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# Seriously Ill Newborns: A Federal Directive and Sample State Statutes



## Discriminating Against the Handicapped by Withholding Treatment or Nourishment\*

There has recently been heightened public concern about the adequacy of medical treatment of newborn infants with birth defects. Reports suggest that operable defects have sometimes not been treated, and instead infants have been allowed to die, because of the existence of a concurrent handicap, such as Down's syndrome.

This notice is intended to remind affected parties of the applicability of section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794). Section 504 provides that "No otherwise qualified handicapped individual...shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance ...." Implementing regulations issued by the Department of Health and Human Services make clear that this statutory prohibition applies in the provision of health services (45 C.F.R. 84.52) and that conditions such as Down's syndrome are handicaps within the meaning of section 504 (45 C.F.R. 84.3(j)).

Under section 504 it is unlawful for a recipient of Federal financial assistance to withhold from a handicapped infant nutritional sustenance or medical or surgical treatment required to correct a life-threatening condition, if:

~~(1) the withholding is based on the fact that the infant is handicapped.~~  
**Handicapped Health Care Providers (May 18, 1982), from the Office of the Secretary, Department of Health and Human Services, 47 Federal Register 26,027 (June 16, 1982).**

(2) the handicap does not render the treatment or nutritional sustenance medically contraindicated.

For example, a recipient may not lawfully decline to treat an operable life-threatening condition in an infant, or refrain from feeding the infant, simply because the infant is believed to be mentally retarded.

We recognize that recipients of Federal financial assistance may not have full control over the treatment of handicapped patients when, for instance, parental consent has been refused. Nevertheless, a recipient may not aid or perpetuate discrimination by significantly assisting the discriminatory actions of another person or organization. 45 C.F.R. 84.4(b)(1)(v). Recipients must accordingly insure that they do not violate section 504 by facilitating discriminatory conduct.

In fulfilling its responsibilities, a Federally assisted health care provider should review its conduct in the following areas to insure that it is not engaging in or facilitating discriminatory practices:

- Counseling of parents should not discriminate by encouraging parents to make decisions which, if made by the health care provider, would be discriminatory under section 504.
- Health care providers should not aid a decision by the infant's parents or guardian to withhold treatment or nourishment discriminatorily by allowing the infant to remain in the institution.
- Health care providers are responsible for the conduct of physicians with respect to cases administered through their facilities.

The failure of a recipient of Federal financial assistance to comply with the requirements of section 504 subjects that recipient to possible termination of Federal assistance. Moreover, section 504 does not limit the continued enforcement of State laws prohibiting the neglect of children, requiring medical treatment, or imposing similar responsibilities.

Betty Lou Dotson,  
Director,  
Office for Civil Rights

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## **Nondiscrimination on the Basis of Handicap\***

Summary: The interim final rule modifies existing regulations to meet the exigent needs that can arise when a handicapped infant is discriminatorily denied food or other medical care. Three current regulatory provisions are modified to allow timely reporting of violations, expeditious investigation, and immediate enforcement action when necessary to protect a handicapped infant whose life is endangered by discrimination in a program or activity receiving federal financial assistance.

Recipients that provide health care to infants will be required to post a conspicuous notice in locations that provide such care. The notice will describe the protections under federal law against discrimination toward the handicapped, and will provide a contact point in the Department of HHS for reporting violations immediately by telephone.

Notice and complaint procedures have been effective instruments for deterrence and enforcement in a variety of civil rights contexts. The Secretary believes that the interim final rule provides the best means to ensure that violations can be reported in time to save the lives of handicapped children who are denied food or are otherwise imperiled by discrimination in the provision of health care by federally assisted programs or activities.

The procedures to be followed for investigation of complaints are outlined in the supplementary information below. The Secretary intends to rely heavily on the voluntary cooperation of State and local agencies, which are closest to the scene of violations, and which have traditionally played the key role in the investigation of complaints of child abuse and neglect. This will not exclude, of course, a vigorous federal role in enforcing the federal civil rights that are at issue.

The Secretary invites comments on all aspects of the interim final rule. Aspects on which comment is particularly invited are set forth in the supplementary information.

Dates: The interim final rule becomes effective March 22, 1983. Comments should be submitted by May 6, 1983.

Addresses: Comments should be submitted in writing to the Director, Office for Civil Rights, Department of Health and Human Services, 330 Independence Avenue, S.W., Room 5400, Washington, D.C. 20201, or delivered to the above address between 9:00 a.m. and 5:30 p.m. on regular business days. Comments received may be inspected during these same hours by making arrangements with the contact person shown below.

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\*Notice of Interim Final Rule. Office of the Secretary, Department of Health and Human Services, 48 Federal Register 9630 (March 7, 1983).

For Further Information Contact: Susan Shalhoub at (202) 245-6585. Office for Civil Rights, Department of Health and Human Services, 330 Independence Avenue, S.W., Room 5514, Washington, D.C. 20201.

Supplementary Information: The President's directive of April 30, 1982, and the HHS Office for Civil Rights "Notice to Health Care Providers" of May 18, 1982, reminded recipients of federal financial assistance of the applicability of Section 504 of the Rehabilitation Act of 1973. Section 504 provides: "No otherwise qualified handicapped individual...shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance."

The Notice to Health Care Providers explained what is already clear from the language of Section 504 and the implementing regulations (45 CFR Part 84): The discriminatory failure of a federally assisted health care provider to feed a handicapped infant, or to provide medical treatment essential to correct a life-threatening condition, can constitute a violation of Section 504.

This interim final rule does not in any way change the substantive obligations of health care providers previously set forth in the statutory language of Section 504, in the implementing regulations, and in the Notice to Health Care Providers. The interim final rule sets forth procedural specifications designed (1) to specify a notice and complaint procedure, within the context of the existing regulations, and (2) to modify existing regulations to recognize the exigent circumstances that may exist when a handicapped infant is denied food or other necessary medical care.

The interim final rule affects the following portions of existing regulations:

1. **45 CFR 80.6(d)**, as referenced by 45 CFR 84.61, which requires recipients to make available such information, in such a manner, as the Department finds necessary to apprise appropriate persons of the protections afforded under Section 504. The interim final rule specifies the type of information and manner of posting that is necessary to bring the protections of Section 504 for handicapped infants to the attention of those persons within the recipient program or activity who are most likely to have knowledge of possible violations as they occur.

2. **45 CFR 80.8**, as referenced by 45 CFR 84.61, which sets forth procedures for the Secretary to effect compliance with Section 504, including referrals to the Department of Justice for the initiation of appropriate legal proceedings. The existing regulations require a 10-day waiting period from the time the Secretary notifies a recipient of its failure to comply to the time the Secretary makes a referral to the Department of Justice or takes other legal actions to effect compliance. When a

handicapped infant is being denied food or other necessary medical care, however, more expeditious action may be required. New Section 84.72 creates a narrow exception to the 10-day waiting period when, in the judgment of the responsible Department official, immediate remedial action is necessary to protect the life or health of a handicapped individual.

3. **45 CFR 80.6(c)**, as referenced by 45 CFR 84.61, which requires each recipient to permit access by Department officials to facilities and information pertinent to ascertaining compliance with Section 504, during normal business hours. Allegations of denial of food or other necessary medical care to handicapped infants may require an immediate effort to ascertain compliance. The interim final rule provides that access to records and facilities of recipients shall not be limited to normal business hours when, in the judgment of the responsible Department official, immediate access is necessary to protect the life or health of a handicapped individual.

The purpose of the interim final rule is to acquire timely information concerning violations of Section 504 that are directed against handicapped infants, and to save the life of the infant. The Secretary believes that those having knowledge of violations of Section 504 against handicapped infants do not now have adequate opportunity to give immediate notice to federal authorities. A telephone complaint procedure can provide information to federal authorities in time to save the life of a handicapped infant who is being discriminatorily denied nutrition in a federally assisted program or activity.

Events of the past several years suggest that handicapped infants have died from denial of food in federally assisted programs. The full extent of discriminatory and life-threatening practices toward handicapped infants is not yet known, but the Secretary believes that for even a single infant to die due to lack of an adequate notice and complaint procedure is unacceptable.

For quick and effective response to complaints, the Secretary counts not only the enforcement resources of the Federal government, but also on the assistance of state child protective agencies, which can respond quickly and effectively to referrals from the Federal government, and which are often closest to the scene for speedy investigation of life-threatening child abuse and neglect. The Secretary intends to contact state child protective agencies whenever a complaint is received that falls within the definition of child abuse or neglect, in order to give States an opportunity to make their own investigation and to take appropriate action.

The Secretary expects that States will follow their customary procedures for investigating allegations of child abuse and neglect that involve an imminent danger to life. State agencies that receive federal financial assistance are under the same

obligation as other recipients not to provide a qualified handicapped person with benefits or services that are less effective than those provided to others.

For those complaints that are expeditiously and effectively investigated and pursued by State agencies, the Secretary anticipates that additional federal efforts will often be unnecessary. The Secretary will closely monitor all investigation and enforcement activity taken pursuant to complaints. The Secretary will make available to State agencies any information and assistance that is helpful and appropriate. For those cases where direct federal action appears helpful, the Secretary will have at his disposal the usual means of federal civil rights enforcement. The interim final rules makes it possible for the Secretary to conduct immediate investigations and to make immediate referrals to the Department of Justice for such legal action as may be necessary to save the life of a handicapped child who is subjected to discrimination by a recipient.

Federal enforcement action can also be taken against any recipient that intimidates or retaliates against any person who provides information concerning possible violations of Section 504. 45 CFR 80.7(e), as referenced by 45 CFR 84.61, prohibits intimidatory or retaliatory acts by recipients against individuals who make complaints or assist in investigations concerning possible violations of Section 504. This provision fully protects individuals who make complaints or assist in investigations concerning possible withholding of food or other necessary medical care from handicapped infants.

**Comments solicited.** The Secretary seeks public comment on all aspects of the interim final rule. Comments will be considered and modifications made to the rule, as appropriate, following the comment period.

The Secretary also solicits comments on the advisability of requiring (1) that recipients providing health care services to infants perform a self-evaluation, pursuant to 45 CFR 84.6(c)(1), with respect to their policies and practices concerning services to handicapped infants; and (2) that such recipients identify for parents of handicapped children those public and private agencies in the geographical vicinity that provide services to handicapped infants.

**Regulatory impact analysis.** This Rule has been reviewed under Executive Order 12291. It is not a major rule and thus does not require a regulatory impact analysis.

**Regulatory flexibility analysis.** The Regulatory Flexibility Act (Pub. L. 96-354) requires the federal government to anticipate and reduce the impact of rules and paperwork requirements on small businesses and other small entities. This Rule has no significant effect on small entities. Therefore, a regulatory flexibility analysis is not required.

**Paperwork Reduction Act.** This Rule contains no information collection requirements subject to the Paperwork Reduction Act of 1980 (Pub. L. 96-511).

**Public participation in rulemaking.** With reference to the Secretary's Statement of Policy, dated January 28, 1971, concerning public participation in rulemaking (printed at 36 FR 2532; Feb. 5, 1971), the Secretary finds that this interim final rule is exempt from the requirements of 5 U.S.C. 553. Under 45 CFR 80.6(d) and 84.61, the Secretary is already authorized to specify the manner in which recipients make available information concerning federal legal protections against discrimination toward the handicapped. The exception to the 10-day waiting period of 45 CFR 80.8(d)(3) and the exception to 45 CFR 80.6(c) to allow access outside normal business hours are minor technical changes and are necessary to meet emergency situations. All modifications made by the interim final rule are necessary to protect life from imminent harm. Any delay would leave lives at risk. Immediate publication and implementation of this rule will not cause undue burden to any party. The Secretary therefore finds it necessary to publish this rule as an interim final rule taking effect less than 30 days following publication. The Secretary deems 15 days to be the minimum in which the necessary apparatus can be in place to receive and respond to telephone complaints. The interim final rule is therefore made effective March 22, 1983.

Approved: March 2, 1983

Thomas R. Donnelly, Jr., Acting Secretary

Part 84--[Amended]

#### **Interim Final Rule**

45 CFR 84.61 is amended by designating the existing provision as paragraph (a) and by adding paragraphs [b], [c], and [d] to read as follows:

S 84.61 [Amended]

(b) Pursuant to 45 CFR 80.6(d), each recipient that provides covered health care services to infants shall post and keep posted in a conspicuous place in each delivery ward, each maternity ward, each pediatric ward, and each nursery, including each intensive care nursery, the following notice:

DISCRIMINATORY FAILURE TO FEED AND CARE FOR  
HANDICAPPED INFANTS  
IN THIS FACILITY IS PROHIBITED BY FEDERAL LAW

Section 504 of the Rehabilitation Act of 1973 states that no otherwise qualified handicapped individual shall, solely by reason of handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.

**Any person having knowledge that a handicapped infant is being discriminatorily denied food or customary medical care should immediately contact:**

Handicapped Infant Hotline  
U.S. Department of Health and Human Services  
Washington, D.C. 20201  
Phone 800-\_\_\_\_\_ (Available 24 hours a day)

or

Your State Child Protective Agency

Federal law prohibits retaliation or intimidation against any person who provides information about possible violations of the Rehabilitation Act of 1973.

Identity of callers will be held confidential.

Failure to feed and care for infants may also violate the criminal and civil laws of your State.

(1) Recipients may add to the notice, in type face or handwriting, under the words "Your State Child Protective Agency," the identification of an appropriate State agency, with address and telephone number. No other alterations shall be made to such notice.

(2) Copies of such notice may be obtained on request from the Department of Health and Human Services.

(3) The required notice shall be posted within five days after the recipient is informed by the Department of the applicable toll-free national telephone number.

(c) Notwithstanding the provisions of paragraph (a), the requirement of 45 CFR 80.8(d)(3) shall not apply when, in the judgment of the responsible Department official, immediate remedial action is necessary to protect the life or health of a handicapped individual.

(d) Notwithstanding the provisions of paragraph (a), access to pertinent records and facilities of a recipient pursuant to 45 CFR 80.6(c) shall not be limited to normal business hours when, in the judgment of the responsible Department official, immediate access is necessary to protect the life or health of a handicapped individual.

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## 1982 Louisiana Act regarding nutrition and medical care of children\*

To enact Part XIX of Chapter 5 of Title 40 of the Louisiana Revised

Statutes of 1950, to be comprised of R.S. 40:1299.36.1 through R.S. 40:1299.36.3, relative to nutritional or medical deprivation of infants, to provide with respect to infants denied or deprived of food, water or medical care with the intent to cause or allow the death of the child, to provide for procedures when parental consent for necessary care and treatment is refused, to provide with respect to judicial proceedings to enforce the provisions of this Part, and otherwise to provide with respect thereto.

Be it enacted by the Legislature of Louisiana:

Section 1. Part XIX of Chapter 5 of Title 40 of the Louisiana Revised Statutes of 1950, comprised of R.S. 40:1299.36.1 through R.S. 40:1299.36.3, is hereby enacted as follows:

### PART XIX. PRESERVING THE LIFE OF CHILDREN

**§1299.36.1.** Infants born alive and other children; nutritional and medical deprivation prohibited.

A. No infant born alive shall be denied or deprived of food or nutrients, water, or oxygen by any person whomsoever with the intent to cause or allow the death of the child for any reason, including but not limited to the following:

(1) The child was born with physical or mental handicapping conditions which, in the opinion of the parent or parents of the child, the physician, or other persons, diminishes the quality of the child's life.

(2) The child is not wanted by the parent.

(3) The child is born alive in the course of an attempted abortion.

No infant child shall be intentionally killed by any other means by any person for any reason.

B. No minor child, from the moment of live birth, shall be intentionally denied or deprived of any medical or surgical care by his or her parent, physician, or any other person when such medical or surgical care is necessary to attempt to save the life of the child, in the opinion of a physician exercising competent medical judgment, despite the opinion of the child's parent or parents, the physician, or others that the quality of the child's life would be deficient should the child live.

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\*Enacted Sept. 10, 1982.

C. Nothing in this Section shall be interpreted to prevent a child's parents and physician from discontinuing the use of life support systems or other medical treatment for a child in a continual profound comatose state where, in the opinion of the child's physician exercising competent medical judgment, the child has no reasonable chance of recovery from said comatose state despite every appropriate medical treatment to correct such condition.

D. This Section shall not be interpreted to require the provision of potentially lifesaving medical or surgical care to a child when in the opinion of the child's parent or parents and their physician exercising competent medical judgment, the potential risks to the child's life or health inherent in the treatment or surgery itself outweigh the potential benefits for survival from the treatment of surgery itself.

E. No child who is being provided treatment in accordance with the tenets of a well-recognized religious method of healing in lieu of medical treatment shall for that reason alone be considered to be neglected under the provisions of this Part, unless the life of the child is substantially and seriously threatened due to the lack of traditional medical care. Provided however that the parents of a child whose life the department alleges is substantially and seriously threatened due to lack of traditional medical or surgical care shall have the right to petition a district court of competent jurisdiction for a temporary restraining order or injunction prohibiting the Department from intervening in the matter. The court shall give preference to such hearings, and such matters shall be tried summarily.

**S 1299.36.2. Parental consent to care and treatment; refusal.**

A. Whenever the parent or parents of a child refuse to consent to the care and treatment of the child protected by R.S. 40:1299.36.1, they shall at all times be free to execute a voluntary act of surrender of the child pursuant to R.S. 9:402, placing the child in the custody of the Department of Health and Human Resources or other licensed adoption agency. All medical expenses incurred by the Department of Health and Human Resources on behalf of the child shall be reimbursed by the parent or parents of the child, provided they have not been declared financially needy. No medical insurer of the parent or parents of a child who would have otherwise been liable for such medical expenses may deny liability to their insured solely because of the parent or parents desire to withhold medical or surgical treatment from the child. The agency shall immediately provide the treatment for the child and shall make every effort to find an adoptive home for the child.

