LESSEN 1

THE PATIENT'S RIGHT TO REFUSE

Section I: THE RIGHT TO REFUSE TREATMENT

2-1. THE RIGHT TO CONSENT IMPLIES THE RIGHT TO REFUSE

a. Adequate Mental Capacity. An adult patient who is conscious and has adequate mental capacity has the right to refuse any medical or surgical procedure. Similarly, most courts have found that surrogate decision makers acting on behalf of incompetent adults and minors have the right to refuse, in appropriate situations. But, those making decisions for others have a narrower range of choices, because of the duty to act with the best interests of the patient in mind.

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<th>ETHICAL PRINCIPLE</th>
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<td>Respect for persons.</td>
<td>Protection of those with diminished autonomy.</td>
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<th>LEGAL-ETHICAL RIGHT</th>
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<td>Right to self-determination.</td>
<td>Right to protection.</td>
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  Right to consent and refuse.  Limited right to consent and refuse.

Figure 2-1. Those making decisions for children and incompetent adults have a more limited right to refuse treatment.

b. Overriding State Interests. While the right to refuse treatment is recognized in appropriate situations, the courts have found state interests to outweigh the patient's right to autonomy in some cases. The state must, however, show a compelling overriding interest to overrule a patient's refusal. The state's interest in promoting the welfare of children, for example, could justify an order for compulsory care to save the life of a pregnant woman or the mother of young children. When the patient's right to refuse is honored, however, the patient may have to forego other benefits. (See other column.) The legal bases for refusal of treatment include: 1) the common law right to freedom from nonconsensual (unauthorized) invasion of bodily integrity; 2) the constitutional rights of privacy and liberty; and 3) the constitutional right to freedom of religion.
IF THE RIGHT TO REFUSE IS HONORED, THE PATIENT MAY HAVE TO FOREGO CERTAIN BENEFITS

In *McQuillan vs. City of Sloux City* (Iowa 1981), the court affirmed the denial of payment to a policeman for his continuing medical expenses. Since he had refused to submit to coronary arteriography that was necessary to diagnose his condition, he was not entitled to reimbursement.

THE RIGHT TO REFUSE BASED ON COMMON LAW BODILY INTEGRITY

In *re Storar* (N.Y.1981), the court recognized the right of Brother Fox, through his guardian, to decline respiratory support based on the common law principle of bodily integrity.

*Latin for "in the matter of" Storar.

THE RIGHT TO PRIVACY AS THE BASIS FOR REFUSAL OF TREATMENT

Twenty-one-year-old Karen Ann Quinlan had become comatose as a result of a combination of alcohol and tranquilizers. She remained alive on a respirator, but was judged by physicians to be irreversibly comatose, with no reasonable possibility of emerging from her comatose condition. Her parents attempted to have the respirator that artificially sustained her breathing to be withdrawn. In *re Quinlan* (N.J. 1976), the right to privacy was recognized as the basis for honoring her parents' right to refuse treatment on her behalf. (Although the respirator was removed, Quinlan died 8 years later.)

REFUSAL BASED ON THE RIGHT TO PRIVACY

In *Lane vs. Candura* (Mass., 1978), the court honored a 77-year-old woman's right to refuse the amputation of her gangrenous leg, based on the right to privacy. Although her decision was medically irrational and would lead to her death, the court found that she understood the alternatives and consequences of her actions. Thus, her right to privacy was upheld.

2-2. COMMON LAW-BODILY INTEGRITY

Common law recognizes the right of all people to be free from unauthorized invasion of their bodily integrity. One element of this right is the freedom to make decisions concerning medical care. Medical care without express or implied authority is battery. Courts have recognized that the right to make decisions concerning health care includes the right to decline such health care.
2-3. THE RIGHT TO PRIVACY

In some cases, medical care is refused on the basis of the constitutional right to privacy. Unwanted infringements of bodily integrity have been recognized to violate the right to privacy, unless state interests outweigh that right. In *re Quinlan* (N.J., 1976), the right to privacy was recognized as the basis for refusal to continue the life support system. The right to privacy has been the basis for allowing refusals in situations where the patient is neither terminally ill nor comatose. In the 1990 case of Nancy Cruzan, a young woman who had been in a persistent vegetative state for 7 years, the constitutional right to liberty was cited as the interest protected by the court, when they ruled that each state could set its own standards for allowing patient refusal.

2-4. FREEDOM OF RELIGION

Freedom of religion is another basis for refusal in a few situations. However, this First Amendment protection applies primarily to freedom of belief, not freedom of action, so the state may restrain religious action. Another reason that this freedom has limited relevance in refusal of treatment situations is because most religions merely permit refusal. Thus, legally required treatment does not necessarily violate religious tenets. The only cases in which freedom of religion has been pivotal have involved Jehovah's Witnesses' refusing blood transfusions or Christian Scientists' refusing all treatment. Although more recently, there have been a few cases pertaining to religious sects that believe in "faith healing," in which the right to refuse was upheld.

