decision making without patient participation.¹⁴⁰ Many found this paternalistic approach to be beneficial, because physicians possessed the knowledge required to understand the proper way to utilize medical technology in order to help, rather than harm, the patient.¹⁴¹

134. *Id.* at 454.

135. *Id.* at 455.

136. *Id.*

137. *Id.* at 456.

138. Elliott & Olver, *supra* note 34, at 207.

139. *Id.*

140. Timothy E. Quill & Howard Brody, *Physician Recommendations and Patient Autonomy: Finding a Balance Between Physician Power and Patient Choice*, 125 ANNALS OF INTERNAL MED. 763, 763 (1996).

141. *Id.* at 764.

C. The Standards Used by Surrogates When Making Medical Treatment Decisions for Incapacitated Patients

When a patient lacks the capacity to make his or her own medical decisions, as is often the case in emergency situations, another person may be required to make the necessary decisions on the patient's behalf. Because current health care policies in the United States pertaining to end-of-life decision making seek to preserve the autonomy of the dying patient, the "substituted judgment" standard represents the clear majority view.¹⁴² Should incapacity prevent a patient from making his or her own end-of-life medical decisions, the substituted judgment standard requires that the surrogate decision-maker make whatever decision he or she believes the dying patient would make if competent to do so.¹⁴³ Living wills, conversations with the patient, and the patient's reaction to prior medical treatment, either for the patient or for others, may inform the surrogate decision-maker of the patient's preferences.¹⁴⁴

A surrogate using a substitute decision-making approach in attempting to determine what action an incompetent patient would take if competent should consider at least six factors: (1) the patient's previously expressed preferences regarding treatment; (2) the patient's religious beliefs; (3) the impact of the decision upon the patient's family; (4) the probability of adverse side effects from the treatment; (5) the consequences to the patient if the treatment is withheld or withdrawn; [and] (6) the patient's prognosis if the treatment is administered.¹⁴⁵

The substituted judgment standard is extremely problematic because of the difficulty in predicting a patient's preferences.¹⁴⁶ A 2001 study illustrated that "surrogates predicting patient preferences without the benefit of an [advance directive] showed only modest accuracy in their substituted judgments" – the majority of errors being errors of overtreatment.¹⁴⁷ The introduction of advance directives into the

142. Sara M. Moorman & Deborah Carr, *Spouses' Effectiveness as End-of-Life Health Care Surrogates: Accuracy, Uncertainty, and Errors of Overtreatment or Undertreatment*, 48 GERONTOLOGIST 811, 811 (2008).

143. *Id.*

144. Jones, *supra* note 37, at § 24.

145. *Id.*

146. *Id.*

147. Peter H. Ditto et al., *Advance Directives as Acts of Communication*, 161 ARCHIVES OF INTERNAL MED. 421, 424 (2001). Furthermore, "[w]hen a . . . surrogate cannot reach a decision about care, treatment is usually continued This practice is intended to protect both patients and care providers, but it may lead to unnecessary cost and distress." Moorman & Carr, *supra* note 142, at 812.

study, however, failed to improve the accuracy of surrogate substituted judgments.¹⁴⁸ Spouses, especially, tend to project their own preferences into the substituted judgment formula, imputing these preferences inaccurately to the patient.¹⁴⁹

Additionally, a patient's treatment preferences may change over time, further limiting the accuracy of surrogate decision making under the substituted judgment standard.¹⁵⁰ "Surrogates cannot be expected to predict patients' future treatment wishes better than patients can predict their own."¹⁵¹ A growing body of research tends to "show that it is either impossible or prohibitively difficult to improve the ability of surrogates to predict patient preferences for specific treatments in specific medical circumstances" under the substituted judgment standard.¹⁵² For example, effective forecasting data reveals the inconsistencies of a patient's wishes at the time of an advance directive's execution and at subsequent points in time.¹⁵³ In addition, research shows that people overestimate the stability of their views over

148. Ditto et al., *supra* note 147. Differences between a surrogate's decision and a patient's expressed wishes, however, may be moot in many cases because significant numbers of patients state that some deviation from their wishes is acceptable. Elliott & Olver, *supra* note 34, at 207.