B. Whenever the parent of a child protected by R.S. 40:1299.36.1 refuses to consent to the necessary care and treatment for the child, but refuses to surrender the child for adoption, the physician, or other persons included in the

provisions of R.S. 14:403 shall report the child as a neglected child or child in need of care to the local child protection agency or to the police.

C. No physician, hospital, or other person authorized by law to provide medical or surgical care shall be held liable for providing medical or surgical care for a child protected by R.S. 40:1299.36.1 without the consent of the child's parent or the agency having custody of the child, when in the opinion of the physician, hospital, or other person authorized by law to provide medical or surgical care, exercising competent medical judgment, the child's life would be threatened by delaying the provision of the care or treatment.

**§ 1299.36.3. Judicial proceedings.**

A. Judicial proceedings to enforce the provisions of this Part may be instituted by any agency, institution, or person interested in the child's welfare in the juvenile court in the jurisdiction where the child is found. All such proceedings shall be heard in confidence without delay, including the holding of special sessions of court. Any appeal or application for writs in any appellate court in cases arising from this Section shall be heard and decided in the shortest possible time. An attorney shall be appointed to represent the child in all trial and appellate proceedings.

B. Nothing in this Part shall diminish the application of the Louisiana Criminal Code where appropriate.

Section 2. If any provision or item of this Act or the application thereof is held invalid, such invalidity shall not affect other provisions, items, or applications of this Act which can be given effect without the invalid provisions, items, or applications, and to this end the provisions of this Act are hereby declared severable.

Section 3. All laws or parts of laws in conflict herewith are hereby repealed.

## **Model Child Protection Act\***

### **§ 1. Title.**

This Act shall be known as the Child Protection Act of 19—

### **S 2. Findings and purpose.**

Abused and neglected children in this state urgently need protection. It is the purpose of this Act to help protect them from further injury and harm. This Act seeks to establish an effective state and local system for child protection by providing those procedures necessary to safeguard the well-being and development of endangered children and to preserve and stabilize family life, whenever appropriate. Recognizing that children also can be abused and neglected while living in public and private residential facilities and institutions meant to serve them, this Act also provides for handling of reports of abuse and neglect of children in residential institutions.

### **S 3. Persons or families needing assistance encouraged to seek it.**

Any person or family seeking assistance in meeting child care responsibilities may use, and is encouraged to use, the services and facilities established by this Act. Such persons or families shall be referred to appropriate community resources or agencies regardless of whether or not the problem presented constitutes child abuse or neglect as defined by this Act. No person seeking assistance under this section shall be required to give his name or any other identifying information.

### **S 4. Definitions.**

When used in this Act and unless the specific context indicates otherwise:

(a) "Child" means a person under the age of **18**.

(b) An abused or neglected child" means a child whose physical health is harmed or threatened with harm by the acts or omissions of his parent or other person responsible for his welfare, or whose mental health is harmed or threatened with harm.

(c) "Harm" to a child's health or welfare occurs when the parent or other person responsible for welfare:

(i) inflicts, or allows to be inflicted, upon the child, physical or mental injury, including injuries sustained as a result of excessive corporal punishment; or

(ii) commits, or allows to be committed, a sexual act with a child; or

\*National Center on Child Abuse and Neglect, U.S. Dept. of Health and Human Services, CHILD PROTECTION: A GUIDE FOR STATE LEGISLATION, U.S. Government Printing Office, Washington, D.C. (1983) at 43.

(iii) allows, encourages, or forces a child to solicit for or engage in prostitution; or engage in the filming, photographing, videotaping, posing, modeling, or performing before a live audience, where such acts involve exhibition of the child's genitals or any sexual act with the child; or

(iv) fails to meet the following needs of the child though financially able to do so or offered financial or other reasonable means to do so:

- such food, clothing, or shelter necessary for the child's health or safety
- education as defined by state law
- adequate health care (adequate health care includes any medical or nonmedical remedial health care permitted or authorized under state law); or

(v) abandons the child, as defined by state law; or

(vi) fails to provide the child with adequate care or supervision necessary for the child's health or safety; or leaves the child unattended over a period of time causing a risk of harm to the child's health or safety.

(d) "Allows to be inflicted" or "allows to be committed" means that the parent or other person responsible for the child's welfare knows or has reasonable cause to suspect that the child has been harmed and did nothing to prevent or stop it.

(e) "Sexual act" means:

(i) any penetration, however slight, of the vagina or anal opening of one person by the penis of another person, whether or not there is the emission of semen; or

(ii) any sexual contact between the genitals or anal opening of one person and the mouth or tongue of another person; or

(iii) any intrusion by one person into the genitals or anal opening of another person, including the use of any object for this purpose, EXCEPT that, it shall not include acts intended for a valid medical purpose; or

(iv) the intentional touching of the genitals or intimate parts (including the breasts, genital area, groin, inner thighs, and buttocks) or the clothing covering them, of either the child or the perpetrator, EXCEPT that, it shall not include acts which may reasonably be construed to be normal caretaker responsibilities, interactions with, or affection for a child or acts intended for a valid medical purpose, or

(v) the masturbation of the perpetrator's genitals in the presence of a child, or

(vi) the intentional exposure of the perpetrator's genitals in the presence of a child, if such exposure is for the purpose of sexual arousal or gratification, aggression, degradation, or other similar purpose; or

(vii) any other sexual act, intentionally perpetrated in the presence of a child, for the purpose of sexual arousal or gratification, aggression, degradation, or other similar purpose.

(f) "Threatened harm" means a substantial risk of immediate harm.

(g) "A person responsible for a child's welfare" includes the child's parent; guardian; foster parent; stepparent with whom the child lives; an employee of a public or private residential home, institution or agency; or other person legally responsible for the child's welfare in a residential setting.

(h) "Physical injury" means death, or permanent or temporary disfigurement or impairment of any bodily organ or function.

(i) "Mental injury" means an injury to the intellectual or psychological capacity of a child as evidenced by an observable and substantial impairment in his ability to function within his normal range of performance and behavior, with due regard to his culture.

(j) "Institutional child abuse and neglect" means situations of known or suspected child abuse or neglect where the person responsible for the child's welfare is a foster parent or the employee or volunteer of a public or private residential care facility, institution, or agency providing around-the-clock care for children.

(k) "State department" means the department designated under section 14 to have prime responsibility for state efforts to strengthen and improve the prevention, identification, and treatment of child abuse and neglect.

(l) "Local agency" means the agency designated under Section 14 to have prime responsibility for providing local child protective services.

(m) "Child protective services" is a specialized child welfare service responsible for the receipt and investigation of reported instances of child abuse and neglect and providing or arranging for needed services in confirmed cases.

(n) "Subject of the report" means any person reported under this Act, including any child or parent, guardian, or other person responsible for the child's welfare.

(o) "Unfounded report" means a report made pursuant to this Act for which there is no reasonable cause to believe that the child is abused or neglected. For the purposes of this Act, it is presumed that all reports are unfounded unless the child protective service determines otherwise.

(p) "Reasonable cause to believe" means facts and circumstances based upon accurate and reliable information that would justify a reasonable person to believe that a child subject to a report under this Act is abused or neglected. Such facts and circumstances may include evidencce of an injury or

injuries, if not satisfactorily explained, and the statements of a person worthy of belief, even if there is no present evidence of injury.

(q) "Reasonable cause to suspect" means facts and circumstances based upon accurate and reliable information that would justify a reasonable person to suspect.

(r) "Excessive corporal punishment" means reckless, unjustifiable, unduly severe, or disproportionate punishment or disciplinary measures which cause, or create a substantial risk of causing, disfigurement, impairment of bodily functioning, or other serious physical or mental injury.

(s) As used in this Act, words of the masculine gender include the feminine.

#### **S 5. Persons and officials required to report known and suspected child abuse or neglect.**

(a) When the following professionals and officials know or have reasonable cause to suspect that a child known to them in their professional or official capacity is an abused or neglected child, they are required to report or cause a report to be made in accordance with this Act: any physician; resident; intern; hospital personnel engaged in the admission, examination, care or treatment of persons; nurse; osteopath; chiropractor; podiatrist; medical examiner or coroner; dentist; optometrist; or any other health or mental health professional; Christian Science practitioner; religious healer; school teacher or other school official or pupil personnel; social worker; day care center staff or any other professional child care workers, foster care providers, residential or institutional worker; or peace officer or other law enforcement official.

(b) Whenever a person is required to report under this Act in his capacity as a member of the staff of a medical or other public or private institution, school, facility, or agency, he shall immediately notify the person in charge, or his designated agent, who shall then become responsible to make the report or cause the report to be made. However, nothing in this section or Act is intended to relieve individuals of their obligation to report on their own behalf, unless a report already has been made or will be made forthwith.

(c) Persons reporting instances of child abuse and neglect occurring in public or private residential institutions shall be immune from any adverse action with respect to employment by or in such institution arising out of such reporting.

#### **§6. Any person permitted to report.**

Any person may make a report under this Act, if he knows or has reasonable cause to suspect that a child is abused or neglected.

#### **S 7. Mandatory reporting of deaths to and postmortem investigation by medical examiner or coroner.**

Any person or official required to report under this Act who has reasonable cause to suspect that a child has died as a result of child abuse or neglect shall report his suspicion to the appropriate medical examiner or coroner and any other person may do so as well. The medical examiner or coroner shall investigate the report and submit his findings, in writing, to the local law enforcement agency, the appropriate district attorney, the local child protective service, and, if the institution making the report is a hospital, the hospital.

**§ 8. Photographs and x-rays.**

Any person or official required to report or to conduct an investigation under this Act may take, or cause to be taken, photographs of the areas of trauma visible on a child who is the subject of a report and, if indicated by medical consultation, cause to be performed a radiological examination of the child without the consent of the child's parents or guardians. Whenever such person is required to report in his capacity as a member of the staff of a medical or other public or private institution, school, facility, or agency, he shall immediately notify the person in charge, or his designated agent, who shall then take or cause to be taken color photographs of visible trauma and shall, if indicated by medical consultation, cause to be performed a radiological examination of the child. The reasonable cost of photographs or x-rays taken under this section shall be reimbursed by the appropriate local child protective service. All photographs and x-rays taken, or copies of them, shall be sent to the local child protective service at the time the written confirmation report is sent, or as soon thereafter as possible.

**§ 9. Protective custody.**

(a) A police or law enforcement official [, *a designated worker of a child protective service,*] and a physician treating a child may take a child into protective custody without the consent of parents, guardians, or others exercising temporary or permanent control over the child when he has reasonable cause to believe that (1) there exists an imminent danger to the child's life or safety, (2) the parents are unavailable or have been asked and do not consent to the child's removal from their custody, and (3) there is not time to apply for a court order.

(b) In the event there is not time to seek a court order the person in charge of any hospital or similar medical institution may retain custody of a child reasonably suspected of being abused or neglected, when he believes the facts so warrant, whether or not additional medical treatment is required and

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<sup>t</sup>Optional; see Comment.

whether or not the parents or other person responsible for the child's welfare request the child's return.

(c) The child shall be taken immediately to a place previously designated for this purpose by the juvenile court or the local agency. Such place may include a foster home; group home; shelter; hospital, if the child is or will be admitted to the hospital; or other institution; but it shall not be a jail or other place for the detention, incarceration, or residential care of criminal offenders or juveniles either alleged or adjudicated as delinquents or status offenders.

(d) No child shall be kept in protective custody under this Act for more than twenty-four hours unless authorized by a judge of a court of record. If after 24 hours there has been no protective custody order from the court, the person having custody of the child shall return the child to his parents.

(e) Any person taking a child into protective custody shall immediately notify the appropriate local child protective service. Upon such notification, the service shall immediately see to the protection of any other children in the home, commence a child protective investigation in accordance with Section 13 of this Act, and make every reasonable effort to inform the parent or other person responsible for the child's welfare as to where the child has been taken. Parents shall be informed of where and when the case will be heard; their right to legal representation as well as the provision of legal representation if indigent; and their visitation rights. The service shall make a reasonable attempt to return the child to his home, whenever it seems safe to do so. At the next regular session of the juvenile court [or family court or similar civil court],\* the service shall (i) commence a child protection proceeding in the court, or (ii) recommend to the court [court intake service or other initiating authority]\*\* that one not be commenced. The court may order commencement of a proceeding even if the service recommends against doing so, if it finds that such a proceeding would be in the best interests of the child. If a proceeding is commenced, the service shall recommend whether or not the child should be returned to his parents or other person responsible for his welfare pending further court action.

#### **§ 10. Immunity from liability.**

Any person, official, or institution participating in good faith in any act authorized or required by this Act shall be immune from any civil or criminal liability which might otherwise result by reason of such action. Any person reporting under the provisions of the Act shall have a civil cause of

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\*As appropriate.

\*\*Optional.

action against any person who causes a detrimental change in the employment status of the reporter by reason of the report.

**§ 11. Abrogation of privileges.**

The marital privilege, including the privilege against adverse testimony and the privilege against disclosure of confidential communications, and the privileged quality of communications between any professional person and his patient or client, and canons of professional ethics, shall not apply, except that between attorney and client, to instances of known or suspected child abuse or neglect and shall not constitute grounds for failure to report as required or permitted by this Act. This privilege will not apply to cooperation with the child protective service in its activities pursuant to this Act, or to provision of evidence in any civil or criminal proceeding relating to child abuse or neglect.

**§ 12. Penalties for failure to report or act.**

Any person, official or institution required by this Act to report known or suspected child abuse or neglect, or required to perform any other act, who knowingly and willfully fails to do so or who knowingly and willfully prevents another person acting reasonably from doing so shall be guilty of a misdemeanor and shall be civilly liable for the damages proximately caused by such failure or prevention.

**§ 13. Legal responsibilities of local agency.**

(a) The local agency shall be capable of receiving reports of known or suspected child abuse or neglect twenty-four hours a day, seven days a week. If it appears that the immediate safety or well-being of a child is endangered, the family may flee or the child disappear, or the facts otherwise so warrant, the agency shall commence an investigation immediately, regardless of the time of day or night. In all other cases, a child protective investigation shall be commenced within twenty-four hours of receipt of the report. To fulfill the requirements of this section, the local agency shall have the capability of providing or arranging for comprehensive emergency services to children and families at all times of the day or night.

(b) For each report it receives, the local agency shall perform a child protective investigation within the time limits specified in (a) to: (i) determine the composition of the family or household, including the name, address, age, sex, and race of each child named in the report, and any siblings or other children in the same household or in the care of the same adults, the parents or other persons responsible for their welfare, and any other adults in the same household; (ii) determine whether there is reasonable cause to believe that any child in the family or household is abused or neglected, including a determination of harm or threatened harm to each child, the nature and extent of present or prior injuries, abuse

or neglect, and any evidence thereof, and a determination of the person or persons apparently responsible for the abuse or neglect; (iii) provided that there is probable cause determine the immediate and long-term risk if each child were to remain in the existing home environment; and (iv) determine the protective, treatment, and ameliorative services that appear necessary to help prevent further child abuse or neglect and to improve the home environment and the parents' ability to care adequately for the children. The purpose of the child protective investigation shall be to provide immediate and long term protective services to prevent further abuse or neglect and to provide, or arrange for, and coordinate and monitor treatment and ameliorative services necessary to safeguard and insure the child's well-being and development and, if possible, to preserve and stabilize family life.

(c) The local agency may waive a full child protective investigation of reports made by agencies or individuals if, after an appropriate assessment of the situation, it is satisfied that: (i) the protective and service needs of the child and the family can be met by the agency or individual, (ii) the agency or individual agrees to attempt to do so, and (iii) suitable safeguards are established and observed. Suitable safeguards shall include a written agreement from the agency or individual to report periodically on the status of the family, a written agreement to report immediately to the local agency at any time that the child's safety or well-being is threatened despite the agency's or individual's efforts, and periodic monitoring of the agency's or individual's efforts by the local service for a reasonable period of time.

(d) The local agency shall convene one or more interdisciplinary "Child Protection Teams" to assist it in its diagnostic, assessment, service, and coordination responsibilities. The head of the local agency or his designee shall serve as the team's coordinator. Members of the team shall serve at the coordinator's invitation and shall include representatives of appropriate health, mental health, social service, and law enforcement agencies.

(e) If the local child protective service is denied reasonable access to a child by the parents or other persons and the local service deems that the best interests of the child so require, it shall seek an appropriate court order or other legal authority to examine and interview such child.

(f) The child protective service may determine that a child requires immediate or long term protection, either through (1) medical or other health care, or (2) homemaker care, day care, casework supervision, or other services to stabilize the home environment, or (3) foster care, shelter care, other substitute care to remove the child from his parent's custody. If such a determination made, services first shall be offered for the

voluntary acceptance of the parent or other person responsible for the child's welfare. If such services are refused and the child protective service deems that the child is in imminent danger the service shall seek an appropriate court order or other legal authority to protect the child.\*

(g) After providing for the immediate protection of the child but prior to offering any services to a family, the local agency shall forthwith notify the adult subjects of the report and any other persons alleged to be responsible for the child abuse or neglect, in writing, of the existence of the report and their rights pursuant to this Act. This notification shall include an explanation of their right to refuse services and their right to obtain access to and amend, expunge, or remove reports in the central register of child protection cases. The local agency shall explain that it has no legal authority to compel the family to accept services; however, it shall inform the family of the obligations and authority of the local agency to petition the juvenile court to decide whether a child is in need of care and protection or to refer the case to the police or the district attorney who will then decide whether there shall be a criminal prosecution. Upon the initiation of any judicial action the parents shall be informed of their legal rights.