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<th>JEHOVAH'S WITNESS PERSPECTIVE</th>
<th>PHYSICIAN'S PERSPECTIVE</th>
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<td>Refusing the blood transfusion. vs. Accepting the blood transfusion.</td>
<td>Respect for the patient's autonomy. vs. The patient's objective best interest.</td>
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<td>Eternal live without damnation. vs. Prolonged life on earth; eternal damnation in the hereafter.</td>
<td>Respect for the patient's right to refuse. vs. Preserving and prolonging life.</td>
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**HIGHER VALUE PLACED ON ETERNAL LIFE**

**HIGHER VALUE PLACED ON PROLONGED LIFE AND CURING DISEASE**

Figure 2-2. Determining what is in the best interests of anyone other than oneself is difficult. In the case of a Jehovah's Witness, the best medical outcome is not the same as the outcome the patient might prefer. And the law, in some instances, recognizes the patient's right to refuse on religious grounds.
2-5. **REFUSAL ON BEHALF OF A MINOR**

*Parental decision makers* acting on behalf of minors have only a *limited right to refuse*, because of their overriding obligation to act in the best interests of the child. If a parent refuses necessary treatment, the courts will intervene and appoint a guardian who will give consent. The court considers the age and maturity of the minor and the risk-benefit factors of the treatment, in determining what weight to give the wishes of the minor. The prerogative to decline is limited to treatment that is *elective or not likely to be beneficial*. Courts have generally permitted the refusal of extraordinary care for terminally ill or irreversibly comatose minors and incompetent adults.

**When acting on behalf of a minor, the surrogate decision-maker must:**

- Act in the best interests of the child.
- Consent to necessary treatment.

Figure 2-3. Surrogate decision makers have a limited right to refuse treatment for minors.

**INCOMPETENT TERMINAL PATIENT'S RIGHT TO REFUSE UPHELD IN ONE CASE, OVERRIDE IN ANOTHER**

In *Superintendent of Belchertown vs. Salkewicz* (Mass. 1977), the court authorized the withholding of chemotherapy for 67-year old Joseph Salkewicz, a profoundly retarded man. It was felt that he would not have understood the pain resulting from chemotherapy, and would have had to be held down physically for doctors to give him the necessary drugs and blood transfusions. The court summed up its decision as follows. "To presume that the incompetent person must always be subjected to what many rational and intelligent persons may decline is to downgrade the status of the incompetent person by placing a lesser value on his intrinsic human worth and vitality," it is of interest to note that, like John Storar, Salkewicz was a mentally retarded person who had never been competent. Yet, in the Storar case (held 4 years later in New York) the court did not allow the terminally ill and incompetent Storar patient to refuse blood transfusions. Observes medical ethicist Ruth Macklin; "Cases that are apparently similar may be decided differently in different jurisdictions."¹ This highlights a point made earlier: In many cases, the courts have as much difficulty making morally equitable decisions as any of us. They too must apply an array of often-conflicting values. There may seem, on the face of it, some differences between the Salkewicz and Storar cases with regard to type of treatment: extraordinary treatment (chemotherapy) vs. routine therapy (blood transfusion, almost as basic as food itself). Says Macklin: "...other factors have a greater moral significance [than the type of treatment, that is, mode of dying ...peaceful and easy vs. painful and frightening."²
2-6. REFUSAL FOR AN INCOMPETENT ADULT

a. More Steps in Honoring the Right to Refuse. When the patient cannot express his or her wishes, important decisions are left up to the family members, doctors, hospital administrators, and if conflict should arise, a court of law. An incompetent adult who was previously competent has the right to refuse treatment. The rules are generally stricter for a never competent patient because of the impossibility of determining his or her wishes. (See anecdote, page 2-7, on John Storar, a never-competent patient.) Because of the state's duty to protect those with limited autonomy, more steps are involved before refusal can be authorized. These additional steps are intended as safeguards to protect the patient from a decision that might not be in his or her own best interests.

b. Subjective (Substituted Judgment) Standard. Under the subjective standard, the patient's definition of "best interests" is sought, rather than some objective standard. Thus, maximum deference is given to the patient's right to self-determination, even if the decision is not objectively in the patient's best interest. The subjective (substituted judgment) standard can only be applied if there is some evidence of what the patient would have wanted. Prior oral or written directives are the best evidence of the patient's desires. Though oral directives have been accepted by some courts, a written directive, i.e. a living will and Durable Power of Attorney for Health Care (DPAHC) (where applicable by state law), are easier to substantiate than an oral directive.

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<th>SUBJECTIVE (SUBSTITUTED JUDGMENT) STANDARD</th>
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<td>• Determining what the patient would have wanted.</td>
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<td>• Using evidence of patient's prior wishes. Oral directives are preferable to written directives.</td>
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Figure 2-4. Under the subjective (substituted judgment) standard, maximum allowance is given for the patient's right to self-determination, even if refusal is not objectively in the patient's best interests.

c. The Objective Best Interests Standard. The best interests standard generally requires the surrogate (next of kin, legal guardian, and so forth) to consider such factors as relief of suffering, preservation or restoration of function, and the quality and extent of the sustained life as viewed by the patient. The quality-of-life component tries to determine the value of the patient's life to the patient, and does not measure the value of life according to the patient's ability to contribute to or produce in society. If a surrogate were to refuse beneficial treatment for no justifiable reason, that decision would be seriously questioned.
OBJECTIVE BEST INTERESTS STANDARD

The surrogate determines the incompetent patient’s best interests by considering:

- Relief of suffering
- Preservation and/or restoration of function.
- Quality and extent of sustained life (as viewed by patient).