149. Rachel A. Pruchno et al., *Spouse as Health Care Proxy for Dialysis Patients: Whose Preferences Matter?*, 45 GERONTOLOGIST 812, 817 (2005).

150. Ditto et al., *supra* note 147, at 428.

151. *Id.*

152. *Id.* "Most broadly, some medical researchers suggest that overall, there is little evidence that the decisions patients make when they are relatively healthy predict their choices when death is imminent." Jeremy A. Blumenthal, *Law and the Emotions: The Problems of Affective Forecasting*, 80 IND. L.J. 155, 220 (2005).

153. Blumenthal, *supra* note 152, at 219. "In one recent study, researchers interviewed patients regarding their desires for medical treatment in several different scenarios." *Id.* Generally, patients initially reported preferences for treatment. *Id.* Upon being hospitalized for treatment, however, patients expressed less interest in life-sustaining treatment. *Id.* at 200. A few months after recovering, the patients reverted to their previously expressed preferences for treatment. *Id.*

Psychological research on decisionmaking indicates that for "choices among options that are important, complex, and unfamiliar, like those consumers face in the current health care environment . . . preferences do not preexist but are constructed on the spot by the decision maker through a process that is heavily influenced by framing and contextual factors." Thus, this body of research finds that in many cases, people are unaware of the way they will respond to a future health situation and do not know what they will want until they actually experience the situation.

Rebecca Dresser, *Precommitment: A Misguided Strategy for Securing Death with Dignity*, 81 TEX. L. REV. 1823, 1835 (2003).

time.¹⁵⁴ Because people may be unaware that their preferences might change, they generally do not alter their advance directives, resulting in advance directives that express inaccurately stated preferences.¹⁵⁵

The inaccuracy of substitute judgments by surrogate decision-makers, as revealed by the empirical evidence, presents an argument that patient autonomy should not continue to function as the primary factor guiding end-of-life decision making.¹⁵⁶ Many people worry less about the specific medical treatments they receive than they do about someone they love and trust being allowed to make the decision.¹⁵⁷

If the incompetent patient's subjective preferences regarding end-of-life care cannot be reliably determined, many jurisdictions follow the "best interests" standard, which allows the surrogate decision-maker to decide objectively the course of treatment that would most likely promote the patient's well-being.¹⁵⁸ Using this best interests standard, the surrogate weighs the burdens and benefits of a particular course of treatment for the reasonable person.¹⁵⁹ As guideposts, the surrogate decision-maker can use a presumption in favor of maintenance of life (because most people, even those who are seriously ill, want to continue living) and the principle that extreme suffering is unacceptable (given people's aversion to extreme pain).¹⁶⁰ The best interests standard, however, still allows the surrogate decision-maker to take the patient's discernible, competently expressed wishes into account.¹⁶¹

Although the best interests standard is not the majority view, the fact that patients commonly prefer that a surrogate override the patient's living will if the surrogate feels it is in the patient's best interests demonstrates its merits.¹⁶² Furthermore, many people acknowledge the impossibility of having all the facts when completing a living will and prefer a requirement that someone who *does* have all the facts

154. R. Mitchell Gready et al., *Actual and Perceived Stability of Preferences for Life-Sustaining Treatment*, 11 J. CLINICAL ETHICS 334, 335 (2000).

155. Dresser, *supra* note 153, at 1835.

156. Pruchno et al., *supra* note 149, at 818.

157. Fagerlin et al., *supra* note 32, at 278.

158. Cantor, *supra* note 18, at 191. "Well-being usually means continued existence. Yet, in the context of close-to-death decisions, the burdens of continued existence may sometimes be judged to outweigh its benefits—that is, the incompetent patient may sometimes be deemed better off dead than alive." *Id.*

159. *Id.*

160. *Id.*

161. *Id.*

162. Fagerlin et al., *supra* note 32, at 279.

make a decision in the patient's best interests.¹⁶³ Rather than attempting to micromanage their own death, research shows that patients prefer to delegate end-of-life decision making to those they trust.¹⁶⁴ The best interests standard is also ideal when a patient's values and end-of-life treatment wishes are unknown or determined not to be sound.¹⁶⁵