(h) If the local child protective service determines that there is not reasonable cause to believe that a child is abused or neglected, it shall close its protective case. However, if it appears that the child or family could benefit from other social services, the local service may suggest such services for the family's voluntary acceptance or refusal. If the family declines such services, the local service shall take no further action.

(i) If the local child protective service determines that there is reasonable cause to believe that a child is abused or neglected, based upon its determination of the protective, treatment, and ameliorative service needs of the child and family, the local service shall develop, with the family, an appropriate service plan for the family's voluntary acceptance or refusal. The local service shall comply with subsection (g) by explaining its lack of legal authority to compel the acceptance of services and shall explain its concomitant authority to petition the juvenile court or refer the case to the police, district attorney, or criminal court.

(j) If the local agency determines that the best interests of a child require juvenile court or criminal court action because the child is in need of protection, the local service may initiate a court proceeding or a referral to the appropriate court related service, police department, district attorney, or any combination thereof.

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\*The police and, if authorized by the optional provision in section 9(a), the child protective service may take the child into protective custody.

(k) The child protective service shall give telephone notice and immediately forward a copy of reports which involve the death of a child to the appropriate district attorney [or *other appropriate law enforcement agency*] and medical examiner or coroner. In addition, upon the prior written request of the district attorney or if the local service otherwise deems it appropriate, a copy of any or all reports made pursuant to this Act which allege criminal conduct shall be forwarded immediately by the child protective service to the appropriate district attorney.

(l) If a law enforcement investigation is also contemplated or is in progress, the child protective service shall coordinate their efforts and concerns with those of the law enforcement agency.

(m) In any juvenile or criminal court proceeding commenced by the child protective service or by any other individual or agency, the service shall assist the court during all stages of the court proceeding, in accordance with the purposes of this Act, the juvenile court act, and the penal law.

(n) The child protective service may request and shall receive from any agency of the state, or any of its political subdivisions such cooperation, assistance, and information as will enable it to fulfill its responsibilities under this section.

#### **S 14. Designation of state department.**

The state department responsible for the supervision or administration of the local agency and having prime responsibility for state efforts to strengthen and improve the prevention, identification, and treatment of child abuse and neglect shall be the State Department of \_\_\_\_\_

#### **S 15. Powers, functions, and duties of the state department.**

(a) The state department shall serve as a state clearinghouse on programs and groups providing or concerned with human services related to the prevention, identification, or treatment of child abuse or neglect. It shall compile, publish, and disseminate public, professional, and staff educational and training materials and provide training and technical assistance, directly or indirectly to personnel and agencies who are engaged or intend to engage in the prevention, identification and treatment of child abuse and neglect. The department shall encourage the development of improved and additional state and local programs and activities; encourage the assumption of prevention and treatment responsibilities by additional agencies and groups; encourage the coordination of existing programs and activities; and conduct, support, or foster research into the causes of child abuse and neglect and into the prevention, identification and treatment of child maltreatment.

(b) The state department shall establish a "statewide child protection office." The office shall be a separate organizational unit, singly administered and supervised within the

state department, with sufficient staff of acceptable qualifications and adequate resources, including telephone facilities, to fulfill the purposes and functions assigned to it by this Act, other laws, or administrative procedures.

**S 16. The information system (central register).**

(a) There shall be a system statewide, for receipt of suspected reports of child maltreatment from persons, whether or not mandated by law, at any hour of the day or night, on any day of the week. Immediately upon receipt of such reports, the contents of the report shall be forwarded either orally or electronically to the appropriate local child protective agency. Any person or family seeking assistance in meeting child care responsibilities may also use this system to obtain assistance or information in accordance with section 3 of this Act. Any other person may use this system to obtain assistance or information concerning the handling of child protection cases.

(b) There shall be a central register of child protection cases maintained in the statewide office. Through the recording of appropriate information, the central register shall be operated in such a manner as to enable the office to evaluate regularly the effectiveness of the child protection system.

(c) The centralized information system (central register) shall perform the following functions:

(i) Maintain information on all reports of suspected child abuse and neglect received by the system in the state.

(ii) Reflect the results of the investigations of all reports of suspected child abuse and neglect received.

(iii) Reflect the management of all cases of child abuse and neglect.

(iv) Produce statistical information reflecting the operation of the child protection system in the state in a timely fashion.

(v) Contain such other information which the department determines to be in furtherance of the purposes of this Act.

(d) All information identifying the subjects of an unfounded report shall be expunged, forthwith. Identifying information on all other records shall be removed from the system no later than five years after the case is closed. However, if another report is received involving the same child, his sibling or offspring, or a child in the care of the same adults, the identifying information may be maintained in the register until five years after the subsequent case or report is closed.

(e) At any time, the information in the system may be amended, expunged, or removed upon good cause shown and upon notice to the subjects of the report and the local child protective service.

(f) Upon request, a subject of a report shall be entitled to receive a copy of all information contained in the system

pertaining to his case. However, there is authority to prohibit the release of data that would identify or locate a person who, in good faith, made a report or cooperated in a subsequent investigation, when it reasonably finds that disclosure of such information would be likely to endanger the life or safety of such person.

(g) At any time subsequent to the completion of the local child protective service investigation, a subject of a report may make a request to amend, expunge identifying information from, or remove the record of the report from the system. If the request is refused or there is a failure to act within thirty days, the subject shall have the right to a fair hearing to determine whether the record of the report should be amended, expunged, or removed on the grounds that it is inaccurate or it is being maintained in a manner inconsistent with this Act.

Such fair hearing shall be held within a reasonable time after the subject's request and at a reasonable place and hour. The appropriate local child protective service shall be given notice of the hearing. In such hearings, the burden of proving the accuracy and consistency of the record shall be on the state department and the appropriate local child protective service. A juvenile court [*family court or similar civil court*] finding of child abuse or child neglect shall be presumptive evidence that the report was not unfounded. The hearing shall be conducted by the head of the state department or his designated agent, who is hereby authorized and empowered to order the amendment, expunction, or removal of the record to make it accurate or consistent with the requirements of this Act. A decision on the request shall be made, in writing, at the close of the hearing, or within thirty days thereof, and shall state the reasons upon which it is based. Decisions of the state department under this section shall be subject to judicial review in the form and manner prescribed by the state civil procedure law.

(h) To the fullest extent possible, written notice of any amendment, expunction, or removal of any record made pursuant to this Act shall be served upon each subject of such report and the appropriate local child protective service. The service, upon receipt of such notice, shall take similar action in regard to the local child abuse and neglect records and shall inform, for the same purpose, any other individuals or agencies which received such record pursuant to this Act or in any other manner. Nothing in this section is intended to require the destruction of case records.

#### **§ 17. Reports of institutional child abuse and neglect.**

(a) The Governor shall designate in writing the public or private agency department or office or agencies responsible for investigating reports involving institutional child abuse or neglect. The designated agency or agencies must be other than

and separately administered from the one involved in the alleged acts or omissions. Subject to the preceding limitation, this may be the state department, the local child protective service, a law enforcement agency, or another appropriate agency.

(b) The designation by the Governor shall describe the specific terms and conditions of the designation, including the manner in which reports of known or suspected institutional child abuse or neglect, will be received and investigated, the remedial action which will be taken, and the manner in which the Governor will be kept fully informed of the progress, findings, and disposition of the investigation.

(c) To fulfill the purposes of this section, the state may purchase the services of the agency designated to investigate reports of known or suspected institutional child abuse or neglect.

**§ 18. Confidentiality of reports and records.**

(a) In order to protect the rights of the child, his parents, or guardians, all records concerning reports of child abuse and neglect, including reports made to the state department, state center, state central register, local child protective services, and all records generated as a result of such reports, shall be confidential and shall not be disclosed except as specifically authorized by this Act or other applicable law. It shall be a misdemeanor to permit, assist, or encourage the unauthorized release of any information contained in such reports or records.

(b) No person, official, or agency shall have access to such records unless in furtherance of purposes directly connected with the administration of this Act. Such persons, officials, agencies, and purposes for access include:

(i) a local child protective service in the furtherance of its responsibilities under this Act;

(ii) a police or law enforcement agency investigating a report of known or suspected child abuse or neglect;

(iii) the agency (agencies) or organizations (including its designated multidisciplinary case consultation team) legally mandated by any state law to receive and investigate reports of known and suspected child abuse and neglect;

(iv) a person legally authorized to place a child in protective custody when such person requires the information in the report or record to determine whether to place the child in protective custody;

(v) an agency with legal responsibility or authorization to care for, treat, or supervise a child or a parent, guardian, or other person responsible for the child's welfare who is the subject of a report;

(vi) any subject of the report or his attorney; if the subject of the report is a minor or is otherwise legally incompetent, the guardian of the person or his guardian *ad litem*;

(vii) a court, when access to such records may be necessary for the determination of an issue before such court; however, such access shall be limited to *in camera* inspection, unless the court determines that public disclosure of the information contained therein is necessary for the resolution of an issue then pending before it;

(viii) a grand jury, upon its determination that access to such records is necessary in the conduct of its official business;

(ix) any appropriate state or local official responsible for administration, supervision, or legislation in relation to the prevention or treatment of child abuse or neglect when carrying out his official functions;

(x) any person engaged in *bona fide* research or audit purposes; provided, however, that no information identifying the subjects of the report shall be made available to the researcher unless it is absolutely essential to the research purpose, suitable provision is made to maintain the confidentiality of the data, and the head of the state department or local agency gives prior written approval. The head of the state department shall establish, by regulation, criteria for application of this subdivision.

(c) upon written request, any person making a report shall be entitled to learn the general disposition of such report.

(d) A person given access to the names or other information identifying the subjects of the report, except the subject of the report, shall not make public such identifying information unless he is a district attorney or other law enforcement official and the purpose is to initiate court action. Violation of this subsection shall be a misdemeanor.

(e) Nothing in this Act is intended to affect existing policies or procedures concerning the status of court and criminal justice system records.

#### **S 19. Right to representation in court proceedings.**

(a) Any child who is alleged to be abused or neglected in a juvenile court (family or other similar civil court] proceeding shall have independent legal representation in all proceedings arising from such allegations, including temporary custody or shelter hearings, adjudication, disposition, reviews, and termination of parental rights. The court shall appoint legal counsel to represent the child in such proceedings at public expense. The attorney representing the child under this section shall also serve as the child's guardian *ad litem* unless one has been appointed by the appropriate court. If, however, the attorney deems that, in a particular case, he cannot perform in this dual

capacity, he shall request that the court appoint a separate guardian *ad litem*.

(b) In a civil proceeding, any parent or other person responsible for a child's welfare alleged to have abused or neglected a child shall be entitled to legal representation in such proceeding, including shelter and custody hearings, adjudication, disposition, reviews and termination of parental rights actions. Such person shall also be entitled to legal representation in any criminal proceeding, including any appeals, arising from such allegations. Those individuals unable to afford private legal representation are to be appointed counsel at public expense.

(c) In every juvenile [*or family*] court proceeding concerning alleged child abuse or neglect in which it is a party, the local child protective service shall be represented by legal counsel [*provided by the local civil law officer of the appropriate county or comparable political subdivision or geographic area.*]

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# Orders Against Resuscitation: Selected Policy Statements

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## **Policies of Professional Societies**

### **No Code Subcommittee, Medical-Legal Interprofessional Committee, Bar Association of San Francisco Medical Society"**

The No Code Subcommittee has reviewed the policies of nine hospitals within San Francisco City and County. It is pleased to note that all general acute care institutions, with the exception of two which are parts of a larger national system (VA and US Army-Letterman), have stated a policy on this subject. However, the Committee found considerable diversity in these policies. In light of current legal opinion and ethical considerations, the Committee recommends that institutions review their policies for adequacy and accuracy. The elements of a model policy, which meets both legal and ethical requisites, are stated below with commentary. It is the opinion of the Committee that every institutional policy should reflect these elements, even though the language and emphasis might be unique to the institution. The issues of primary importance in all policies should be the patient's wishes and medical condition.

**1. A statement that Orders to Resuscitate are a standing order in the institution and that this procedure should be initiated unless there is an express order to the contrary.**

**Commentary.** Patients who are admitted to general acute care hospitals are to receive all procedures indicated for the treatment of their admitting diagnosis or complaint. If cardiac arrest occurs during an admission, the standard of care requires full resuscitative measures, since this event will either be unexpected or the anticipated, but undesirable, effect of their condition. Thus, each institution should have procedures for prompt response to this event and the only condition which justifies withholding this response is a written order to the contrary. In certain institutions, such as hospices, the presumption in favor of resuscitation may not be appropriate. However, all institutions providing health care should have an explicit policy.

**2. A statement regarding the patient's wishes.**

**Commentary.** A competent patient has the legal and moral right to refuse medical treatment, even if it is lifesaving, at any time. Thus, such a patient may exercise this right by requesting "no code" and this request should, as a general rule, be honored.

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\* Final Report, the Bar Association of San Francisco Medical Society, 250 Masonic Ave., P.O. Box 18719, San Francisco, Calif. 94118 (July 20, 1982).

If the patient is competent, it is morally incumbent on the physician to inform the patient of the diagnosis of an irremediable condition and to discuss the eventuality of demise by cardiac or respiratory arrest. The patient, in such a situation, should be offered the choice to refuse resuscitation. Occasionally, the physician may judge that a discussion of this sort would so distress the patient as to render him or her incapable of a rational choice. Such judgment should be reached after thoughtful and sympathetic discussion with colleagues and with the family or friends of the patient. Even if a direct approach to the patient is judged inadvisable, a general discussion concerning the patient's preferences in advance of the critical situation is highly advisable.

The medical situation that makes a DNR order appropriate (see Section 3) will often be reached only after the patient has lost the ability to comprehend or express his or her wishes. This incapacity should be verifiable by a clinical assessment of mental and emotional status. If the patient has left advance directives, such as the directive to physicians in the California Natural Death Act, these should be honored, according to circumstances.

**3. A statement of the medical conditions which should be present to justify an order not to resuscitate.**

**Commentary.** DNR (Do Not Resuscitate) orders are appropriately recommended when the patient suffers from a known lethal disease and when further medical treatment of that disease will not, in all probability, reverse the course of that disease toward the patient's death. The legal cases which have upheld no-code orders have noted that the condition of the patient should be such that death is imminent as a result of the disease. Thus, the physician makes a judgment that a point of medical futility has been reached and that any sort of intervention would, at best, only prolong the patient's dying. In a condition of such futility, an order to refrain from such stop-gap measures is appropriate. Obviously, no medical judgment is absolutely certain, but the physician's experience and accumulated evidence should lend high probability to the determination that further medical treatment for the condition and resuscitation are useless in seeking the goals of medical care, such as restoration of health or satisfactory function. Thus, a policy should contain some such phrase, as, "irreversible and irremediable condition," "imminent death," etc.

**4. A statement regarding the role of family or close associates.**

**Commentary.** In many situations, patients will be incompetent to participate in a choice. They will often be surrounded by family or by friends. There are, at present, no legal grounds

to require consent for DNR orders from such persons, unless one of them has been appointed legal guardian or conservator.

However, good clinical practice requires a thoughtful and compassionate discussion with them. In addition, family and friends may be able to provide evidence of the patient's wishes, expressed to them at an earlier time. Such evidence, either verbal or written, (particularly in the form of the California Natural Death Act), while it must be carefully evaluated in the circumstances, can support the physician's recommendation not to resuscitate.

If there is disagreement among family members or between family and physician, consultation should be sought as mentioned in paragraph 7.

**5. A statement regarding the entry of the DNR order in the patient's record.**

**Commentary.** All general acute care institutions in San Francisco now require the physician to enter the DNR Order in the record. This practice, formerly avoided on the basis of fear of liability, is now universally recommended. The order and its reasons, together with comments about discussion with patients, colleagues and family, is, in fact, the best defense against liability. In addition, the order allows all who are responsible for the care of the patient to act with unanimity in this situation and avoids confusion and uncertainty. It is reasonable also to require some regular review of the order, should conditions change unexpectedly. The extent of regular review should be determined by the institution in a prudent and reasonable way.

**6. A statement about the scope of the order.**

**Commentary.** An order not to resuscitate refers strictly to the practice of cardiopulmonary resuscitation. When a patient is "full code," the entire range of procedures, as stated in Standards for Cardiopulmonary Resuscitation, (JAMA 1980; 244:453) should be followed. If the physician wishes to issue limited orders, these should be stated explicitly rather than in such cryptic and confusing terms as "partial code," "slow code," or "chemical code." Thus, if, for some reason, cardiac massage and ventilatory efforts are desirable, but intubation and pressors are not, this should be stated explicitly in the order.

Further, a DNR order does not imply a change in other clinical procedures. Thus, a patient receiving artificial ventilation or intravenous nutrition would continue to be so treated until these procedures are explicitly discontinued or a patient who is "no code" but develops an infection should be given appropriate antibiotic unless *there is a specific order not to do so*.

Finally, the modality of care subsequent to DNR order should be expressed. Namely, that all efforts to provide comfort and relief of pain will be provided. This is, of course, the highest obligation of health care professionals once their obligation to save life and restore health is extinguished by the inevitability of death.

**7. A statement regarding the obligation of various persons responsible for the care of the patient.**

**Commentary.** Physicians are obliged to inform others who are responsible for care of the patient about the decision not to resuscitate. The written order is only one part of the communication necessary in this case. In order to provide the best care for the patient, all who are responsible for the care of the patient should clearly understand the order and its rationale. These persons have the right to clear, definitive and written instructions. In addition, if there is a disagreement about orders, there should be an opportunity to resolve differences.