**NOTE:** The individual's value to society is not a factor.

Figure 2-5. Under the objective best interests standard, the surrogate decides whether refusal is in the best interests of the patient by considering the factors shown. The patient's wishes and his or her value to society are not considered.

RISK-BENEFIT ANALYSIS

- Extent of impairment of patient's mental faculties.
- Whether or not patient is in the custody of the state.
- Prognosis with and without treatment.
- Complexity, risk, and novelty of treatment.
- Possible side effects.
- Patient’s level of understanding and probable reaction.
- Urgency of the decision.
- Consent of patient, spouse, or guardian.
- Good faith of those participating in the decision.
- Clarity of professional opinion as to what is good medical practice.
- The interests of third persons.
- Administrative requirements of the institution (different in each hospital).

Figure 2-6. A risk-benefit analysis may have more of a role to play for a never-competent patient whose wishes are unknown. It may also be useful as an aid to parents making decisions for minors.
SUBJECTIVE (SUBSTITUTED JUDGMENT) STANDARD APPLIED: PREVIOUSLY COMPETENT PATIENT'S WISHES HONORED

In re Storar (N.Y. 1981), the subjective (substituted judgment) standard was applied. The court upheld the right of the previously competent but now comatose patient, Brother Fox, to refuse treatment based on an oral statement he had made to his religious brethren. Shortly before suffering a cardiac arrest, becoming comatose, and being placed on a respirator, he had told his brethren that he would not want to be kept alive by "extraordinary means," were he to become like Karen Ann Quinlan (irreversibly comatose but kept alive by a respirator). The New York State Court of Appeals authorized removal of the respirator, since they considered his oral statement to be "clear and convincing" evidence of his prior wishes.

OBJECTIVE BEST INTERESTS STANDARD APPLIED: RIGHTS TO REFUSE DENIED NEVER COMPETENT PATIENT

The same court denied a never competent patient the right to refuse treatment because his wishes could not be determined. In the absence of expressed wishes, the objective standard had to be applied. John Storar, a 52-year-old man who was profoundly retarded (with a mental age of about 18 months) was suffering from terminal cancer of the bladder. His legal guardian and mother had consented to radiation treatments for him and, after internal bleeding had begun, regular blood transfusions. She then requested that her son’s transfusions be terminated, because he was suffering from both the pain of his cancer and the discomfort of being tied down for transfusions. She then estimated that the transfusions would only add 3 to 6 months to his life. Unlike a respirator, which is considered "extraordinary" treatment, blood transfusions are viewed as routine (as basic as food itself). Unlike Brother Fox, Storar had never been competent. The court ruled that since the patient was mentally an infant, he should be given the same protections as a minor whose guardian seeks to refuse life-saving transfusions. The decision, which seems cruel, was well-intentioned in that it sought to protect a patient, who could not speak for himself, from relatives acting contrary to what was believed to be the patient’s best interests.

The court decided both Brother Fox’s and John Storar’s cases in an opinion entitled re Storar.
2-7. CRITERIA TO CONSIDER FOR INCOMPETENT ADULTS

a. Written Document or Living Will. Forty-four states have enacted "living will" statutes. These are written directives by the patient for use in making health care choices in the event that the patient should become incompetent. Having a living will is no guarantee that a patient's advance directives will be followed. A recent study of 175 nursing home residents found that in about 25 percent of the cases, the patient's instructions were not followed. The Army recognizes living wills and complies with them where possible. But, the existence of such a will does not really change the attending physician's responsibility to determine that the patient, in fact, meets the requirements for withdrawal of life support. What the living will does is to provide evidence of the patient's previously stated desires while he or she was competent to do so. If the family does not wish the living will to be honored, the matter should be referred to the hospital ethics committee.

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LIVING WILL AND DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Says Doron Weber, spokesperson for the National Council on Death and Dying and the Society for the Right to Die, "The Supreme Court essentially gave constitutional stature to living wills," by its decision in the Cruzan case (emphasis added). There has been increased public interest in drawing up a living will since that decision, because it enables you (while you are still competent) to specify which treatments you would or would not want if you became irreversibly incapacitated and dependent on life-sustaining treatment. The guidance that you provide will increase the likelihood that your wishes are honored. It will also help your family get through some tough decisions. Some living will forms simply refuse all "heroic" treatment. But, it is best to list specific procedures you would or would not want such as: cardiac resuscitation (Do Not Resuscitate [DNR] order), withdrawal of life-sustaining treatment (a mechanical respirator or a feeding tube). You can specify conditions, for example, withdrawal of life support for a terminal condition, permanent vegetative state, or irreversible brain damage that makes one unable to swallow, cessation of circulatory and respiratory functions (traditional definition of death), or cessation of all functions of the entire brain, including the brain stem. You can ask for painkillers or request to die at home. Though living wills are not legally binding, 44 states have "right-to-die' laws, and often recognize living wills as good evidence of intent (needed to apply the subjective standard of refusal for incompetent adults). In some states, like New York and California, a living will should be supported by a Durable Power of Attorney for Health Care. This legally binding document enables the person you designate and a backup (people who presumably understand your wishes) to make health care decisions for you should you become incompetent. In Texas, the Natural Death Directive is needed to supplement the living will and ensure the legal right to die.
A LIVING WILL MAY NOT BE ENOUGH IN AN EMERGENCY