D. Out-of-Hospital Procedures Regarding End-of-Life Medical Treatment

Literature regarding end-of-life care in the emergency room is scant. However, the dilemmas faced by emergency personnel in administering care in the out-of-hospital setting have received some consideration.¹⁶⁶ The emergency room setting can readily be analogized to the out-of-hospital setting because both occur pre-hospital, where personnel provide immediate care and the patient's medical records often are unavailable.¹⁶⁷ It is, therefore, extremely useful to look to the literature dealing with out-of-hospital emergency care to inform the discussion of advance directives as they pertain to the emergency room.

Eighty percent of sudden cardiac arrest cases occur in the patient's home.¹⁶⁸ "Family and surrogate discomfort with the home death and dying experience, as well as the lack of timely outpatient palliative care planning in the majority of end-of-life situations, continues to place Emergency Medical Services (EMS) personnel in the difficult position of first response."¹⁶⁹ In this out-of-hospital setting, the patient's medical records may not be readily available, resulting in a strong possibility that the patient's preferences regarding end-of-life

163. *Id.*

164. *Id.*

165. Nelson & Lindemann, *supra* note 125, at 221.

166. See, e.g., Denis Fitzgerald et al., *Creating a Dignified Option: Ethical Considerations in the Formulation of Prehospital DNR Protocol*, 13 AM. J. EMERGENCY MED. 223 (1995) (detailing different approaches taken by states regarding DNR orders).

167. Gadzinski Interview, *supra* note 9.

168. Michael S. Goldrich, *Universal Out-of-Hospital DNR Systems*, 2005 REP. OF THE COUNS. ON ETHICAL & JUD. AFF., 2, http://www.ama-assn.org/ama1/pub/upload/mm/369/ceja_6a05.pdf (last visited Feb. 24, 2011). These cases are often transferred to the ER. Gadzinski Interview, *supra* note 9.

169. 'Do Not Attempt Resuscitation' Orders in the Out-of-Hospital Setting, AM. C. OF EMERGENCY PHYSICIANS (Oct. 2003), <http://www.acep.org/publications.aspx?id=30108>.

treatment will be unknown and not honored by EMS personnel.¹⁷⁰ In this situation, ambulance and rescue personnel generally have a legal obligation to institute life support measures.¹⁷¹

To promote patient autonomy in the out-of-hospital setting, forty-two states have enacted statewide protocols to guide EMS personnel regarding end-of-life patient care in emergency situations.¹⁷² These protocols allow EMS personnel to follow a patient's wishes to avoid unwanted medical care under certain conditions.¹⁷³ All states, however, provide some form of immunity to EMS personnel who provide life-support or other emergency medical treatment, recognizing the difficult decisions that must be made in the emergency setting.¹⁷⁴ For example, resuscitation is permitted when EMS personnel question the validity of the out-of-hospital do not resuscitate (DNR) order or if the EMS personnel are unaware of the DNR.¹⁷⁵ To aid in the emergency medical service provider's determination of the validity of the out-of-hospital DNR, all states that allow for out-of-hospital DNR orders require that some form of specifically designed identification be on or near the patient.¹⁷⁶ Most states allow identifiers such as bracelets, necklaces, or wallet cards, but for nine states, the DNR form serves as the only allowable identification.¹⁷⁷

Some states also give immunity to ensure the safety of the EMS personnel and those present at the scene.¹⁷⁸ Under this safety exception, EMS personnel receive immunity if someone present at the scene

170. Goldrich, *supra* note 168, at 2.

171. *Id.*

172. Sabatino, *supra* note 11, at 297-98. Of these, thirty-four are authorized by statute and eight are implemented solely through regulations or guidelines as of September 1999. *Id.* at 298.

173. *Id.* at 297. However, "[f]ifteen states limit eligibility for [these types of protocols] to patients who are diagnosed with a terminal condition." *Id.* "Six more states require that the patient either be terminally ill or meet one or more other medical preconditions." *Id.* "In the remaining twenty-one states with protocols, no medical preconditions are imposed; instead, the decision is treated like any other medical decision requiring medical judgment." *Id.* at 299.