Since some cases in which the issue of nonresuscitation is raised are complex, it is advisable to institute a system to facilitate the seeking of advice and the reconciliation of differences. Some institutions have found it useful to establish a "medical ethics committee" for this purpose. Such committees can have a form and function suited to the needs and character of the individual institution.

### **Guidelines for Hospitals and Physicians on "Do Not Resuscitate," Medical Society of the State of New York\***

The following are intended *only* to be guidelines for physicians and hospitals. Hospital medical staffs and governing bodies are encouraged to develop policies consistent with their respective by-laws and rules and regulations.

#### **Definition**

DNR (Do Not Resuscitate) means that, in the event of a cardiac or respiratory arrest, cardiopulmonary resuscitative measures will not be initiated or carried out.

#### **Background**

1. An appropriate knowledge of the serious nature of the patient's medical condition is necessary.
2. The attending physician should determine the appropriateness of a DNR order for any given patient.

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Medical Society of the State of New York, 420 Lakeville Road, Lake Success, N.Y. 11042 (Sept. 20, 1982).

3. DNR orders are compatible with maximal therapeutic care. A patient may receive vigorous support in all other therapeutic modalities and yet a DNR order may be justified.

4. When a patient is capable of making his own judgments, the DNR decision should be reached consensually by the patient and physician. When the patient is not capable of making his own decision, the decision should be reached after consultation between the appropriate family member(s) and the physician. If a patient disagrees, or, in the case of a patient incapable of making an appropriate decision, the family member(s) disagree, a DNR order should not be written.

#### **Implementation**

1. Once the DNR decision has been made, this directive shall be written as a formal order by the attending physician. A verbal or telephone order for DNR cannot be justified as a sound medical or legal practice.

2. It is the responsibility of the attending physician to insure that this order and its meaning are discussed with appropriate members of the hospital staff.

3. The facts and considerations relevant to this decision shall be recorded by the attending physician in the progress notes.

4. The DNR order shall be subject to review at any time by all concerned parties on a regular basis and may be rescinded at any time.

### **Do Not Resuscitate (DNR) Guidelines, Medical Association of the State of Alabama\***

It is widely recognized that in some clinical situations the initiation of potentially life-prolonging treatment is inappropriate. While there may be a variety of situations in which it is justifiable to withhold or withdraw medical treatment, the guidelines presented here cover only one specific aspect of the dilemmas created by modern medical technology, issues surrounding the question of whether or not to initiate cardiopulmonary resuscitation (CPR) when the patient experiences an acute cardiac or respiratory arrest.

#### **Definition**

DNR (do not resuscitate)—In the event of an acute cardiac or respiratory arrest, no cardiopulmonary resuscitative measures will be initiated.

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\* Approved by the Board of Censors, Medical Association of the State of Alabama, P.O. Box 1900-C, Montgomery, Ala. 36197 (Aug. 19, 1981).

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**Considerations**

1. An appropriate knowledge of the patient's medical condition is necessary before consideration of a DNR order.
2. The attending physician should determine the appropriateness of the DNR order for any given medical condition.
3. DNR orders are compatible with maximal therapeutic care. The patient may be receiving vigorous support in all other therapeutic modalities and yet justifiably be considered a proper subject for the DNR order.
4. When the patient is competent, the DNR decision will be reached consensually by the patient and physician. When the patient is judged to be incompetent, this decision will be reached consensually by the appropriate family member(s) and physician. If a competent patient disagrees, or, in cases of incompetency, the family member(s) disagrees, a DNR order will not be written.

**Implementation**

1. Once the DNR decision has been made, this directive shall be written as a formal order by the attending physician. It is the responsibility of the attending physician to insure that this order and its meaning are discussed with appropriate members of the hospital staff.
2. The facts and considerations relevant to this decision shall be recorded by the attending physician in the progress notes.
3. The DNR order shall be subject to review on a regular basis and may be rescinded at any time.

**Do Not Resuscitate (DNR) Guidelines, Minnesota Medical Association\***

These guidelines have been drafted by the Ad Hoc Committee on Death of the Minnesota Medical Association. It is widely recognized that in some clinical situations the initiation of potentially life-prolonging treatment is inappropriate. While there may be a variety of situations in which it is justifiable to withhold or withdraw medical treatment, the guidelines presented here cover only one specific aspect of the dilemmas created by modern medical technology, issues surrounding the question of whether or not to initiate cardiopulmonary resuscitation (CPR) when the patient experiences an acute cardiac or respiratory arrest.

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\* The MMA Board of Trustees, Health Association Center, Suite 400, 2221 University Ave., S.E., Minneapolis, Minn. 55414 (Jan. 24, 1981).

**Definition**

DNR (do not resuscitate)—In the event of an acute cardiac or respiratory arrest, no cardiopulmonary resuscitative measures will be initiated.

**Considerations**

1. An appropriate knowledge of the patient's medical condition is necessary before consideration of a DNR order.
2. The attending physician should determine the appropriateness of the DNR order for any given medical condition.
3. DNR orders are compatible with maximal therapeutic care. The patient may be receiving vigorous support in all other therapeutic modalities and yet justifiably be considered a proper subject for the DNR order.
4. When the patient is competent, the DNR decision will be reached consensually by the patient and physician. When the patient is judged to be incompetent, this decision will be reached consensually by the appropriate family member(s) and physician. If a competent patient disagrees, or, in cases of incompetency, the family member(s) disagrees, a DNR order will not be written.

**Implementation**

1. Once the DNR decision has been made, this directive shall be written as a formal order by the attending physician. It is the responsibility of the attending physician that this order and its meaning are discussed with appropriate members of the hospital staff.
2. The facts and considerations relevant to this decision shall be recorded by the attending physician in the progress notes.
3. The DNR order shall be subject to review on a regular basis and may be rescinded at any time.

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## Policies of Health Care Institutions

### Beth Israel Hospital, Guidelines: Orders Not To Resuscitate\*

#### I. Summary

The Medical Executive Committee has adopted guidelines for the entry of orders not to resuscitate. If questions arise which are not answered by the Guidelines, the Administrator on call should be consulted. The Committee's recommendations are described in full in the attached Guidelines.

#### A. Medical Record

Orders not to resuscitate (DNR) should be entered in the patient's record with full documentation by the responsible physician as to the patient's prognosis and the patient's concurrence (competent patients) or family's concurrence (incompetent patients).

#### B. Chief of Service

The Chief of Service (or his designee) must concur in the appropriateness of a DNR order on *incompetent* patients. This second opinion should be entered in the patient's record.

The Chief of Service (or his designee) must be notified promptly of DNR orders on *competent* patients.

#### C. Daily Review

All DNR orders should be reviewed daily.

#### D. Competent Patients

Competent Patients must give their informed consent to a DNR Order.

If, however, it is the responsible physician's opinion that a full discussion of whether CPR should be initiated would be harmful to the patient, this conclusion and its rationale should be documented. If the physician and the Chief of Service deem a DNR order appropriate, and the patient's family concurs the order may be written.

#### E. Incompetent Patients

The assessment of incompetence should be documented, together with the documentation of patient's medical condition and prognosis and the concurrence of the Chief of Service or his designee.

If the patient's available family agrees that a DNR order is appropriate, the order may be written.

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\* Beth Israel Hospital, 330 Brookline Ave., Boston, Mass. 02215 (March 5, 1981).

If there are no available family members, the responsible physician may, enter an order with the written concurrence of the Chief of Service.

**Judicial Approval Required**

Judicial approval should be obtained before entering a DNR order if:

1. Patient's family does not agree to a DNR order.
2. There is uncertainty or disagreement about a patient's prognosis or mental status.

The Administrator on call must be contacted on any case which warrants judicial review.

FOR FULL DETAILS SEE COMPLETE POLICY  
AVAILABLE AT  
ALL NURSING STATIONS AND DEPARTMENTAL  
OFFICES

**II. Guidelines: Orders Not To Resuscitate**

In certain circumstances it becomes appropriate to issue a "Do Not Resuscitate" (DNR) order and to enter this order in a patient's medical record. In all cases, the procedures and documentation described below should be carried out. Observe that in certain cases the Hospital Administrator on call must be contacted to assess the necessity of prior judicial approval. In all cases the Chief of Service should be kept informed as specifically listed below.

The following procedural guidelines have been adopted by the Medical Executive Committee of the Beth Israel Hospital to promote thorough decisionmaking, and to ensure accurate and adequate record keeping and the clear communication of all such decisions. When individual patient decisions present questions which are not answered by these guidelines, or when judicial approval may be required, nursing and medical staff should contact the Hospital administration through the Administrator-on-call who is available 24 hours a day.

**A. The Competent Patient**

A competent patient, for the purpose of these guidelines, is an adult (18 or over, or an emancipated minor) patient who is conscious, able to understand the nature and severity of his or her illness and the relative risks and alternatives, and able to make informed and deliberate choices about the treatment of the illness.

The competent patient may request the entry of a DNR order at any time without prior judicial approval. The attending physician must then consult with the patient to insure that the patient understands his or her illness and the probable consequences of refusing resuscitation treatment, that is, that the decision represents the informed choice of a competent patient. The patient's mental condition should be documented

in the medical record. If there is any question about the patient's competence, a consultation should be obtained from the psychiatry service.

The execution of a "living will," if any, should be considered by the staff, but it is neither essential nor sufficient documentation of a decision to order the entry of a DNR order.

In this circumstance, approval of the next-of-kin is not required, and their refusal of such approval is not sufficient to overrule the informed decision of a competent patient. Nevertheless, the patient's family should be informed of the patient's decision and of the Hospital's intention to abide by that decision.

In all instances where a competent patient requests entry of a DNR order, the Chief of Service or his designate must be informed promptly that such orders have been written, even though the Chief of Service cannot deny such a request from a competent patient.

If in the opinion of the attending physician the competent patient might be harmed by a full discussion of whether resuscitation would be appropriate in the event of an arrest, the competent patient should be spared the discussion; therefore if the physician and the Chief of Service deem a DNR order appropriate and the family members are in agreement that the discussion might harm the patient and that resuscitation is not appropriate, the DNR order may be entered by the physician. In such cases, the physician shall follow the procedures described below for orders on incompetent patients.

### **B. The Incompetent Patient**

An "incompetent" patient, for the purpose of these guidelines, is a patient who is under 18 (unless an emancipated minor) or who is unable to understand the nature and consequences of his or her illness or is unable to make informed choices about the treatment of the illness.

If an incompetent patient is *irreversible and terminally ill, and death is imminent*, DNR orders may be entered without prior judicial approval, if family members concur in this decision. Before entering such an order the attending physician must consult with the patient's family including, at least, the same family members who would be sought out to consent to post-mortem examination. In addition, the attending physician should consult with, *and have the concurrence of*, the Chief of Service or his designate, before entering such orders. This second opinion as to the irreversible nature of the patient's illness and his or her moribund condition should be entered in the patient's record as well as the opinion of the first physician.

If the patient has no family who can be contacted, the DNR order may be entered by the responsible physician with the written concurrence of the Chief of Service or his designee.

### **C. Review**

DNR orders for all patients should be reviewed at least daily to determine if they remain consonant with the patient's condition and desires. Therefore, it is most appropriate for the physician to discuss his or her opinion and decision with nursing and house staff from the outset and frequently thereafter.

### **D. Documentation**

When a "DNR" order is decided upon, the order should be entered in the patient's chart along with the justification for the order and notes by all consultants involved. Specific reference should be made to:

1. Summary of a staff discussion regarding the patient's condition.
2. A descriptive statement of patient's competence or incompetence. For the incompetent patient, the record should include a notation of signs or conditions which indicate or constitute his or her inability to understand and make medical decisions on his or her own behalf.
3. A statement of the circumstances of the consent by the patient if the patient is competent, including staff discussions with the patient concerning the consequences of the DNR order, and any discussion with the family. For the incompetent patient, note in detail the discussions with and concurrence of all involved family.

### **E. Prior Judicial Approval**

In any instance where judicial review is sought, the Administrator on call and the Chief of Service or his designate must be consulted in advance. The decision to seek judicial approval of an order not to resuscitate should be made jointly and hospital counsel should be consulted prior to initiating contact with the court.

Prior judicial approval should be sought if:

1. an incompetent patient is not suffering from a terminal illness or death is not imminent;
2. family members do not concur in the entry of a DNR order.

### **F. Support and Counseling for Patients, Families and Staff**

Nothing in these procedures should indicate to the medical and nursing staff or to the patient and family an intention to diminish appropriate medical and nursing attention for the patient, whatever his or her situation.

When the incompetent patient is sufficiently alert to appreciate at least some aspects of the care he or she is receiving (the benefit of doubt must always assign to the patient the likelihood of at least partial alertness or receptivity to verbal stimuli), every effort must be made to provide the emotional comfort and reassurance appropriate to the patient's state of consciousness and condition regardless of the designation of incompetence.

In every case in which DNR orders are issued, the Hospital shall make resources available to the greatest extent practicable to provide counseling and other emotional support as appropriate for the patient's family and for all involved Hospital staff, as well as for the patient.

### **City of Boston Department of Health and Hospitals, Guidelines: Do Not Resuscitate Orders\***

There are circumstances in which an order not to resuscitate may properly be issued in connection with the care of a patient. In light of recent court cases, especially *In the Matter of Shirley Dinnerstein*, Department of Health and Hospitals wishes to promulgate formal guidelines with respect to Do Not Resuscitate (DNR) orders.

These guidelines apply only in the case of irreversibly, terminally ill patients. "Irreversible, terminally ill" is not further defined by law, however, the thrust of this phrase is that the law does not require a prolongation of the act of dying simply because the current state of medical technology has put measures in the physician's hands that permit the postponement of the time of death. A significant factor to be taken into account in determining whether the patient is "irreversibly terminally ill" is whether there is any treatment available that offers the patient a reasonable expectation of even a temporary return towards a normal, functioning, integrated, cognitive experience. If the physician has any questions about the meaning of the phrase "irreversibly, terminally ill," he/she should consult with another physician.

1. In the case of a *competent*, irreversibly, terminally ill patient, a DNR order may be written upon the patient's informed consent to issue an order not to resuscitate. If the physician has any doubts whether a patient is

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\* Executive Committee, Medical and Dental Staff, Boston City Hospital, 818 Harrison Avenue, Boston, Mass. 02118 (Jan. 6, 1981). (signed) David L. Rosenbloom, Commissioner, Department of Health and Hospitals (Jan. 14, 1981).

competent or not, a consultation must be obtained with a psychiatrist.

2. If the patient is incompetent, or a minor and irreversibly, terminally ill, a DNR order may be written if the attending physician determines in light of the patient's history and condition and the wishes of the patient's immediate family that it would be medically inappropriate to institute efforts at resuscitation. Where possible immediate family should be limited to spouse, children, and parents. Consent of the spouse alone should be sufficient, but if the spouse is deceased, the consent should be given by all children who have reached majority or, if there are no children, by both parents. The limitation to immediate family members is not intended to prohibit a physician from contacting other family members who the physician may feel have a close relationship with the patient and who may desire to be involved in the process.

No DNR order should be issued and an AOD [Administrative Officer of the day] should be contacted in the following circumstances:

- a. no family is available,
- b. only family members other than a spouse, child, or parents are available,
- c. the physician wishes to issue a DNR order and faces opposition from the patient's family,
- d. there is dissention among the patient's family, or
- e. a competent patient has requested resuscitation and then becomes incompetent.

3. In the case where a DNR order is decided upon, the order must be recorded by the physician clearly and promptly in the patient's chart. The following must be included in the progress notes:

- a. a summary of staff discussion and decision regarding the patient's condition,
- b. documentation of the patient's competence or incompetence,
- c. a summary of disclosures made to the patient or family,
- d. a summary of the patient's or family's response,
- e. *a statement of the circumstances of the consent by the patient,*
- f. *signature or cosignature of Attending Staff on all DNR orders,*
- g. in the case of a court order, a copy of the order should be put in the chart.

The recording requirement, whether met by "documentation," "summaries" or "statements," is fully intended to be a flexible concept requiring the establishment of a record of the events, incidents, discussions, professional decisions and their basis, which have led to the order, in a manner which is sensitive to patients and their families.

The decision not to resuscitate must be conveyed to all appropriate medical, nursing and other staff. The responsible physician should continually re-evaluate the patient's competency and consent. This must clearly be noted in the chart and, if appropriate, the DNR order revoked.

4. Any physician may contact hospital counsel directly in issues regarding DNR orders. In following these guidelines, however, all physicians are urged to contact the AOD before speaking with the lawyers for the Department. The role of the AOD in this process is to assist in gathering information necessary to make a full and complete presentation of the particular issue to hospital counsel, or assist in gathering information which may obviate the need to contact hospital counsel, and to provide administrative expertise which may have been gained in dealing with similar issues in the past.

### **Somerville Hospital, Guidelines: Orders Not to Resuscitate\***

It is sometimes appropriate to issue a "Do Not Resuscitate" (DNR) order and to enter this order in a patient's medical record. In all cases, the procedures and documentation described below must be carried out. In some cases prior judicial approval is required, and in all cases the Chief of Service must be kept informed.

These guidelines have been adopted by the Medical Board and approved by the Board of Trustees to assist the medical and nursing staff in decisionmaking and in the preparation of an adequate record for the entry of a DNR order, and for the open sharing of that decision once properly made. When individual patient decisions present questions which are not answered by these guidelines, or when judicial approval may be required, nursing and medical staff should contact the hospital administration regardless of the time or day.