A retired Los Angeles bus driver, suffering from lung cancer, drew up a living will to avoid life-sustaining technology that would prolong his life and suffering. Then one morning, while preparing breakfast, he felt a sudden intense pain in his back and cried out. Paramedics, called on the scene by his wife, began a massive resuscitation effort when they found no pulse. (They passed a line in a vein in his arm and a tube through his mouth into his lungs.) A DNR order in the living will did not hold, because living wills do not apply during emergencies that are in or out of the hospital. (Emergency teams are required to act first, lest crucial time to save a person's life be lost. This is what the bus driver's daughter was told when she complained that her dad had a living will specifying no massive resuscitation.) The paramedics rushed the man to the hospital, Emergency room staff drew a blood sample, attached wires and hooked him up to a respirator, and sent him to an intensive care unit, where he remained unconscious with a prognosis of continued unconsciousness until death. The doctor agreed not to provide further aggressive care, but did not feel he could disconnect the respirator. Despite the living will, despite the fact that medical ethicists draw no ethical distinction between discontinuing existing treatment and starting new treatment, the doctor's own values got in the way. Though California courts have allowed respirators to be turned off in such cases, the only thing the doctor could offer was to have the hospital ethicist review the case. Five more days lapsed before the ethics consultation concluded, and the man was taken off the respirator. In this case, if the patient's daughter had had a Durable Power of Attorney for Health Care, she would have been able to make medical decisions for her father as if she were making them for herself. A Durable Power of Attorney for Health Care in combination with a living will may be a more effective means of increasing the chances that one's health care wishes will be followed.

b. Oral Directives. Written evidence is preferable to oral directives conferred to a family member, friend, or health care provider. Brother Fox's verbal statements to brethren regarding his desire to avoid heroic treatment were accepted as clear and convincing evidence of his wishes. (See anecdote, p 2-7, "Subjective (Substituted Judgment) Standard Applied....") But in Cruzan vs. State of Missouri (1990), the Supreme Court denied Nancy Cruzan's family the right to terminate life-support equipment for their daughter, who had been in an irreversible coma for 7 years, for lack of "clear and convincing" evidence defining the patient's wishes. Statements by friends and family did not hold up as "clear and convincing" in the state of Missouri. (The Supreme Court later upheld each state's right to develop its own standards for clear and convincing evidence.) Granting someone power of attorney gives that individual the instrument of authority to act on your behalf. Historically, once a person became incapacitated, the power lapsed. To overcome this limitation, all states have passed
legislation allowing a power of attorney to be "durable," that is, enduring even if the maker's competency doesn't last. To create a Durable Power of Attorney for Health Care, the instrument must merely state that it is intended to be durable, or that the power created will not be affected by the incapacity of the maker. Durable-power-of-attorney laws vary by state, with some states allowing Durable Power of Attorneys for Health Care to cover health care decisions. (The person designated as primary and backup should, of course, have a full understanding of the patient's desires.) Some states with DPAHC laws may allow agents to be named to make medical treatment decisions, to include withdrawal of life-sustaining treatment. Other states do not include decisions for withdrawal of treatment. Still other states have durable-power-of-attorney laws that do not address medical treatment decisions at all.

c. Durable Power of Attorney for Health Care. Since there is only one state court decision in this area (from New Jersey), there is an insufficient basis for anticipating how the courts will interpret the use of a Durable Power of Attorney for Health Care. For example, it is not known whether or not the "Do Not Resuscitate (DNR)" decision made by the holder of a power of attorney for an incapacitated patient would be upheld, especially if there were no other indication of what the patient would have wanted. In principle, a Durable Power of Attorney for Health Care would be effective in a military treatment facility (MTF) under the reasoning expressed, above, for living wills. In any case, a DPAHC (where applicable) may increase the likelihood that one's living will be honored.

d. Preparing Advance Directives that Carry Clout. To ensure that the living will is as effective as possible, you should. 1) specify applicable conditions and treatments, 2) renew the document at least every 2 years, and 3) in the states where applicable, have a DPAHC drawn up, as well.

(1) Be specific. The living will should be as specific as possible in citing the conditions for which the patient does not wish heroic treatment and the types of interventions not desired, for example, respirator, feeding tube, and so forth.