174. *Id.* at 304.

175. *Id.* at 303.

176. *Id.* at 299.

177. *Id.* Since wearing the traditional medical-alert bracelets, which can be cumbersome and embarrassing, may be an undesirable reminder of a disease or condition, a number of jewelry companies make medical-alert accessories that look like fine jewelry. Laura Landro, *The Informed Patient: The Jewelry Prescription*, WALL ST. J., Aug. 31, 2010, at D1. For example, Tiffany & Co. sells a gold medical-alert bracelet for \$2250. *Id.*

178. Sabatino, *supra* note 11, at 304-05.

objects to the DNR order and a confrontation is likely to ensue.¹⁷⁹ Several states even allow resuscitation when withholding resuscitation would conflict with the “provider’s conscience.”¹⁸⁰

IV. Recommendation

The 2009 debate regarding “death panels” and its aftermath focused on whether Medicare should reimburse physicians for providing end-of-life counseling for Medicare patients.¹⁸¹ This controversial topic spurred scholarship and contentious discourse throughout society. This debate, however, fails to recognize that even if patients receive physician direction in making end-of-life treatment decisions and executing advance directives, the planning may be moot because advance directives generally have little relevance in the emergency room where patients close to death often present for care.

The need for emergency care may present a plethora of decision-making dilemmas not present in the oft-considered inpatient setting.¹⁸² First, emergency physicians may lack access to a patient’s medical records and, thus, be unaware of the patient’s end-of-life medical care choices.¹⁸³ Also, even if the emergency physician knows that the patient has chosen to forego treatment under certain conditions, a family member of the patient may demand heroic measures. In this case, the question remains whether the physician should honor the wishes of the incapacitated patient or the competent family member. Furthermore, the medical circumstances imagined by the advance directive may not accurately reflect the actual circumstances in which the patient finds himself or herself, and an immediate decision must be made regarding what course of treatment to pursue.¹⁸⁴ “How valid is a decision that has been made far removed from the context in which it is meant to apply?”¹⁸⁵

179. *Id.*

180. *Id.* at 305.

181. *A Minute With . . . Elder Law Expert Richard Kaplan*, UNIV. OF ILLINOIS AT URBANA-CHAMPAIGN (Aug. 27, 2009), <http://illinois.edu/lb/article/72/28708/page=3/list=list>.

182. MORRISON, *supra* note 5, at 133.

183. Kevin B. O’Reilly, *Defective Directives? Struggling with End-of-Life Care*, 52 AM. MED. NEWS 7, 7 (2009). “Three in five patients with living wills do not give them to their doctors, and families often are unaware of whether their loved ones have an advance directive.” *Id.*

184. Hawkins et al., *supra* note 42, at 108.

185. Fitzgerald et al., *supra* note 166, at 226.

Additionally, if an emergency physician already has begun treatment and subsequently learns that the patient requested no treatment, should treatment cease? Some would argue that to cease treatment once it has begun is comparable to actively killing the patient, and many physicians find this unacceptable.¹⁸⁶ Finally, if an incapacitated patient presents for care in the emergency room, how can the emergency physician know that the wishes previously expressed by the patient in an advance directive have not changed since the execution of the advance directive? “[T]he fact that individuals are often unaware of changes in their preferences raises important questions regarding the authentic nature of medical decisions made in advance of serious illness.”¹⁸⁷

The fact that advance directives have little relevance in the emergency room should be taken into account in end-of-life planning. Informing people of what to expect when they execute an advance directive, especially concerning emergency medical care, is of utmost importance to end-of-life planning. A clear policy needs to be developed regarding how advance directives should be considered in the emergency room setting.¹⁸⁸ Only when people know what to expect, can they make decisions that accurately reflect their wishes and, thus, respect their autonomy.