#### **1. Cases Not Requiring Judicial Approval**

##### **a. The Competent Patient**

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\* Somerville Hospital, 230 Highland Ave., Somerville, Mass. 02143 (Feb. 27, 1980).

A competent patient, for the purpose of these guidelines, is an adult (18 or over, or an emancipated minor) who is conscious, able to understand the nature and severity of the illness and the relative risks and alternatives, and able to make informed and deliberate choices about the treatment of the illness.

A competent patient may request the entry of a DNR order at any time without prior judicial approval. The attending physician must then consult with the patient to insure that the patient understands the illness and the probable consequences of refusing resuscitation treatment; that is, that the decision represents the informed choice of a competent patient. The patient's mental condition should be documented in the medical record. If there is any question about the patient's competence, a consultation should be obtained from a psychiatrist. The patient must always receive the benefit of doubt concerning competence. The irrationality from a purely medical perspective of a patient's request for a DNR order or refusal to consent to a DNR order is not sufficient in itself to deem a patient incompetent. In doubtful cases, judicial review of competence may be obtained.

The execution of a "living will" may be considered, but it is neither essential nor sufficient documentation of a decision to order the entry of a DNR order.

In this circumstance, approval of the next-of-kin is not required, and they cannot overrule the informed decision of a competent patient. Nevertheless, the patient's family should be informed of the patient's decision and of the hospital's intention to abide by that decision.

In all instances where a competent patient requests entry of a DNR order, the Chief of Service or his designate must be informed before such orders are written, even though the Chief of Service cannot deny such a request from a competent patient.

#### **b. The Incompetent Patient**

An "incompetent" patient, for the purpose of these guidelines, is a patient who is under 18 (unless an emancipated minor) or who is unable to understand the nature and consequences of the illness or is unable to make informed choices about treatment of the illness.

If an incompetent patient is *irreversibly and terminally ill, and death is imminent*, DNR orders may be entered without prior judicial approval. Before entering such an order the attending physician must consult with and have the consent of the patient's family including, at least, the same family members who would be sought out to consent to post-mortem examination. In addition, the attending physician should consult with, *and have the concurrence of*, the Chief of Service

or his designate, before entering such orders. This second opinion as to the irreversible nature of the patient's illness and the patient's moribund condition and imminence of death should be entered in the patient's record as well as the opinion of the first physician. If the incompetent patient has no family or the family cannot be located, hospital administration should be consulted.

### **c. Review**

The competence of any patient previously deemed incompetent without court order should be reviewed at least daily. DNR orders for all patients should also be reviewed at least daily to determine if they remain appropriate to the patient's condition and desires.

The physician must discuss his/her opinion and decision concerning both competence and DNR orders with the nursing staff from the outset and frequently thereafter.

### **d. Documentation**

When a "DNR" order is decided upon, the order must be entered in the patient's chart along with the justification for the order and notes by all consultants involved. Specific reference should be made to:

- (1) Summary of initial staff discussion regarding the patient's condition as well as all subsequent follow-up discussions.
- (2) A descriptive statement of patient's competence or incompetence. For the incompetent patient, the record should include a notation of signs or conditions which indicate the patient's inability to understand or make medical decisions.
- (3) A statement of the circumstances of the consent by the patient if the patient is competent, including staff discussions with the patient concerning the consequences of the DNR order. For the incompetent patient, note in detail the discussions with the concurrence of all involved family as well as the Chief of Service or his designate.

## **2. Illustrative Cases of the Incompetent Patient Requiring Prior Judicial Approval**

a. When a patient is terminally ill but there is a chance of remission if treatment is administered, a decision to withhold resuscitation requires prior judicial approval. Even if the patient's next-of-kin assents, the physician may not withhold resuscitation without a court order.

b. When a patient is acutely but not terminally ill (in need of medical intervention or death will soon occur), and the quality of the life saved would be marginal, the decision to withhold resuscitation must have prior judicial approval.

c. When family members persist in demanding, for a terminally ill, dying patient, resuscitative efforts or DNR orders which are clinically inappropriate or not in the patient's interest, staff should consult hospital administration concerning judicial review of the patient's condition.

d. In any instance where judicial review is sought, the Chief of Service or his designate must be consulted in advance.

e. These guidelines may not be used to discontinue life supporting therapies or equipment. Should such questions arise, hospital administration should be consulted.

### **3. Other Important Considerations**

Nothing in these procedures should indicate to the medical and nursing staff or to the patient and family an intention to diminish appropriate medical and nursing attention for the patient, whatever the situation.

When the incompetent patient is sufficiently alert to appreciate at least some aspects of the care being received, every effort must be made to provide emotional comfort and reassurance appropriate to the patient's state of consciousness and condition. Unless it is clear to the contrary, the patient should always be presumed to be at least partially alert and receptive to verbal stimuli.

In every case in which DNR orders are issued, the hospital shall make available, to the greatest extent practicable, resources to provide counseling and other emotional support as appropriate for the patient's family and for all involved hospital staff, as well as for the patient.

(Signed)  
Norman E. Girard  
President

### **Guidelines for "No-Code" Orders in Los Angeles County Department of Health Services' Hospitals\***

Cardio-Pulmonary Resuscitation (CPR) is unique among therapeutic modalities in that it is initiated without a physician's order when cardiac or respiratory arrest is recognized. A specific instruction is necessary if CPR is not to be initiated.

The term, "No-Code Order," refers to the suspension of the otherwise automatic initiation of CPR.

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\* Los Angeles, Calif. (July 5, 1979).

"No-Code" Order will be considered only when there is an underlying incurable medical condition and when death is expected, imminent and inevitable.'

A "No-Code" Order may be considered when a patient's physician feels that CPR is not indicated should the natural course of a patient's medical condition cause vital functions to fail. Before the order is written, the patient, if competent, will be consulted. If the patient is a minor or has been adjudicated incompetent, or adjudicated to lack the capacity to make medical decisions, the patient's guardian or conservator will be consulted. If a competent patient or a legal guardian or conservator disagrees, the order will not be written. In all cases, the wishes of the immediate family should be given very great weight in arriving at the decision.

The physician will write and sign the order on the Physician Order Sheet. Physicians in training (interns and residents) must obtain concurrence from a member of the attending staff before the order is written. The circumstances surrounding the "No-Code" order will be documented in the progress notes. Documentation must include but not be limited to:

- a. A summary of the medical situation.
- b. The outcome of consultation with other physicians.
- c. A statement summarizing outcome of consultations with patient, guardian, conservator or family.

The order must be reviewed periodically as medically indicated.

Every necessary measure will be taken to relieve the patient's suffering and to maintain the patient's comfort.

CPR will be initiated automatically if there is no written and signed "No-Code" Order on the order sheet.

## **Northwestern Memorial Hospital, Do Not Resuscitate Orders\***

### **I. Purpose**

It is the purpose of this policy to enunciate clearly the practice which should be followed when a member of the

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<sup>1</sup> An exception may be made when a competent, knowledgeable patient has clearly expressed the desire that no CPR procedures be instituted in specified circumstances. Consultation with hospital counsel is suggested to insure appropriately documented informed consent.

\* Northwestern Memorial Hospital. 303 East Superior St., Chicago. Ill. 60611 (March 15, 1978).

Medical Staff issues an order that "heroic" or extraordinary means should not be employed on behalf of his patient. Such orders are often colloquially referred to as "Do Not Resuscitate" orders, but it should be understood that the use of the words "Do Not Resuscitate" is not determinative of the policy or the issues involved. The writing of any order, irrespective of the language used, which has the effect of precluding the use of extraordinary or "heroic" measures to maintain life is covered by this policy.

## **II. Definition**

For purposes of this policy, "resuscitation" will be defined as any extraordinary or "heroic" means employed to maintain the life of a patient including any *one* of the following: intubation/ventillation, closed chest cardiac massage, and defibrillation. Resuscitation does *not* mean or refer to ordinary or reasonable methods used to maintain life or health.

## **III. Written Order**

All orders not to resuscitate a patient *must* be written or signed by the member of the Medical Staff attending the patient on the Physician's Order Sheet in the patient's medical record. The writing of the order in any other document (e.g. Kardex) will be violative of this policy. *Failure to write such an order in the chart will result in the initiation of resuscitative measures.* In addition to the order itself, physicians may wish to write an entry attendant to the order in the progress notes which includes the following information:

1. A short description of the patient's physical condition corroborating the terminal prognosis.
2. Reference to any consultations which corroborate a DNR order.
3. Reference to any discussions concerning the prognosis or the DNR order with the patient, his family, conservator or guardian.

Such an entry is *not* legally required, for it should only constitute a distillation and/or restatement of information found elsewhere in the patient's record, but it may be made if the member of the Medical Staff desires.

## **IV. Communication With Patient and Family**

Physicians should realize that members of the patient's family either individually or collectively do not necessarily have a legal right to impose their wishes or decisions either on a physician or his patient as to the care to be rendered to that patient. If the patient is an adult, the decision not to resuscitate need only be discussed with him, or, in the event that the patient has been adjudged to be mentally incompetent by a court of competent jurisdiction, with the patient's guardian or conservator. In the event that the patient is a minor (under the age of 18), the decision need only be discussed with the minor's

parent or legally appointed guardian. (In the event the minor's parents are divorced, the physician should discuss the decision with the parent who has been awarded custody of the minor.) Conversations and discussions with family members who do not have the legal authority to act for the patient may be advisable for a variety of reasons, but are not necessarily legally binding upon the physician.

#### **V. Verbal Orders**

Verbal DNR orders can be received only by a licensed physician and must be witnessed by two other individuals. These individuals must each individually hear the order and document it with the physician's order in the chart. Verbal or telephone orders must be authenticated and countersigned by the member of the Medical Staff attending the patient within twelve hours.

DO NOT RESUSCITATE ORDERS (Supplement #1 to policy of same title and number dated March 15, 1978)  
July 1, 1978

The following is an addendum to policy 5.53.

1. The DNR order must be written and signed by an attending physician in the physician's order sheet. The order is invalid if written anywhere else.
2. Verbal order must be written only by a licensed physician and must be witnessed by two other individuals who personally hear and document the order. Verbal order must be countersigned by an attending physician within twelve hours of its being given. If it is not countersigned within that time period, it is invalid.
3. Failure to comply with paragraphs one and/or two result in the patient being resuscitated.
4. Explanatory notes may be written in the progress notes by the attending physician.
5. As used in this policy, the term "Medical Staff" means attending physicians *only*. It does not include resident physicians.

(signed)  
David L. Everhart

### **University of Wisconsin Hospital and Clinics, Guidelines Regarding Decisions to Give, Withhold or Terminate Care'**

#### **I. Purpose**

- A. To establish guidelines for making decisions to give,

withhold or terminate care to a specific patient.

B. To determine if care is to be given, withheld or terminated depending first on the *competence* of the patient.

1) Competence is defined as the mental ability to know reality so that the nature and effect of illness and treatment can be understood and decisions made which are a product of a reasoning thought process.

2) Competence to make medical decisions may be an inherent quality of mature minors and persons legally incompetent, *e.g.*, children, prisoners and those under guardianship, or persons legally incompetent during some periods of time and not others; however, these cases must be handled carefully and on an individual basis.

## II. Policy

A. Generally, decisions are made as follows for *competent patients*:

1) If a patient is fully informed and *competent*, his/her wishes, however unconventional, must be obeyed except where danger of suicide exists. (See A 3 below) Competence to make decisions about medical care is a factual/medical question in each case; where competence is unclear, emergency medical treatment should be given even against the patient's apparent will. A consultation is recommended.

2) Whether the patient is competent or incompetent, violent behavior may always be controlled with medication, if necessary. Protection and Security should be called for help when needed.

3) Where danger of suicide exists, steps to prevent it should be taken, pending a decision regarding presence of mental illness (not competence) and of immediate risk to the patient.

B. If a patient is *incompetent*, terminating or withholding care is reasonable where the following conditions are true: (below)

1) Patient is terminally ill and irreversibly incompetent; patient is expected to die within two weeks despite maximum medical care. It is recommended that consultation be obtained regarding determination of irreversible incompetence and terminal illness.

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\* Center for Health Sciences, University of Wisconsin-Madison, 600 Highland Ave., Madison, Wisc. 53792 (effective Dec. 1980; as of March 10, 1983, this policy was undergoing revision; the proposed changes involve procedural steps, however, that do not affect the substance of the policy.)

2) Patient is irreversibly comatose even though death is not foreseeable in the near future.

3) Care will prolong a painful dying process with little possibility of benefit. Whether or not a patient may benefit from medical care is a value judgment and not simply a question of whether life can be prolonged.

*and if 4) or 5) is also true:*

4) Patient has previously indicated orally or in writing that s/he would wish to have care terminated in his/her present circumstances.

5) In the absence of such a previous statement by the patient, his/her family or other appropriate person (see below) desire that care be terminated or withheld.

6) In case of death, including brain death, no consent is necessary to discontinue care.

C. If a patient is incompetent, terminating or withholding care is *clearly unreasonable* (regardless of family wishes) if any one of the following is true:

1) patient appears terminally ill but a reasonable hope of temporary remission exists, or there is some possibility of cure; many patients elect to undertake treatment in this situation.

2) The incompetence is temporary and the decision can wait.

3) The patient has previously requested full treatment under the circumstances at hand, and the patient's physician did not clearly decline to be bound by such wishes.

4) The proposed care is accepted medical practice (benefits outweigh risks). Objections to such care, even if based on religious grounds, prevail only when made by the fully competent patient.

D. Giving care against an incompetent patient's apparent will is reasonable if:

1) There is sound reason to believe that care will benefit the patient, outweighing risks, and is generally accepted medical practice in such cases.

2) It is especially permissible in situations where the patient has previously, while competent, asked that care be given in the now present circumstances, or

3) Appropriate spokespersons (see below) agree that care should be given.

E. Decisions about care of an incompetent patient should be made by other persons in the following priority order:

1) Guardian, if appointed

2) Spouse

3) Adult son or daughter

- 4) Parent
- 5) Adult brother or sister
- 6) Other close relative or close friend

When caring for incompetent patients, it is always appropriate to obtain the consent of such a spokesperson. Where none are available, or when a natural representative of the patient is acting unreasonably, the physician may be required to seek the court appointment of a guardian, especially in cases of long-term care.

#### F. Addendum

- 1) Where nontreatment is reasonable, *i.e.*, the patient would probably elect nontreatment if competent, others may act for the patient without court action. If the patient by previous expression, physician and family agree that withholding treatment is the proper choice, little likelihood exists that such a decision will be challenged. The physician's decision, however, must be based on a determination that it is generally accepted medical practice to elect nontreatment in this situation.
- 2) If it is unclear whether nontreatment criteria are satisfied, continue care for the time being. If prognosis or accepted therapy is in doubt, consult with other physicians either informally or by committee. If prognosis is certain but family consent to termination or withholding of care is absent or doubtful, or if intra-family conflicts exist, attempt to obtain the family's consent; failing that, after adequate efforts, petition Probate Court for appointment of guardianship; the guardian will make decisions for the patient.
- 3) Those persons who have a court-appointed guardian (most prisoners referred for medical care) should not suffer medical disadvantage because of their legal (or prisoner) status. Where care is medically necessary, consent of the patient in such cases will be sufficient if they possess actual (as opposed to legal) competence.
- 4) Next of kin may insist on their legal right to speak for the patient; however, only court-appointed guardians may speak for adults with full legal authority. Parent's authority is conditioned on their legal duty to provide necessary medical care for their children, even if defective or potentially retarded. Physicians have direct obligations to their patients and should not permit unreasonable family pressure or threat of legal action to delay or deter action in the best interests of the patient. In general persons who act for incompetent patients must do so reasonably to retain their status as the patient's representative.

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5) The advice and counsel of colleagues should normally be sought in difficult cases and legal advice obtained as indicated.

**IV. To terminate or withhold care:**

A. Document patient's condition, prognosis, mental status, consultations and treatment options in the clinical record.

B. Include patient's prior instructions (document patient's competency when making them) or consent of family, guardian (or court) in patient's clinical record.

C. Enter orders such as "No Bluecart" on Kardex or patient's refusal of care on consent form, and verbally inform health care team that this has been done.

D. Discontinue treatment, if appropriate.

**V. Approved by UWHC Medical Board (August 1980).**

(signed)  
Gordon M. Derzon,  
Superintendent

## Statements Concerning Federal Agencies

### **Veterans Administration, Chief Medical Director's Letter on "No Code" and other Similar Orders\***

1. Technological advances in medicine are usually hailed as providing great new benefits for patients. Often the social, moral, ethical and financial impact of these same advances are not perceived until years later. Perhaps some of the most perplexing issues before us today have followed in the wake of our ability to delay the moment of death by the application of a variety of technological devices. Professional publications, the news media and the law have wrestled with, and given visibility to, many of these issues. The heightened awareness of these issues has raised questions from many anxious health care professionals: *viz.*; when should support for a terminally illpatient be discontinued, who is responsible for such a decision, what are the legal liabilities of various persons under such circumstances and can a doctor order other providers (doctors or nurses) to refrain from doing something they (the providers) feel conscience bound to do? We recognize these genuine expressions of concern on the part of every health care professional but are unable to resolve most of these controversies.

2. It is worthwhile, however, to simply state that the policy of the Veterans Administration's Department of Medicine and Surgery should continue to be consistent with those ethical principles adhered to by the medical and allied professions. We should also make accommodations for those state laws which provide for certain defined rights of patients but we must also give recognition to the rights of others, including family members and health care providers, in the exercise of their religious and moral beliefs.