(2) Renew every two years. The document would be renewed every two years. Physicians are apt to disregard a living will if it is several years old, or if it fails to specify the particular condition that you happen to develop.

(3) Have a Durable Power of Attorney for Health Care if applicable. Having a DPAHC, if applicable in your state, increases the likelihood of compliance with your living will.
DO HEALTH PROVIDERS HAVE LIVING WILLS?

Dr. Christine Castle, Medical Ethicist and Chief of Internal Medicine at the University of Chicago Medical Center observes that although 44 states recognize living wills, few people exercise their option to prepare advance directives. This is true, even among health care providers. Dr. Castle remarks that in any given audience of doctors and nurses that she addresses, invariably no more than ten percent raise their hand when asked if they have a living will. She concludes from this telling fact that "there is something fundamentally human about not wanting to think about one's own death."  

PATIENT SELF-DETERMINATION ACT of 1991

Currently, only 5 to 10 percent of all adults have advance directives. The Patient Self-Determination Act of 1991 encourages more patients to think ahead by requiring every hospital, hospice, nursing home, and health-maintenance organization participating in Medicare and Medicaid to inform patients of their right to decide how they want to live or die should they become gravely ill. Each state has to develop its own laws on advance directives. Each hospital, in turn, has to make that information available to its patients upon admission. At the present time, medical treatment facilities are not covered, however, this does not preclude a future requirement for them to comply with these guidelines.  

e. Deduced From Religious Beliefs. An oral directive might play a role for patients expressing opposition to treatment on religious grounds. The refusal of care could be deduced from the patient's statements of religious beliefs, provided these beliefs were sincerely held and practiced while the patient was competent. (On the other hand, religious beliefs might not play a role. An individual might not agree with all of the teachings of his or her own faith. Some Jehovah's Witnesses, for example, will accept a blood transfusion if convinced they would die without one.)

f. Condition, Prognosis, and Nature of the Treatment. Generally, if the patient's condition is extremely grave, some courts have permitted refusal of any type of treatment.

g. Risk-Benefit Analysis. If there is no knowledge of what the patient's wishes were, as in the case of a never-competent patient, a risk-benefit analysis will have a greater role to play in arriving at a treatment decision. (A risk-benefit analysis may also be helpful to parents trying to make a decision regarding treatment for a minor.)
h. **Degree of Consensus Between the Surrogate and Physician.** The court attaches great weight to what the treating physician has to say about the surrogate's decision. If the surrogate's decision is consistent with good medical practice, the court is more likely to honor refusal of treatment. The court attaches great weight to the physician's opinion because the physician is the person most familiar with the patient's condition. The physician has had previous experience in making this type of decision, and he or she is, in principle, less apt to be acting out of self-interest or bias.

i. **Nature of the Surrogate's Relation to the Patient.** This is the least important of the factors. But it still plays a role when the court decides to uphold a decision that goes beyond medical custom and practice, as in the case of Karen Quinlan. The court looks for a close loving relationship. Any evidence of conflicting motivations or special interests will affect the credibility of the surrogate's decision.

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2-8. **DO NOT RESUSCITATE ORDER**

a. **A Written do not resuscitate Order Required.** Resuscitation is a *standing* order that will be initiated unless there is a written Do Not Resuscitate (DNR) order. The DNR order is a written order to suspend otherwise automatic initiation of cardiopulmonary resuscitation (CPR). The *only treatment suspended is CPR*. The DNR order is not a withdrawal of life support and should not affect other treatment and efforts to provide comfort and relief from pain. A DNR order is in writing and must be reviewed every 72 hours.

**Do Not Resuscitate (DNR) order:** a written order to suspend otherwise automatic initiation of cardiopulmonary resuscitation (CPR).

b. **Candidates for a Do Not Resuscitate Order.** Potential candidates for a DNR order are irreversibly, terminally ill patients and those in a persistent vegetative state.

**irreversible terminal illness:** a progressive disease or illness known to terminate in death, and for which additional therapy offers no reasonable expectation of remission.

**persistent vegetative state:** a chronic state of diminished consciousness resulting from severe generalized brain injury, in which there is no reasonable possibility of improvement to a cognitive (perceiving and knowing) state.

c. **Competent Patients Make Own Choices.** As stated earlier, under state laws competent patients are adults or emancipated minors, who have the ability to communicate and understand information and the ability to reason and deliberate sufficiently well about the choices involved. A decision made while the patient is competent will be honored if subsequent incompetence occurs, *unless there is reason to believe that the patient's choice has changed or would change*. This sometimes happens when living wills are so generally worded that there is doubt as to whether or not certain specific medical conditions are covered by the will. Questions may also arise if time has elapsed since the initial drafting of the will.
d. **Confidential Do Not Resuscitate Orders.** If the patient chooses not to inform his or her family of the DNR decision, the patient should be made aware of the problems that can result. If, for example, the family should demand resuscitation, the physician would then be placed in the difficult position of having to deal with the family's demands, while still trying to honor the patient's desire for confidentiality.

e. **Surrogate Do Not Resuscitate Orders.** When no prior decision has been made and the patient is incompetent, the next of kin (generally the spouse or competent adult child) may choose to exercise the DNR option for the patient.