Developing a policy regarding such a sensitive subject, however, does not involve any easy answers. One must decide what the overarching goal of such a policy should be and what type of regime to implement in order to achieve the desired goal. Possible goals may include preserving patient autonomy, minimizing patient suffering, preserving human life, or simply reducing the utilization of unwarranted health care resources. Currently, the primary focus of advanced medical care jurisprudence is to preserve patient autonomy.¹⁸⁹ Society generally believes that people are entitled to make critical decisions that affect their lives for themselves.¹⁹⁰ Advance directives exist “to extend this right to those who – due to illness or injury – can no

186. Gadzinski Interview, *supra* note 9.

187. Fagerlin et al., *supra* note 32, at 273.

188. See MORRISON, *supra* note 5, at 133. “Nonvoluntary admissions may require special consideration in the development of facility policy, professional practice, staff education, and statewide protocols.” *Id.*

189. Cantor, *supra* note 18, at 183.

190. Fagerlin et al., *supra* note 32, at 270.

longer make or express their treatment preferences.”¹⁹¹ This goal, however, often proves unworkable, especially in the emergency medical setting, where physicians may lack access to a patient’s medical record and an immediate decision is required.

Furthermore, a policy that truly focuses on patient autonomy likely would require emergency physicians to treat the patient’s advance directive, if the physician has access to the document, as authoritative under all circumstances. The downside of this type of requirement is that empirical research reveals the inconsistencies that exist between a patient’s wishes at the time the patient executes his or her advance directive and the patient’s wishes at subsequent points in time.¹⁹² Thus, the emergency physician would never be sure that the advance directive accurately reflects what the patient would have wanted if the patient could make his or her own decisions at the time of the emergency.

Another issue with requiring the emergency physician to follow the patient’s advance directive in every situation is that advance directives, even if available to the emergency physician, may not provide the guidance the physician requires. For example, if the patient has completed a document giving someone durable power of attorney for health care, the surrogate may not be readily available or may lack decision-making capacity. Also, if the patient has completed a living will, “living wills are often brief, not very descriptive, and thus never completely represent the person’s actual illness.”¹⁹³ When this occurs the emergency physician will not know what the patient would have wanted in the particular situation in which the patient currently finds himself.

If the goal of a policy regarding the consideration of advance directives in the emergency room setting is to minimize patient suffering, emergency physicians likely would be required to use their best medical judgment to balance the benefit to the patient of pursuing a particular course of treatment and the harm the treatment may cause the patient. However, minimizing patient suffering may not always be what family members present at the scene want; family members may want the physician to save the patient even with the consequence

191. *Id.*

192. Blumenthal, *supra* note 152, at 219.

193. Fagerlin et al., *supra* note 32, at 276.

of extended or increased pain. The goal of minimizing patient suffering likely would give the physician the final choice, since the physician possesses the medical expertise to know the likely outcomes of certain procedures. Society, though, may not be willing to give the physician this kind of authority over treatment decisions.

If the policy focuses on the preservation of life, the emergency physician likely would be obligated to attempt to save every patient who presents for care in the emergency room. This would negate any patient autonomy since, whether or not a patient specified his or her treatment preferences in an advance directive, the emergency physician would be required to attempt to save the patient's life. Furthermore, society may not be comfortable with the emergency physician keeping a patient alive if the result would be a dramatically inferior quality of life.

If the policy goal is simply to reduce the utilization of unwarranted medical resources, the emergency physician likely would be required to balance the cost of the resources used in the course of treatment at issue with the benefit to the patient. Even if it creates some benefit to the patient, a policy focusing on cost would require the physician to forego a treatment if too costly, a proposition society may find troubling. On the other hand, decreased utilization of unwarranted medical resources "may ultimately save the lives of individuals who might otherwise die while paramedics [and emergency physicians] are forced to render lengthy and unwanted care . . ." ¹⁹⁴

A policy cannot and should not be developed based on a single, overarching goal; the subject matter is simply too sensitive. Emergency physicians need the freedom to make reasonable decisions on a case-by-case basis keeping in mind patient autonomy and minimizing patient suffering while taking family member input into account. First, advance directives should not be binding on the emergency physician when the physician is deciding on a course of treatment. Studies show that "the increasing institutionalization of [advance directives] in [United States] law and medical practice stands in stark contrast to a growing body of research challenging the effectiveness of advance care planning to produce specific improvements in end-of-life medical care." ¹⁹⁵ Because research increasingly illustrates the con-