3. In a few states, the legislatures have enacted "Natural Death" or "Death with Dignity" statutes. Our VA medical centers located in such states are already under the direction of DM&S Circular 10-79-160, dated July 25, 1979, Subj.: "State laws regarding the withholding or withdrawal of life-sustaining procedures." Although the majority of our medical centers are not affected by such legislation, they may be affected by a variety of other local laws (*e.g.*, "Brain Death"). Nevertheless, it must be remembered that every competent adult patient usually has the right to refuse any medical treatment offered, even if that refusal might result in death.

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\* James C. Crutcher, M.D., Chief Medical Director, Department of Medicine and Surgery, Veterans Administration (Washington, D.C. 20420) Doc. No. IL 10-79-66 (Nov. 20, 1979).

4. In some of our medical centers a few physicians have felt compelled, under certain circumstances, to write "no code" orders. Such orders may direct someone (usually a member of a nursing staff) to refrain from performing an act which their conscience dictates be done or may intimidate someone who, in the absence of such an order, would normally have performed the act. We believe such orders are inappropriate and do not contribute to high quality patient care. The preferable alternative is to permit health care professionals in such situations to be free to exercise their judgment guided by their education, experience and ethical and moral persuasion.

5. On the other hand, it is essential that the progress notes entered in the record for a terminally ill patient be fully informative of the diagnosis, the prognosis, the patient's wishes (when known), the wishes of the family members and the recommendations of the attending staff (not resident) physician. With a well documented record, the choice to "code" or "no code" will remain one of professional judgment on the part of the appropriate health care provider caring for the patient at the time of cardiopulmonary arrest.

6. Compassionate care of the sick guided by the high ethical standards demanded of doctors and nurses for centuries will continue to be the best policy. With the same dedication with which we provide high quality care to patients who survive their illness, we will find satisfaction in the knowledge we have done the best possible to provide comfort, compassion and dignity for those who do not survive.

## **National Institutes of Health, The Clinical Center\***

### **PURPOSE**

The purpose of this communication is to institute a mechanism whereby requests not to administer cardiac resuscitation can be brought to the attention of all those who might be required to respond.

### **DELEGATION OF AUTHORITY**

Pursuant to its responsibilities for developing policies concerning medical practice, the ultimate responsibility for making policy decisions concerning orders not to attempt cardiac resuscitation shall belong to the Medical Board. The Board delegates operating responsibility for the conduct of this policy to Clinical Directors, and through them to attending

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\* Medical Administrative Policy No. 82-4, Subject: Orders Not to Attempt Cardiac Resuscitation Policy and Communications Bulletin, Medical Administrative Series (July 12, 1982).

physicians. In the case of dispute or doubt, an *ad hoc* advisory committee of physicians, nurses, social workers and others may be formed at the request of the family, medical or hospital staff, or members of the Board.

#### **POLICY STATEMENT**

A note indicating that the physician had approached the patient on this subject shall precede the order in the chart. If the patient is an unemancipated minor or is unable to understand the nature and consequences of his or her illness, or is unable to make informed choices about the treatment of the illness, the patient's next of kin or legal guardian shall be approached. If the patient has no next of kin or legal guardian who can be contacted, the Do Not Resuscitate (DNR) order may be entered by the responsible physician with the written concurrence of another member of the senior staff and the Clinical Director.

If in a physician's judgment a patient should not receive cardiac resuscitation, a progress note written by the attending and senior physician, and an order to that effect, should be written in the patient's chart. All such orders shall be signed by the attending physician and another member of the senior staff familiar with the particular circumstances. The order not to resuscitate would then be entered into MIS [Medical Information Systems Service].

Absence of an order not to attempt cardiac resuscitation shall be interpreted by the nursing staff as requiring such efforts should the patient have a cardiac arrest.

### **Department of the Army, Surgeon General's Letter on the Texas Natural Death Act\***

1. Neither the "Directive to Physicians" (State of Texas Natural Death Act) nor any similar directives regarding the withholding or withdrawal of life-sustaining procedures will be accepted or honored by Army Medical Treatment Facility [MTF] personnel.
2. The Texas Natural Death Act (TNDA) has been thoroughly evaluated by the Office of the Judge Advocate General. It appears that a "Directive to Physicians" executed in accordance with the TNDA would be legally effective only in the case of a physician licensed in the State of Texas, who is not a member of the Armed Forces, and who is practicing in an area over which the United States holds only a proprietary interest.

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\* DASG-PSA (13 Dec 77) 1st Ind; DA, OTSG, Washington, D.C. 20310, To: Commander, US Army Health Services Command, ATTN: HSJA Fort Sam Houston, TX 78234 (May 23, 1978).

3. MTF's may be, located on land under various kinds of Federal legislative jurisdiction: exclusive jurisdiction, concurrent jurisdiction, partial jurisdiction, and proprietary interest only. "Exclusive Federal jurisdiction" means that only the Federal Government may legislate as to the area in question. "Concurrent jurisdiction" means that both the Federal Government and a state government may legislate as to all matters within the area. "Partial jurisdiction" means that at least one of the two governments may legislate as to some, but not all, questions with regard to the area. "Proprietary interest only" means that the Federal Government owns or has an interest in the land in question but has acquired none of the state's power to legislate with respect to it. It is likely, but not certain, that in at least some cases, in the absence of the TNDA, the deliberate withholding or withdrawal of medical attention resulting in the death of a patient would be a criminal homicide under both State and Federal law. Section 6 of the TNDA immunizes certain "physicians" and "health professionals" from criminal liability for the non-negligent compliance with a properly executed Directive. But, there are specific Federal statutes against homicide in areas of exclusive Federal or concurrent (and, perhaps, partial) jurisdiction (18 U.S.C. 1111-1113). The TNDA cannot affect these Federal statutes because the State of Texas cannot change Federal laws. Accordingly, whether compliance with a directive resulting in a patient's death is a crime may depend on the type of jurisdiction on which the MTF is located. Furthermore, portions of many military installations were acquired at different times and are subject to different forms of jurisdiction. Thus, it is possible for one part of a single MTF to be under exclusive Federal jurisdiction and another part to be subject to only a Federal proprietary interest.

4. To complicate the situation further, the effect of a TNDA directive may depend on the status of the physician in question.

a. Military physicians. While applicability of 18 U.S.C. 1111-1113 depends on the nature of Federal jurisdiction over the place, the Uniform Code of Military Justice (UCMJ) is applicable to active duty members of the Armed Forces acting in their official capacities regardless of their location. It has not been authoritatively decided that allowing a patient to die in compliance with a TNDA Directive would be a crime under the UCMJ, but that is a possibility. That the same act would not be a crime under a law of the state where it occurred is immaterial. Thus, a military physician could be subject to prosecution for homicide regardless of whether he was licensed in Texas and regardless of the nature of jurisdiction over the MTF where the act occurred.

b. Civilian physicians. The applicability of the TNDA to civilian physicians would depend on the nature of jurisdiction

over the place and whether the physician is licensed in Texas or in another state. As Section 2(4) of the TNDA defines "physician" as a physician or surgeon licensed by the Texas State Board of Medical Examiners, a civilian physician licensed by another state working in a MTF in Texas would not be considered a physician for purposes of the TNDA. The Act provides immunity only for "physicians" and "health professionals acting under the direction of a physician." The term "health professional" is not defined in the TNDA, and it is uncertain whether it would include non-Texas civilian physicians. If it did not, a non-Texas civilian physician complying with a TNDA Directive in an area under the criminal jurisdiction of Texas could be subject to prosecution by Texas for homicide.

5. Based on the discussion above, it is clear that the only possible uniform rule for dealing with TNDA Directives, and similar state directives, is to prohibit their use in Army MTF's. Any other approach would create an impossible situation from the standpoints of both medical and legal administration of MTF's.

6. Request this policy be given appropriate dissemination.

(signed)  
ENRIQUE MENDEZ, JR.,  
M.D.  
Major General, MC  
Acting The Surgeon  
General

**Letter from James G. Zimmerly, M.D., J.D. to the Surgeon General, Department of the Army\***

SUBJECT: Termination of Life Support and Entering of No-Code Orders

LTC Bernhard T. Mittemeyer, MC, USA

The Surgeon General

Department of the Army

Room 3-E-469

Washington, D.C. 20310

1. We are writing to express our concern regarding policy DAGS-PSA (13 Dec 77) 1st Indorsement (Inclosure #1) regarding application of the Texas Natural Death Act and similar directives in Army Medical Treatment Facilities. In particular our concerns are as follows: 1) the policy has caused great confusion in military treatment facilities and is being given

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\* (April 1, 1982).

different applications; 2) the policy is contrary to both established legal principles and a developing body of case law on point; 3) continuation of the policy is exposing the United States of America and its agents to civil liability; 4) fears of criminal prosecution are unjustified. Each of these concerns will be addressed more fully as follows:

**A. The policy has caused confusion in military treatment facilities (MTFs)**

Some MTFs have interpreted the policy to mean that their medical personnel cannot enter "no-code" orders on any patient or either withhold or withdraw extraordinary life-support measures from any patient under any circumstances. At least one MTF that has come to our attention is completely ignoring the policy. What has become clear is that most MTF medical personnel and JAG officers are quite confused as to how strictly the policy is to be interpreted. Particularly confusing is the language "similar directives." Does this mean directives exactly like that encompassed in the Texas Natural Death Act or any type of request from a terminally ill patient to cease or not begin treatment? At the very least this policy must be clarified.

**B. The policy is contrary to established principles of medical law**

A basic tenet of medical law is that any adult of sound mind may refuse medical treatment, even if such refusal would result in the person's death. One recent case illustrating this principle is "In the Matter of Robert Quackenbush, an alleged incompetent," 383 A.2d 785 (1978). In *Quackenbush* a 72-year old patient refused to consent to the amputation of his gangrenous legs. The hospital sought a court order to do so alleging that the patient was incompetent and that failure to have the operation would result in the patient's death. The court ruled that the patient was, in fact, competent and that as a competent adult he had the right to make an informed choice about treatment even though the choice would lead to his death.

In federal law, the United States Supreme Court has stated in two landmark cases that there is a right to privacy under the United States Constitution. Therefore, governmental interference with medical treatment arranged between a physician and his or her patients would be a violation of the patient's constitutional right to privacy absent a compelling state interest. *Griswold v. Connecticut*, 381 U.S. 479, 85 S. Ct. 1678, 14 L.Ed.2d 510 (1965) and *Roe v. Wade*, 410 U.S. 113, 93 S. Ct. 705, 35 L.Ed.2d 147 (1973). Other federal cases have held that patients have the right to refuse medical treatment. *Winters v. Miller*, 446 F.2d 65, cert. denied, 404 U.S. 985, 92 S.Ct. 450, 30 L.Ed.2d 369 (1971) and *Rogers v. Okin*, 634 F.2d 650 (1980).

Of the few cases that take a contrary position most have involved either a pregnant woman or a parent with minor children. In those cases, the courts found that the state had a compelling interest in seeing that the parent stayed alive to give birth to or take care of the child involved. *Raleigh Fitkin-Paul Morgan Memorial Hospital v. Anderson*, 42 N.J. 421, 201 A.2d 537, cert. den. 377 U.S. 985 (1964).

Finally, AR 600-20, paragraph 5-29 states that "An Army member on active duty or active duty for training will *usually* be required to submit to medical care considered necessary to preserve his life, *alleviate undue suffering*, or protect or maintain the health of others." (Emphasis added.) The word "usually" leaves the door open for exceptions to the rule that life-preserving treatment can be rendered without consent. Surely either a terminally ill patient or a patient in an irreversible comatose state would fall into the exception. The rule also states that medical care can be given without consent in order to "alleviate undue suffering." It would make sense that the converse would also be true. That is, that further medical care would not be given to a patient dying of a painful disease in order to "alleviate undue suffering." Further, paragraph 5-29 defines medical care as "...preventive, diagnostic, therapeutic, and rehabilitative medical, surgical and psychiatric and dental treatment." It can certainly be argued that extraordinary life support measures do not fall within this definition. Finally, in discussing referral of a serviceman to a medical board for refusal to submit to medical treatment, paragraph 5-31 states that the medical board must answer the following question: "(1) is the proposed treatment required to relieve the incapacity and aid the soldier's return to a duty status, and may it be expected to do so?" Obviously, if the patient was terminally ill or in a permanent comatose state, the answer would be "No." As such a soldier would never be able to return to a duty status, the United States Army would not have a compelling government interest in forcing such a patient to submit to medical care against his or her wishes.

**C. The policy is contrary to a growing body of case law dealing directly with no-code orders and the right of a terminally ill or comatose patient to refuse life-sustaining treatment**

1. Eight major state court decisions have been rendered which are applicable. They have predominately upheld the right of a competent adult or person acting on behalf of an incompetent adult, to refuse further treatment. The cases are as follows:

a) *In the Matter of Karen Quinlan, An Alleged Incompetent*, 70 NJ 10, 355 A.2d 647, 79 ALR3d 205 (1976)—the Supreme Court of New Jersey held that a 22-year old patient in a comatose state had a constitutional right to privacy and,

therefore, could have life-sustaining apparatus discontinued, through her guardian, if hospital ethics committee and attending physicians agreed that there was no reasonable possibility of her ever emerging from her comatose state. The court made clear that this was a decision to be made between physicians and patients, and that no court order was necessary.

b) *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977)—the court gave permission to the guardian of a 67-year old mentally retarded patient dying of acute myeloblastic monocytic leukemia to refuse painful chemotherapy treatment on behalf of the patient. The court applied the "substituted judgment doctrine," that is, what the patient would have wanted if competent. The court also based its decision on the constitutional right to privacy.

c) *In re Shirley Dinnerstein*, 380 N.E. 134 (1978)—the court held that a physician attending an incompetent, terminally ill patient may lawfully direct that resuscitation measures be withheld in the event of cardiac or respiratory arrest *without prior court approval*.

d) *Satz v. Perlmutter*, 362 So.2d 160 (1978), *affd* Fla. Supreme Ct. 379 So.2d 359 (1980)—held that a competent 73-year old patient suffering from Lou Gehrig's disease could have respirator removed from his trachea even though such removal would result in life expectancy of less than one hour. The court based its decision largely on the constitutional right to privacy.

e) *Severns v. Wilmington Medical Center*, 421 A.2d 1334 (1980); 425 A.2d 156 (1980)—husband was allowed to assert constitutional right to privacy of comatose wife and, therefore, could instruct medical authorities not to place her on a respirator, not to surgically replace a feeding tube, not to administer any drugs or medicine other than those normally used for bodily hygiene, and finally that a so-called no-code blue order be entered on her medical chart.

f) *In re Spring*, 399 N.E.2d 493 (1979), 405 N.E.2d 115 (1980)—guardian allowed to end dialysis treatment of a 77-year old man suffering from end stage renal disease and organic brain syndrome. Decision based in part upon federal constitutional right to privacy.

g) *Matter of Storar; Eichner v. Dillon*, 52 N.Y.2d 363, 438 N.Y.S.2d 266, (1981); see also Appellate Division opinion *In re Eichner "Brother Fox,"* 73 A.D.2d 431, 426 N.Y.S. 2d 517 (1980)—83-year old patient, prior to becoming incompetent due to illness, had consistently expressed his views that his life not be prolonged by medical means if there was no hope of recovery. Therefore, guardian was allowed to obtain discontinuance of patient's respirator on which patient was being maintained in a permanent vegetative state.

h) *Leach v. Akron General Medical Center*, 426 N.E.2d 809, 68 Ohio Misc. 1 (1980)—guardian of patient who was

terminally ill and in a permanent vegetative state was granted order to have the patient removed from a respirator when it was shown that the patient, if competent, would have elected not to be placed on life supports.

2. Although there is no federal case law directly on point, six of the eight state cases cited above based their decisions at least in part on the federal constitutional right to privacy enunciated in the two U.S. Supreme Court cases, *Griswold v. Connecticut* and *Roe v. Wade*, supra. Therefore, it is inconceivable that a federal court would not uphold the right of a competent, terminally ill patient (through his or her guardian if incompetent) to refuse further medical treatment.

#### **D. The policy exposes the United States of America and its agents to civil liability**

1. Several federal courts have held that providing medical care that has not been consented to constitutes an assault and battery. In *Mink v. University of Chicago*, 460 F.Supp. 713, (1980) the plaintiffs brought a class action suit on behalf of themselves and approximately 1,000 other women who had been given DES without their consent as part of a double blind study. The federal court ruled that the plaintiffs had a cause of action for battery. In *Hernandez v. United States America*, 465 F.Supp. 1071 (1979) a federal court ruled that an unconsented to operation performed in a Veterans Administration Hospital constituted an assault and battery. The court further ruled that a claim for assault and battery was not cognizable under the Federal Tort Claims Act due to the exception to such an action found in 28 U.S.C. S 2680(h). However, the court noted a few cases wherein the plaintiffs managed to get around this section in medical cases based upon negligence theory. *Lane v. United States*, 225 F.Supp. 850 (1964); *Fontenelle v. United States*, 327 F.Supp. 80 (1971).

There is also a distinct possibility that military medical personnel involved in rendering unconsented to treatment to a terminally ill or comatose patient could be held individually liable since an intentional assault and battery is generally considered to be outside the scope of a federal employee's practice and therefore coverage would not be available under the *Gonzales Act*, 10USC §1089.