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**THE COMPETENT PATIENT'S REFUSAL PREVAILS OVER FAMILY'S WISHES**

Mrs. Jones, a 45-year-old wife and mother suffering from the advanced stages of terminal leukemia, was nearing death. She was tired of the normal and experimental treatments she had undergone over the preceding year. The only thing she wanted now was to be made comfortable and sleepy. On the hospital admission form, she refused all further routine treatment and supportive measures (antibiotics, blood transfusions, and so forth). She also indicated that she did not wish to be resuscitated in the event of cardiac arrest. The physician complied, ordering only an IV morphine drip "until the patient becomes lethargic." But, Mrs. Jones' husband and child, unwilling to let go and still hoping for a miracle, demanded continued aggressive treatment. (Does the family have the right to overrule the patient's refusal? No. As long as the patient is competent the patient remains the primary health care decision maker). Once the patient lapsed into unconsciousness, the physician continued to comply. This is as it should be. To begin aggressive treatment once the patient had become unconscious would have violated the respect-for-persons principle.\textsuperscript{11}

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**DNR ORDER**

- Without a DNR order, CPR is obligatory.
- Written.
- Reviewed every 72 hours.
- Affects CPR only. Other treatments continue.
- Can be made confidential by the patient.

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Figure 2-7. A Do Not Resuscitate order suspends the otherwise automatic initiation of CPR.
f. **When No Next of Kin or Guardian.** When there is no next of kin or guardian and the physician feels that a DNR order is appropriate, the matter may be referred to the Deputy Commander of Clinical Services (DCSS) and the ethics committee for decision and approval. The ethics committee, by regulation, should consist of at least two physicians, a nurse, a chaplain, and a Judge Advocate officer. (The panel can also resolve conflicts between the physician and family members regarding the appropriateness of a DNR order. If there is still no agreement between the surrogate decision maker and the staff after the ethics committee has reviewed the case, it will then go to court.)

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**IS SUBSTITUTED JUDGMENT A LEGAL FICTION?**

Dr. Christine Castle, Medical Ethicist and Chief of Internal Medicine at the University of Chicago Medical Center, believes that living wills are not the real solution to the problem of preserving the autonomy of incompetent patients. The appointed decision makers must decide what the patient would have wanted in a given situation. Most of the judgments that the guardian or next of kin must make involve complex emotional relationships. It is, she contends, hard to sort out one's own feelings from what the patient would have wanted. She believes that the courts are realizing that substituted judgment is, in fact, a legal fiction, that we cannot really place ourselves in the shoes of another. But admittedly, at the present time we do not have a better alternative.

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2-9. **WITHDRAWAL OF LIFE SUPPORT**

a. **Criteria for Withdrawal of Life Support.** Patients with a terminal condition or those in a persistent vegetative state (irreversible coma) are candidates for withdrawal of life support.

b. **Treatment That Artificially Prolongs Life.** Life-sustaining treatment that serves only to artificially prolongs life such as: intravenous therapies (artificial nutrition and hydration), lavage feedings (nasogastric tube), kidney dialysis, CPR, and artificial respiration may be withdrawn in the event of a terminal condition.

**life-sustaining treatment:** any medical procedure or intervention which serves only to artificially prolong the dying of a patient, diagnosed and certified by at least two physicians as afflicted with a terminal condition or as being in a persistent or chronic vegetative state.

It should be noted that medical interventions necessary to alleviate pain are not considered life sustaining.
c. **The Physician's Decision.** While a living will may request that life-sustaining procedures be withheld or withdrawn under certain conditions, it is only the physician who can determine whether or not the patient meets the criteria for withdrawal of life support. The order for withdrawal of life support is written with the concurrence of the patient or, in the case of incompetent patients, with the concurrence of the next of kin or surrogate decision maker. If the next of kin does not wish the living will to be honored, the matter should be referred to the hospital ethics committee.

d. **Brain Death Not a Criterion.** The traditional clinical definition of death is not required for life support to be withdrawn. Once brain death has occurred, there is no legal obligation to continue treatment.

**brain death:** the irreversible cessation of circulatory and respiratory functions or of all functions of the entire brain, including the brain stem.

2-10. **REFUSAL IN AN EMERGENCY**

a. **Competent Patients Refusing Emergency Care.** Normally, in an emergency, treatment can be given without obtaining prior consent and without fear of liability if there is a threat of serious bodily harm or death. However, if a competent patient refuses treatment in an emergency, the normal emergency rule waiving consent requirements does not apply. For example, the police alert an ambulance to the scene of an auto accident. The ambulance picks up a person who is unconscious. By the time the ambulance reaches the emergency room, the patient is conscious and raises objections to treatment. This person cannot be treated even though it is an emergency. Nor can the physician, in this case, wait until the patient's condition worsens or until the patient lapses into unconsciousness to commence treatment.

b. **Refusal as a Possible Sign of Incompetence.** Health care providers are required to respect a competent patient's right to refuse treatment, even in an emergency. But providers have an equal responsibility to identify cases in which irrational self-destruction is contemplated by the patient. In these instances, refusal of care may be a sign of incompetence. Let us imagine that a patient is brought to the emergency room with slashed wrists and says that he or she does not wish to live or be treated. It cannot automatically be assumed that the patient really wishes to die. Bioethicists hold that the slashed wrists may be a cry for help. In such cases, treatment should be provided under implied consent, until such time as the patient's competence and consent can be ascertained. Only after the patient is revived and the situation is talked through can a determination be made as to the patient's true needs and desires. If, at that point, the patient still wishes no further treatment, the physician has a moral obligation to seek help for the patient.