194. Fitzgerald et al., *supra* note 166, at 226.

195. Ditto et al., *supra* note 147, at 428.

cerns with advance directives in general, the emergency room, which requires urgent decisions, is not an appropriate place for sensitive judgment calls.¹⁹⁶

Even though advance directives should not be conclusive in the emergency room, they still should be considered. In the case of a living will, “[a]lthough [living wills] may not improve decisions made by family members, they may be more effective in improving the poorer accuracy expected from decision-makers with little or no past relationship with the patient such as an emergency department physician.”¹⁹⁷ If the emergency physician has access to a living will and needs to make an urgent decision without the guidance of a surrogate decision-maker or family members, the living will may give the physician a sense of what the patient would have wanted.

Knowing that advance directives will not be binding in the emergency room will incentivize people to discuss values and treatment goals with loved ones so that a proper decision may be made if an emergency occurs. Furthermore, awareness that advance directives are not conclusive in the emergency room may serve to inform people regarding the appropriate use of emergency services and what to expect if emergency services are engaged.¹⁹⁸

In addition to advance directives not being conclusive in the emergency room, the standard that should be used by surrogate decision-makers and physicians is the best interests standard. The patient autonomy framework that underlies the substituted judgment standard fails to function for an incapacitated patient in the emergency room. The inaccuracy of the substituted judgment standard contradicts the inherently urgent decisions required in the emergency setting. Furthermore, studies show that patients who document their preferences in advance directives often do not want their advance directives strictly followed.¹⁹⁹ In a recent study, ninety-one percent of patients surveyed “desired that surrogate decision makers be allowed

196. MORRISON, *supra* note 5, at 134. “Supporters of this view argue that they would opt to treat the patient under typical implied consent protocols, at least to the point of stabilization, and then follow advance directive procedures—even if that meant withdrawing life-sustaining treatment.” *Id.*

197. Ditto et al., *supra* note 147, at 428.

198. “Some consumer groups, as well as providers, have already begun efforts to educate consumers about the appropriate use of emergency services.” MORRISON, *supra* note 5, at 134.

199. Hawkins et al., *supra* note 42, at 113.

at least some leeway to override [the patient's] written directives if the surrogates believed it would be best."²⁰⁰

The emergency physician and family members present at the scene should make the medical decision they believe represents the patient's best interests.²⁰¹ In making the decision, the physician and family members should balance the wishes of the patient, if known, and the advantages and disadvantages of a particular course of treatment to the patient. If the desires of family members conflict, the emergency physician may look to the state surrogacy statute for guidance when determining who should make the final decision. These statutes, however, should not be paramount, because they may not represent changing norms in family composition or the possibility that the patient may want to delegate medical decision-making authority to a non-family member.²⁰²

V. Conclusion

The current status of advance directives in the emergency room remains unclear. An urgent need exists for establishing a clear protocol for end-of-life planning in the emergency room setting as it pertains to advance directives. When an individual executes an advance directive, designated surrogate decision-makers or family members may assume that the document will be effective in any medical setting and, thus, fail to adequately discuss the patient's treatment wishes under emergency conditions before a medical crisis occurs. Knowing that the advance directive will not be binding on the emergency physician will encourage patients to discuss their values and goals with surrogate decision-makers and family members. Furthermore, knowing that family and surrogate decision-makers will be making decisions that are in the patient's best interests and not attempting to channel what the patient would have wanted if he or she had the ca-

200. *Id.* This study also revealed the fact that "few patients desired an advance directive that would allow them to express only precise directions for medical care. Instead, most desired a document that would allow them to make personal statements about their values and goals for care." *Id.*

201. In making this urgent medical treatment decision, the physician and family members should consider any known wishes of the patient as represented in an advance directive or otherwise.

202. See *supra* text accompanying notes 116-117.

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capacity to make medical decisions will provide a more workable standard for both decision-makers and emergency physicians.