2. It has come to our attention that at one particular MTF several families have threatened to bring suit against the U.S. Government because the MTF will not honor any directives to terminate life-support, executed in accordance with that state's natural death legislation. It has also come to our attention that, in fact, the Veterans Administration has recently been sued successfully based upon somewhat similar circumstances. The case, *Foster v. Tourtellotte, et al.*, (1981-82) U.S. District Court, Los Angeles, Hon. Robert Takasugi, Judge, was filed in October of 1981 when VA medical personnel refused to remove a

patient dying from Lou Gehrig's disease from a ventilator at his request. The plaintiff filed a complaint alleging battery, breach of fiduciary duty, violation of constitutional right of privacy, and for injunctive and declaratory relief. In support of his request to be removed from the ventilator, the plaintiff asserted his constitutional right to privacy and his common law right to refuse medical treatment.\*

In granting an injunction and ordering the defendants to disengage the plaintiff from the ventilator, the court held "...as we balance the contentions of plaintiff with the concern of society for the life prolongation, this Court cannot conceive a real, substantive collision of philosophies because a reasonable society could not mandate Mr. Foster to bear the unbearable or tolerate the intolerable... Whether Mr. Foster experiences subjective pain at this time, I don't think is truly the issue. He has asserted his constitutional rights of self-dignity to demand that future medical care be terminated." *Foster*, at 22-23. Although the plaintiffs stated causes of action were not cognizable under the Federal Tort Claims Act, and he was therefore not entitled to monetary damages, the plaintiffs attorney is appealing the decision not to grant him attorney's fees which he may be entitled to. More importantly, the suit brought extremely adverse publicity to the Veterans Administration.

In conclusion, it is conceivable that military medical personnel could be sued successfully on an individual basis, and be held personally liable, on the theory of an intentional assault and battery. There is a further possibility that the United States could be sued successfully. Even if monetary damages were not awarded, patients could seek injunctive relief which would engage the United States in costly litigation and further result in adverse publicity.

#### **E. Fears of criminal prosecution are unwarranted**

The JAG [Judge Advocate General] opinions upon which the policy in question is based are primarily concerned with criminal prosecution under state laws, federal laws, and the Uniform Code of Military Justice (UCMJ). The theories of criminal liability would be assisting a suicide and homicide.

*1. State Law* — Twenty-three states currently have statutes against assisting suicide. An extensive search of cases over the past fifteen years revealed only a few reported cases that have ever been prosecuted under these statutes, none of which dealt in any way with a terminally ill patient or a physician. The only reported case having even a remote

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\* A number of the arguments that the plaintiff successfully used in *Foster* have subsequently been used herein. Copies of all of the briefs filed in and on behalf of *Foster* are available for inspection at the Armed Forces Institute of Pathology.

connection took place in 1920 in the case of *People v. Roberts*, 211 Mich. 187, 178 N.W. 690. *Roberts*, a husband, was prosecuted for administering poison to his dying wife at her request. The case did not involve physicians or extraordinary life support.

Under the case law reported in section C. above, a physician would not be guilty of homicide if he were operating under guidelines established in accordance with the said law. (To be discussed, *Infra.*)

2. *Federal Law* — Assisting a suicide is not a crime under the federal code. An extensive search of reported cases revealed no federal cases wherein a federally employed physician was ever prosecuted for homicide for either terminating or withholding life support of a terminally ill patient, or for entering a "do not resuscitate" order in a patient's chart. Further, such a prosecution would be inconceivable if the physician were following guidelines established in accordance with reported cases on the subject.

3. *UCMJ* — Assisting a suicide is not listed as an offense under the UCMJ. Extensive research did not reveal any cases wherein a physician was prosecuted under the UCMJ for homicide for either terminating or withholding life support of a terminally ill patient, or for entering a do not resuscitate order in a patient's chart. Clearly, if the Surgeon General issued a policy setting forth appropriate guidelines for dealing with terminally ill patients, any physician following the guidelines would not be subject to prosecution under the UCMJ.

### **Conclusions**

#### **1. The Department of the Army must develop guidelines for handling terminally ill patients in MTFs that are in accordance with applicable state and federal case law**

The eight cases mentioned in section C. above set forth certain methods of handling terminally ill patients consistent with the right of such patients to refuse treatment. In addition, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research has formulated a draft paper, dated January 8, 1982, entitled "Resuscitation and the Decision Against." This paper is an example of the type of guidelines that the Department of the Army should formulate. Numerous other writings and research exist which can give the Department of the Army guidance on formulating appropriate guidelines that would be consistent with the current state of the law on this subject.

#### **2. State directives should be honored in MTFs**

Natural Death Legislation has been enacted in eleven states and is being considered in others. The scope of most of these acts is quite limited. If the Department of the Army had its own broad guidelines, execution of a state directive with its

limited scope of application would be covered under the guidelines. Even in the absence of appropriate Army guidelines, criminal prosecution for following such directives is unlikely for the reasons stated above.

2. The Department of Legal Medicine stands ready to discuss this matter further, to assist in the development of appropriate guidelines, and to provide any other necessary expertise.

(signed)  
James G. Zimmerly,  
M.D., J.D.,  
MPH, Col, MC, USA  
Chairman, Dept. of Legal

Medicine

Prepared by:

(signed)

Jane G. Norman, J.D.  
Department of Legal Medicine

### **Department of the Navy, National Naval Medical Center\***

**1. Purpose.** To establish guidelines for writing orders not to resuscitate ("no code" orders).

**2. Background.** The routine application of cardiopulmonary resuscitation and Advanced Cardiac Life Support has given rise to serious questions regarding the appropriateness of resuscitating every patient who suffers an arrest. Confusion as to criteria for decisions not to resuscitate, identity of decision makers, and a proper decision making process has further obscured an already difficult problem. This instruction is intended to simplify the problem by establishing a clearly delineated decision making process, identifying the appropriate decision makers and providing both criteria for making such decisions and a system of review.

**3. Policy.** The overriding policy of this hospital is to maintain life and health, and the autonomy of both patients and medical department personnel.

**4. Procedures for Writing Orders Not to Resuscitate.** The following elements must be contained in every instance of writing orders not to resuscitate (DNR orders). (Terms are defined in paragraph 8.)

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\* Guidelines for orders not to resuscitate NHBETH INSTRUCTION 6320.37, National Naval Medical Center, Bethesda, Md. 20814 (Feb. 9, 1983).

- a. Only credentialed physicians may write orders not to resuscitate.
- b. Orders must be clearly written, signed, dated and immediately shown to the ward or unit charge nurse.
- c. The order not to resuscitate must be accompanied by a progress note describing the application of the decision making process. (See Tables 2 and 3) [drawn from earlier drafts of the Commission's Report; see Tables 2 and 3, pp. 244, 247 *supra*]. The description will include:
  - (1) A statement indicating: *condition* (reversability/irreversability), *physical status* (reparability/irreparability), *mental status* (competent/incompetent/diminished competence), and *prognosis* (death imminent/nonimminent).
  - (2) Patient and family involvement including their attitudes and responses.
  - (3) Optimal care treatment plan.
- d. The physician's discussion with the patient or family shall be witnessed by a registered professional nurse, or social worker, who will countersign the doctor's progress note.
- e. DNR orders must be reviewed daily by the ward medical officer.
- f. A staff physician must countersign all DNR orders and progress notes within twelve hours of their writing.
- g. The Quality Assurance/Risk Management officer must be notified of the DNR order by the physician writing the order within twelve hours of writing the order. The QA/RM officer will then notify the Chairman of the Medical Ethics Committee of the order.

**5. Questions or Disagreement.** The patient, any member of the family or of the health care provider team who questions or disagrees with the writing of the DNR order, or the absence of a DNR order, should express that disagreement in writing to the medical ethics committee.

**6. Medical Ethics Committee.** The committee will act as a decision making and review committee on matters relating to DNR orders, as well as other matters at the direction of the Commanding Officer.

a. Composition. The committee will be composed of the following seven members:

- One Medical Officer
- One Chaplain Corps Officer
- One Judge Advocate General Corps Officer
- One Medical Service Corps Officer (administrative)
- One Nurse Corps Officer
- One psychiatrist or psychologist
- One senior member of the Hospital Corps Staff

b. Action and Decision.

(1) The committee will review monthly all DNR orders. It will act immediately, however, in those cases where immediate action is warranted or requested.

## 7. Discussion.

a. Paramount Role of the Patient. Underlying guidance on DNR orders the time the question of resuscitation arises. There are two is the fundamental principle that the patient's desires play the dominant role in the decision process; however, patients may not be competent at dimensions to competence: factual and legal. The dimensions can be classified on a two by two matrix.

b. Lenally and Factually Competent Patient. In general, when the competent patient requests a DNR order, the request will be honored, as outlined by Table 2 [drawn from the Commission's Report, *see* Table 2, p. 244 *supra*] regardless of the expected benefits of resuscitation.

The following cases will be given immediate attention by the committee:

(1) Third Party Interests. If reasons exist not to honor the patient's request for a DNR order (e.g., the patient is pregnant, is a sole or primary provider, and so forth), the case shall be referred to the committee. If the committee agrees there is a third party interest but the patient persists in his decision, the case will be referred to the courts. If the committee concludes that there is no third party interest, then the committee will consult with the individual asserting the third party interest. If this person then agrees with the committee, the patient's wishes are followed; if not, the case may be referred to the courts.

(2) Disagreement with Patient. In the event of disagreement with the patient by any health care provider or family member, the case will be referred to the committee. If the committee concurs with the individual in disagreement with the patient, the committee will recommend that a coercive offer (i.e., that the patient be transferred to another facility) be made or will refer the case to the courts. If the committee agrees with the patient, it will meet with the disagreeing person. If the health care provider does not agree, he shall comply with the committee's decision or be removed from the case. If the family continues in disagreement, it may refer the case to the courts.

(3) Military Personnel. Governmental claims of a right to require medical care for the individual member obtain only when it can reasonably be expected that the member can be returned to duty as an active and contributing member of the armed forces. Governmental rights should not, therefore, be considered in the case of the terminally ill patient or in the patient in which treatment could constitute undue suffering. In such cases, the patient is to be treated as a legally and factually competent patient.

c. Legally Incompetent, Factually Competent Patient.

(I) Minors. The decision not to resuscitate a minor must be made by the parent or a person standing in place of the parent. In making the decision, the parent or substitute must act in the best interest of the minor. In addition, in the case of a mature minor, the minor's assent should be obtained.

d. Incompetent Patient. Subsumed under the category of the incompetent patient is the patient with diminished competence. In all decisions the underlying principle is to attempt to determine the decision the patient would have made were he fully competent and informed. This is especially true in the case of the patient whose capacity is diminished as a consequence of pain, therapeutic regimen, or other factors associated with the illness.

(1) Table 3 [drawn from an earlier draft of the Commission's Report, see Table 3, p. 247 *supra*] summarizes the decision alternatives first as a function of the provider's assessment of benefit vis a vis the family's views and second as a function of the provider's recommendation and the family's views.

(2) All cases involving incompetence or diminished competence will be routinely reviewed by the committee. Before the DNR order is written, however, the case must be reviewed at least by a legal officer and psychologist or psychiatrist to establish competence. If the order is one that on Table 3 calls for review or reexamination, then the case must be reviewed by the committee before the order is written.

(3) When the committee concurs with the physician, members of the committee may assist the physician in clarifying the provider's assessment for the family. If the family remains unpersuaded, the provider may make a coercive offer or refer the matter to the courts.

(4) When the committee concurs with the family, it shall confer with the physician. If the disagreement remains, the physician shall comply with the committee's decision or be removed from the case.

**8. Definitions.** In general, the definitions contained herein are either consistent with or derived from the President's Commission for the Study of Ethical Problems in Medicine, and where applicable, local laws and military regulations.

a. Assent. The passive acceptance of a decision made by others.

b. Autonomy. The right of self determination, i.e., the right of competent persons to form, revise and pursue a plan of life. In matters of patient care and orders not to resuscitate, it means that the competent patient's own values shall be decisive. It also means that health care providers shall not be

required to act in a manner contrary to their own values or professional standards.

c. Competence. The ability to make an informed choice. In the case of orders not to resuscitate, it means that the patient understands the relevant risks and alternatives with their attendant consequences. The decision should reflect deliberate choice.

(1) Legal Incompetence. That situation in which an individual is incompetent by operation of law, e.g., a minor or a person previously declared incompetent by judicial decree. Under Maryland state law, a minor who is married or who is a parent is legally competent.

(2) Factual Incompetence. Those situations in which a patient is comatose, unconscious, suffering insane delusions or is otherwise unable to manage his or her personal affairs due to mental disability or disease.

d. Consent. Active participation in and agreement with a decision.

e. Death Imminent. That condition in which in the ordinary course of events, death will probably occur within two weeks. Note that while a death imminent prognosis is a contributing factor for an order not to resuscitate, its absence does not create a prohibition.

f. Diminished Competence. This condition exists when a patient cannot make decisions that promote his well being in accordance with his own previously expressed values and preferences. Diminished competence is often seen as a consequence of pain, therapeutic regimen, or other factor associated with the patient's illness.

g. Family. Those persons sharing a consanguineous relationship (blood) with the patient. In order of consanguinity, this includes the patient's spouse, children, parents and siblings.

h. Informed Consent. A principle of law embodied within the patient's autonomy or right of self determination. It requires that the patient must be informed of all proposed medical procedures, the material risks of those procedures, alternative courses of action and the material risks attendant to the alternatives.

i. Mature Minor. Those above the age of 14 will generally be considered mature minors. Those under the age of fourteen may be so considered at the discretion of the committee.

j. Optimal Care. Care which assures the comfort, dignity, and physical maintenance of the patient regardless of the existence of orders not to resuscitate.

k. Reparability. The extent to which the illness can be cured, corrected, or otherwise stemmed within existing knowledge and technology.

1. Reversability. The extent to which known therapeutic measures can effectively reverse the course of the illness.

m. Terminally Ill. That condition in which there is no reasonable medical possibility that the patient will avoid death and return to a normal cognitive and sapient state.

**9. Action.** Chiefs of directorates are required to ensure that the provisions of this instruction are understood and carried out. It is also highly recommended that those providers having to deal with orders not to resuscitate become familiar with the bibliography on the subject in the E. R. Stitt Library.

(signed)  
J. J. Quinn

## Statements from California State Government

### Department of Health Services\*

When considering the need for acute hospitalization, these five areas of care must be considered:

1. Physician Services

Specific requirement for daily visits, *e.g.*, situations requiring physician skills to observe, evaluate and adjust orders.

2. Skilled Nursing Services

Need for continuous availability of nurse for decision making and intermittent observation.

Frequent skilled nursing services, treatment or procedures.

3. Medical Services Only Available in Acute Facility

Surgical procedures usually performed in acute hospital operating room.

Medical procedures usually performed in acute hospital. Diagnostic services that are complicated or prolonged if performed by outpatient department— Cases that make access to post-test bed rest and observation mandatory or cases which require special continued assistance by nurses or physician (*e.g.*, cardiac catheterization, carotid, lumbar and femoral arteriography; pneumoencephalography).

Patients condition is fragile and complications would be likely to occur.

4. Rehabilitation Services

Initial rehabilitation efforts.

Rehabilitation requiring a multidisciplinary approach.

Intensive therapy or rehabilitation requiring two or more sessions daily.

5. Psychiatric Services

Patient requires a combination of two of the following:

- a. psychotherapy by the attending physician
- b. hospital drug management, *e.g.*, tricyclics, phenothiazines, or lithium
- c. shock therapy

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\* *Level of Care Determination on Acute Care Patients, and How It Relates to a Terminal Patient With a "No Code" Status*, Field Instruction Notice 5-81, to Field Office Administrators, Medical Consultants, and HCSNs from Stephen Harrison, Asst. Chief, Field Services Section (Feb. 6, 1981).

Patient requires services for the purpose of diagnostic study and/or services to reduce or control the patients psychotic symptoms necessitating hospitalization.

Environmental control for patients with acute psychiatric problem.

While the above is presented in general terms and is not meant to be either all inclusive, or mutually exclusive, it is used to show the major service areas and how they would relate to individual patients.

It should be noted that of the five (5) hospital service areas, only service area number two (2), Skilled Nursing Services, of and by itself is *not* justification for acute care hospitalization. Therefore, a terminally ill patient with a "no code" status and those care needs limited to making the person as comfortable as possible and free from pain, while preserving that person's personal dignity to the extent possible, would not meet the criteria for acute hospitalization.

It should be noted that some of the patients' skilled nursing care services may require the number of nursing hours or suppliers that will prevent a skilled nursing facility from accepting them. In these cases we should endeavor to have the patient admitted to a distinct part of an acute care hospital (SNF/DP) as an SNF patient. Should this not be possible, we should authorize the patient to be admitted to the acute hospital level and give the hospital realistic instructions regarding continued SNF placement efforts.

### **Attorney General's Office\***

A California superior court lacks jurisdiction to order or approve the withholding or withdrawal of extraordinary life support systems or procedures from a person made a ward or conservatee pursuant to the Probate Code.

Requested by: COUNTY COUNSEL CONTRA COSTA COUNTY

Opinion by: GEORGE DEUKMEJIAN, Attorney General  
Jack R. Winkler, Assistant

The Honorable John B. Clausen, County Counsel of Contra Costa County, has requested an opinion on the following question:

Does the Probate Court in California have the jurisdiction and power to order or approve the withholding or withdrawal

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\* Opinion on jurisdiction to Order Withdrawal of Extraordinary Life Support Systems from Ward or Conservatee, Opinion No. 81-508 (July 2, 1982).

of extraordinary life support systems or procedures from a ward or conservatee?

#### CONCLUSION

A California superior court lacks jurisdiction to order or approve the withholding or withdrawal of extraordinary life support systems or procedures from a person made a ward or conservatee pursuant to the Probate Code.