*Continue with Exercises, Section 1*
EXERCISES, LESSON 2, SECTION I

It is recommended that you work the following exercises (1 through 28) before beginning the next section of the lesson. After you have completed the exercises, check your answers against the solutions following the exercises. For any answer missed, reread the material referenced in the solution.

MULTIPLE-CHOICE. Select the ONE response (a, b, c, or d) that BEST completes the statement or BEST answers the question.

1. Compared to competent adults refusing treatment for themselves, those making decisions on behalf of incompetent adults and minors have ______ right to refuse because of their duty to act in the best interests of the patient.
   a. A greater.
   b. A more limited.
   c. The same.
   d. No.

2. In which case would the State be likely to overrule the patient’s right to refuse treatment, based on a compelling and overriding state interest?
   a. Extraordinary care for a terminally ill minor.
   b. Extraordinary care for a comatose incompetent adult.
   c. Life-saving care for a young child.
   d. Life-saving care for a Christian Scientist (a competent, single adult).

3. Those making decisions for minors and incompetent adults can generally decline:
   a. Any treatment they deem inappropriate.
   b. Treatment that is elective or not likely to be beneficial.
   c. Any treatment that they would refuse if making a health care decision for themselves.

4. A mentally retarded, 18-year-old male is brought to the emergency room. He has attempted suicide by taking an overdose of sleeping pills. He flails his arms about, and threatens to sue the hospital if his stomach is pumped. The health care team should:
   a. Explain the consequences of no treatment and have him sign a patient waiver.
   b. Comply with his wishes.
   c. Begin treatment right away.
   d. Obtain a bedside consultation from the hospital ethics committee.
5. A competent 18-year-old female is admitted to the emergency room for rectal bleeding. The injury is the result of an accident and is not an attempted suicide. The patient refuses the proposed treatment with a full understanding of the consequences. The staff should:

a. Try to force her to consent.

b. Get a court order declaring her incompetent, and obtain substitute consent from a surrogate decision maker.

c. Sedate her; then begin the treatment.

d. Comply with her wishes.

6. In which instance would the state’s interest in preserving life be most likely to outweigh the patient’s right to refuse treatment?

a. A schizophrenic who refuses a biopsy with apparent understanding of the adverse consequences.

b. A minor suffering from terminal leukemia that refuses chemotherapy.

c. A competent adult who refuses to have his gangrenous arm amputated.

d. An incompetent adult who would benefit from treatment, who has left no evidence of his or her wishes when competent.

7. Under the subjective (substituted judgment) standard of a patient’s best interests, maximum deference is given to:

a. The patient’s right to self-determination.

b. The integrity of the health care profession.

c. The res ipsa loquitur doctrine.

d. The state’s interest in public welfare and safety.

8. Under the subjective (substituted judgment) standard of a patient’s best interests:

a. Some evidence of the patient’s prior wishes is needed.

b. The family’s wishes are given primacy.

c. Maximum deference is given to the needs of the institution.

d. The individual’s value to society is considered.

9. In which situation is the patient’s right to refuse most likely to be overridden by the state’s interest in preserving life?

a. A terminally ill minor who is in agreement with parents and physician on refusing further treatment.

b. A terminally ill and competent adult who refuses surgery.

c. An incompetent patient whose guardian refuses beneficial medical intervention for no justifiable reason.

d. A competent adult who refuses treatment in an emergency room.
10. A pregnant woman refuses care that might affect the life of the fetus. What is the likely outcome?
   a. The court might override her refusal for the sake of the fetus.
   b. The court might override her refusal for both her sake and the sake of the fetus.
   c. The court would respect her right to self-determination because it is her body.
   d. The court would declare her incompetent, and have her institutionalized for the course of the pregnancy.

11. A competent adult has a living will that specifies that she does not want extraordinary or heroic treatment (resuscitation) in the event that she should suffer a massive heart attack. She also has a Durable Power of Attorney for Health Care drawn up. Nine months later she has a heart attack and lapses into an irreversible coma. She is likely to be:
   a. Placed on a respirator.
   b. Allowed to die without extraordinary resuscitative efforts being applied.
   c. Placed on a respirator until the hospital ethics committee can make a determination.
   d. Be treated for lack of sufficient evidence of her prior wishes.

12. A living will is a written directive concerning health care choices that:
   a. Guarantees one's wishes will be honored if one becomes incompetent.
   b. Is legally binding.
   c. Gives clear and convincing evidence of a patient's previously stated desires while competent.
   d. Is required by law for all individuals.

13. Army policy on living wills is to:
   a. Comply in all cases.
   b. Comply, if the physician determines that the patient meets the requirements for withdrawal of life support.
   c. Comply, even if the next of kin voices opposition.
   d. Refer all living will situations to the hospital ethics committee.

14. For states with durable-power-of-attorney laws, having a Durable Power of Attorney for Health Care, together with a __________________ may increase the likelihood that one's health care wishes are honored.
   a. General power of attorney.
   b. Last will and testament.
   c. Bequest to the hospital.
   d. Living will.
15. An incompetent patient's ________________ when sincerely held and practiced while competent, may be considered, in some cases, as evidence of the patient's wishes regarding treatment.

   a. Religious beliefs.
   b. Personal affiliations.
   c. Attitude toward work.
   d. Political convictions.

16. When evaluating refusal of treatment for a never competent patient, the court may consider.

   a. The patient's past contributions to society.
   b. The patient's potential value to society.
   c. Risk-benefit factors associated with the proposed procedure.

17. One factor that holds a great deal of weight with the court is whether or not a physician finds the surrogate's decision to refuse care to be:

   a. Cost-effective.
   b. Consistent with good medical practice.
   c. Unbiased.
   d. Merciful.

18. The least important factor to the court in assessing refusal of care for incompetent patients is:

   a. The patient's religious beliefs.
   b. A living will.
   c. The nature of a surrogate's relationship to the patient.
   d. A Durable Power of Attorney for Health Care.
   e. Oral directives to family, friends, and health care providers.

19. What does a Do Not Resuscitate (DNR) order mean?

   a. It triggers cardiopulmonary resuscitation (CPR).
   b. It is a withdrawal of life support.
   c. It suspends the otherwise automatic initiation of CPR.
   d. It permits the withdrawal of a respirator.

20. The next of kin can choose the DNR option for:

   a. A competent patient.
   b. An incompetent patient who made no indication of his or her wishes while competent.
   c. An incompetent patient with a living will, specifying his or her wishes regarding a DNR order.
   d. A patient who makes his or her DNR request confidential.
21. A DNR order must be in writing and reviewed every _________ hours.
   a. 24.
   b. 48.
   c. 72.
   d. 96.

22. A patient with ____________ may be a candidate for withdrawal of life support.
   a. A terminal condition or in a persistent vegetative state.
   b. Cessation of all functions of the circulatory and respiratory functions.
   c. Irreversible cessation of all functions of the entire brain, including the brain stem.

23. A determination that the criteria for withdrawal of life support are met is generally made by consulting the:
   a. Living will.
   b. Next of kin.
   c. Ethics committee.
   d. Physician.

24. In some states, the patient's preferences regarding withdrawal of life support may be expressed in a:
   a. Living will combined with a Durable Power of Attorney for Health Care.
   b. Last will and testament.
   c. Regular nondurable power of attorney.
   d. Written consent form.

25. Which of the following is **NOT** considered a life-sustaining procedure that artificially prolongs life?
   a. Intravenous therapies.
   b. Lavage feedings (nasogastric tube).
   c. Medical intervention to alleviate pain.
   d. A respirator.

26. Which is **NOT** the basis for the right to refuse?
   a. The freedom of assembly amendment.
   b. Common law bodily integrity.
   c. The right of privacy or liberty.
   d. The freedom of a religion amendment.
27. Which is NOT a factor for consideration in determining the best interests of an incompetent patient, under the objective best interests standard?

   a. Relief of suffering.
   b. Preservation or restoration of function,
   c. Quality and extent of life sustained (as viewed by the patient).
   d. Ability to contribute to society.

28. Which is NOT a requirement for a Do Not Resuscitate (DNR) order?

   a. Brain death.
   b. Irreversible terminal illness.
   c. A persistent vegetative state.
   d. An irreversibly comatose state.

Check Your Answers on Next Page
SOLUTIONS TO EXERCISES, LESSON 2, SECTION I

1. b (para 2-1a & figure 2-1)
2. c (para 2-1b)
3. b (para 2-5)
4. c (para 2-10b)
5. d (para 2-10a)
6. d (para 2-6c)
7. a (para 2-6b & caption, figure 2-4)
8. a (para 2-6b)
9. c (paras 2-6c & 2-1b)
10. a (para 2-1b)
11. b (para 2-7d)
12. c (para 2-7a)
13. b (para 2-7a)
14. d (para 2-7c)
15. a (para 2-7e)
16. c (para 2-7g)
17. b (para 2-7h)
18. c (para 2-7i)
19. c (para 2-8a)
20. b (para 2-8e)
21. c (para 2-8a)
22. a (para 2-9a)
23. d (para 2-9c)
24. a (para 2-7c)
25. c (para 2-9b)
26. a (paras 2-2 thru 2-4, para titles)
27. d (para 2-6c)
28. a (para 2-9d & 2-8b)

Go to Section II