#### ANALYSIS

Some definition of the terms used in the question is needed to focus upon the legal issues involved. The question concerns the jurisdiction of the "probate court." Strictly speaking there is no probate court as such in California. (*Schlyen v. Schlyen* (1954) 43 Cal. 2d 361, 371.) Article VI, section 10 of the California Constitution places the "original jurisdiction in all causes" except those given by law to municipal and justice courts in the superior court. Probate matters are civil cases and proceedings within the original jurisdiction of the superior court. (*Schlyen v. Schlyen*, *supra*.) Thus we understand the question to refer to the superior court exercising its original jurisdiction in probate matters and specifically to guardianship and conservatorship proceedings. (See Probate Code, §2200.)<sup>1</sup>

The words "jurisdiction and power" in the question need some clarification. The term "jurisdiction" has so many meanings that no single statement can be entirely satisfactory as a definition. (*Abelleira v. District Court of Appeal* (1941) 17 Cal. 2d 280, 287.) Lack of jurisdiction in its most fundamental or strict sense means an entire absence of power to hear or determine the case, an absence of authority over the subject matter or the parties. (*Id.*, p. 288.) As we have noted the constitution gives the superior court jurisdiction over all probate matters in this fundamental sense. The court's fundamental probate jurisdiction in guardianship matters is a continuing one which is not concluded until the guardian is discharged. (*Guardianship of Reynolds* (1943) 60 Cal. App. 2d 669, 677.) The word jurisdiction is sometimes used to mean "simply authority over the subject matter or question presented," the "authority to do the particular thing done, or putting it conversely, a want of jurisdiction frequently means a want of authority to exercise in a particular manner a power which the board or tribunal has, the doing of something in excess of the authority possessed." (*Abelleira v. District Court of Appeal*, *supra*, at 290.) Since the "probate court" undoubtedly has fundamental jurisdiction over the guardian appointed by it and the ward we understand the words "jurisdiction and power" in the question to refer to the court's jurisdiction in the sense of

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<sup>1</sup> Section references are to the Probate Code unless otherwise indicated.

its authority to make the particular order referred to in the question. It is in this latter sense that we use the word "jurisdiction" in this opinion.

The question concerns the extent of the court's jurisdiction over a "ward or conservatee." California statutes create more than one kind of guardianship and conservatorship. Division 4 of the Probate Code governs the guardianship of minors generally and the conservatorship of the person and estate of incompetent adults generally. The Juvenile Court Law governs wards of the Juvenile Court. (Welf. & Inst. Code, § 601 et seq.) Under the Lanterman-Petris-Short Act a person committed to a state mental institution who is gravely disabled is subject to conservatorship proceedings under that law. (Welf. & Inst. Code, § 5350 et seq.) Since the question is concerned only with the court's probate jurisdiction we are here concerned only with those guardianships and conservatorships created pursuant to division 4 of the Probate Code. The question further limits the analysis to guardianships and conservatorships of the person as distinguished from those created solely to safeguard the estate of the ward or conservatee.

The question concerns "extraordinary life support systems or procedures." We understand life support systems or procedures to refer to those measures applied to a person's body which sustain some bodily function artificially and without which the person would be expected to die.<sup>2</sup> We further understand the word "extraordinary" to distinguish those systems or procedures which are utilized on a continuing basis as necessary to the person's health. Thus we are not here concerned with those treatment measures employed to replace or assist a vital function on a continuing basis such as a heart transplant, a pacemaker, kidney dialysis and the like. On the other hand we understand the systems and procedures referred to to be limited to those of a medical nature.

We understand the thrust of the question to be limited to those situations where the anticipated result of the withholding or withdrawal of extraordinary life support systems or procedures is the death of the ward or conservatee. Thus we do not

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Compare Health and Safety Code section 7187(c) in the Natural Death Act which reads:

"(c) 'Life-sustaining procedure' means any medical procedure or intervention which utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function, which, when applied to a qualified patient, would serve only to artificially prolong the moment of death and where, in the judgment of the attending physician death is imminent whether or not such procedures are utilized. 'Life-sustaining procedure' shall not include the administration of medication or the performance of any medical procedure deemed necessary to alleviate pain."

consider in this opinion those situations where withholding or withdrawal of extraordinary life support systems or procedures is done for the purpose of sustaining or improving the medical condition of the ward or conservatee.

A person of adult years and in sound mind has the right, in the exercise of control over his own body, to determine whether or not to submit to lawful medical treatment. (*Cobbs v. Grant* (1972) 8 Cal. 3d 229, 242.) Thus in most cases the decision whether to undertake treatment is vested in the party most directly affected: the patient. (*Cobbs v. Grant*, *supra*, at 244.) Some authorities indicate that this right is included within the constitutionally protected right of privacy (see 58 Ops. Cal. Atty. Gen. 849 (1975)) but this is questionable since *People v. Privitera* (1979) 23 Cal. 3d 697 held that the constitutional right to privacy does not include medical treatment in a decision denying a person's right to take laetrile as a cure for cancer.

As new medical techniques have developed which artificially prolong vital body functions the decisions to employ them become more complex in particular situations. Even our traditional notions of life and death require more precise definition. When a person's circulation is maintained by a heart-lung machine and the person's brain has ceased functioning, can we say the person is still alive? When the patient is unable to decide whether such extraordinary life support measures are to be taken, who is to make such an awesome decision on his behalf?

As the questions have become more complex the laws governing their resolution have also become more complex. In 1974 Health and Safety Code section 7180 was enacted defining death as including total and irreversible cessation of brain function in addition to the customary procedures for determining death. In 1976 the Natural Death Act (Health & Saf. Code, S 7185 et. seq.) was enacted declaring an adult's fundamental right to control the decisions regarding his or her own medical care and establishing procedures to implement a decision that measures to artificially prolong life not to be taken in specified circumstances.

In 58 Ops. Cal. Atty. Gen. 849 (1975) we concluded that a conservator appointed under the Lanterman-Petris-Short Act had no authority to consent to medical treatment on behalf of the conservatee unless the conservatee was unable to give informed consent by reason of incompetence. Chapter 905, Statutes of 1976, amended Welfare and Institutions Code sections 5357, 5358 and 5358.2 in the Lanterman-Petris-Short Act to authorize a conservator appointed under that act to consent to medical treatment of a gravely disabled conservatee but requiring the conservatee's consent to any nonemergency surgery in the absence of a court order specifically authorizing such surgery. In 60 Ops. Cal. Atty. Gen. 375 (1977) we indicated

our view that guardians and conservators appointed pursuant to the Probate Code may not have a like authority to consent to medical treatment and suggested that they obtain court authorization for any medical decisions respecting their wards and conservatees until the law was clarified.

The extent of the authority of the court to authorize medical treatment of wards and conservatees was similarly uncertain. In *Guardianship of Kemp* (1974) 43 Cal. App. 3d 758 the father of an adult daughter who was capable of sex but mentally unable to understand its consequences was appointed the guardian of her person and estate. Doctors advised the father that the ward's pregnancy would probably result in her reconfinement in a state hospital, that other birth control measures were contraindicated and that her mental deficiencies might be transmitted to any child born to her. The father sought court approval to consent to the sterilization of his daughter. The superior court made an order authorizing the guardian to consent to the sterilization finding authority for its order "in the exercise of its residual chancery powers under the provisions of California Probate Code section 1400."<sup>3</sup> On appeal the court stated the issue thus:

"Assuming that under the reasoning of the Reynolds<sup>4</sup> case, the probate court in the exercise of its continuing jurisdiction over a guardianship has authority by virtue of Probate Code section 1400 to issue instructions providing for the mental and physical welfare of an incompetent person, it must be determined whether a judgment of a probate court ordering a sterilization operation to be performed upon the person of an incompetent is within the limits of such jurisdiction."

The court noted that the only statute authorizing sterilization of a mentally incompetent person was Welfare and Institutions Code section 7254 which authorized sterilization of those committed to state mental hospitals under specified conditions. After reviewing California and out of state cases the court found no persuasive authority that a probate court had jurisdiction to authorize sterilization of a ward in the absence of a statute. The court reversed the superior court order

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<sup>3</sup> Probate Code section 1400 then provided:

"A guardian is a person appointed to take care of the person or property of another. The latter is called the ward of the guardian. The relation of guardian and ward is confidential, and is subject to the provisions of law relating to trusts. In the management and disposition of the person or property committed to him, a guardian may be regulated and controlled by the court."

<sup>4</sup> *Guardianship of Reynolds* (1943) 60 Cal. App. 2d 669.

authorizing the guardian to consent to the sterilization holding that the order was in excess of the court's jurisdiction.

In *Guardianship of Tulley* (1978) 83 Cal. App. 3d 698 the court affirmed an order denying authorization for sterilization of a ward following the *Kemp* decision. The court in *Tulley* observed (at p. 701):

"To begin with, it has been widely recognized that sterilization (even if medically and socially indicated) is an extreme remedy which irreversibly denies a human being the fundamental right to bear and beget a child. Accordingly, the overwhelming majority of courts hold that the jurisdiction to exercise such awesome power may not be inferred from the general principles of common law, but rather must derive from specific legislative authorization. The position of case law is thus clear that in the absence of specific statutory authority the courts may not order the sterilization of a mentally defective person. (Citations.)"

If the courts lack jurisdiction to authorize the sterilization of a ward in the absence of statutory authority, their jurisdiction to order or approve the withholding or withdrawal of extraordinary life support systems or procedures upon which the life of the ward or conservatee depends must also be doubtful in the absence of specific statutory authorization. We conclude that a superior court's jurisdiction to order or approve the withholding or withdrawal of extraordinary life support systems or procedures from wards or conservatees may not be found in common law principles but must be derived, if it exists, from specific statutory authorization. (*Guardianship of Tulley*, *supra*, and *Guardianship of Kemp*, *supra*.)

Chapter 726, Statutes of 1979 (operative Jan. 1, 1981) provided clarification and statutory authorization for the medical treatment of wards and conservatees. It rewrote the whole of division 4 of the Probate Code relating to guardianships and conservatorships. Proceedings concerning unmarried minors are termed "guardianships" while those concerning married minors and adults are called "conservatorships." (See SS 1485, 1490.) Part 4 of division 4 concerns provisions common to guardianships and conservatorships and chapter 5 of part 4 defines the powers and duties of the guardian or conservator of the person. The provisions concerning medical treatment of wards and conservatees are sections 2252, 2353, 2354, 2355, 2356 and 2357. These sections are set forth in full in the Appendix. Under section 2353(a) the guardian of a minor has the same right as a parent having legal custody of a child to give consent to medical treatment of the ward. The parent's rights are defined in Civil Code section 25.8 which reads:

"Either parent if both parents have legal custody, or the parent or person having legal custody or the legal

guardian, of a minor may authorize in writing any adult person into whose care the minor has been entrusted to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care to be rendered to the minor under the general or special supervision and upon the advice of a physician and surgeon licensed under the provisions of the Medical Practice Act or to consent to an X-ray examination, anesthetic, dental or surgical diagnosis or treatment and hospital care to be rendered to the minor by a dentist licensed under the provisions of the Dental Practice Act."

These new statutes provide a comprehensive legislative scheme to determine who is to authorize medical treatment for wards and conservatees. The guardian of a ward is given the same authority as a parent to consent to medical treatment of his minor child. (3 2353.) The only exception is surgery for a ward 14 years of age or older in which case the consent of the ward as well as the guardian is required. The right to consent to medical treatment is not taken from a person who is made a conservatee unless it has been expressly found and adjudicated that he lacks the capacity to make an informed consent therefor, though the conservator may consent to medical treatment for the conservatee in emergencies. (S 2354.) Where the conservatee has been adjudicated to lack the capacity to make an informed consent to medical treatment, the conservator is authorized to provide such consent. [S 2355(a).] A temporary guardian or conservator has the same powers as a permanent representative under sections 2353 and 2354 (not under S 2355) unless the court orders otherwise. (S 2252.) Section 2357 authorizes the court to authorize medical treatment for wards and conservatees under specified circumstances. Our research has revealed no case construing these new statutes. Accordingly, we must resort to the applicable rules of statutory construction which were summarized in *Moyer v. Workmen's Comp. Appeals Bd.* (1973) 10 Cal. 3d 222, 230, as follows:

"We begin with the fundamental rule that a court should ascertain the intent of the Legislature so as to effectuate the purpose of the law. In determining such intent the court turns first to the words themselves for the answer. We are required to give effect to statutes according to the usual, ordinary import of the language employed in framing them. If possible, significance should be given to every word, phrase, sentence and part of an act in pursuance of the legislative purpose; a construction making some words surplusage is to be avoided. When used in a statute words must be construed in context, keeping in mind the nature and obvious purpose of the statute where they appear. Moreover, the various parts of a statutory enactment must be harmonized by considering the particular

clause or section in the context of the statutory framework as a whole." (Citations and quotations omitted.) Section 2357(b) provides:

"If the ward or conservatee requires medical treatment for an existing or continuing medical treatment which is not authorized to be performed upon the ward or conservatee under section 2252, 2353, 2354 or 2355, and the ward or conservatee is unable to give an informed consent to such medical treatment, the guardian or conservator may petition the court under this section for an order authorizing such medical treatment and authorizing the guardian or conservator to consent on behalf of the ward or conservatee to such medical treatment."

Section 2252 gives a temporary guardian or conservator the powers specified in sections 2353 and 2354 unless the court orders otherwise. Section 2353(b) provides that surgery may not be performed on a ward 14 years of age or older without the consent of both the ward and the guardian or "a court order obtained pursuant to section 2357 specifically authorizing such treatment." Section 2354(b) provides:

"The conservator may require the conservatee [who has not been adjudicated to lack the capacity to give informed consent for medical treatment] to receive medical treatment whether or not the conservatee consents to such treatment, if a court order specifically authorizing such medical treatment has been obtained pursuant to section 2357." Section 2355(b) limits the authority of a conservator of a conservatee adjudicated to lack the capacity to give informed consent to medical treatment and was an adherent of a religion whose tenets and practices call for reliance on prayer alone for healing before the conservatorship was established to consent to treatment of such conservatee only by an accredited practitioner of that religion. The Law Revision Commission Comment to section 2355 notes that subdivision (b) "does not limit the authority of the court under Section 2357." Interpretive comments by the California Law Revision Commission are viewed as particularly well-accepted sources from which to ascertain legislative intent. (*Davis v. Cordova Recreation & Park Dist.* (1972) 24 Cal. App. 3d 789, 796.) In the foregoing situations the guardian or conservator may petition the court for an order authorizing medical treatment of the ward or conservatee if the ward or conservatee is unable to give an informed consent therefor.

Section 2357(i) provides in part:

"Upon petition of the ward or conservatee or other interested person, the court may order that the guardian or conservator obtain or consent to, or obtain and consent to, specified medical treatment to be performed upon the ward or conservatee..."

The Law Revision Commission Comment to section 2357 states:

"This subdivision covers the situation where the ward or conservatee or some interested person believes the ward or conservatee needs medical treatment which the guardian or conservator is unwilling to obtain or has failed to obtain."

Except for special notice requirements specified in the last sentence of subdivision (i) we believe the Legislature intended the same procedural requirements for court orders authorizing medical treatment of wards or conservatees upon the petition of the ward, conservatee or other interested persons under subdivision (i) as those sought by petition of the guardian or conservator under subdivision (b), namely those required by section 2357.

A procedural requirement of particular significance on the question presented is section 2357(h) which provides:

"(h) The court may make an order authorizing the recommended course of medical treatment of the ward or conservatee and authorizing the guardian or conservator to consent on behalf of the ward or conservatee to the recommended course of medical treatment for the ward or conservatee if the court determines from the evidence all of the following:

"(1) The existing or continuing medical condition of the ward or conservatee requires the recommended course of medical treatment.

"(2) If untreated, there is a probability that the condition will become life-endangering or result in a serious threat to the physical health of the ward or conservatee.

"(3) The ward or conservatee is unable to give an informed consent to the recommended course of treatment."

We note first that the courts' authority under section 2357(h) is to "make an order authorizing the recommended course of medical treatment of the ward or conservatee." What is the "recommended course of medical treatment"? Section 2357(c) provides that the petition shall state or set forth by medical affidavit:

"(1) The nature of the medical condition of the ward or conservatee which requires treatment.

"(2) The recommended course of medical treatment which is considered to be medically appropriate.

"(3) The threat to the health of the ward or conservatee if authorization to consent to the recommended course of treatment is delayed or denied by the court.

"(4) The predictable or probable outcome of the recommended course of treatment.

"(5) The medically available alternatives, if any, to the course of treatment recommended.

"(6) The effort made to obtain an informed consent from the ward or conservatee."

The information required, at least as to the first five items, would appear to be matters within the special knowledge of the doctor or doctors in charge of the medical treatment of the ward or conservatee. We think it is the recommendation of those medical practitioners which the Legislature had in mind when it required the petition to state "The recommended course of medical treatment which is considered to be medically appropriate." It is that statement and the evidence which supports it that constitutes the "recommended course of medical treatment" which the court may authorize under section 2357(h).

Next we note that section 2357(h) requires that the court must make three findings before it may make an order authorizing the recommended course of medical treatment, namely:

"(1) The existing or continuing medical condition of the ward or conservatee requires the recommended course of medical treatment.

"(2) If untreated, there is a probability that the condition will become life-endangering or result in a serious threat to the physical health of the ward or conservatee.

"(3) The ward or conservatee is unable to give an informed consent to the recommended course of treatment."

We noted previously our understanding that the question was directed at those situations in which the anticipated result of the withholding or withdrawal of extraordinary life support systems or procedures is the death of the ward or conservatee. Neither of the findings required by paragraphs (1) or (2) of section 2357(h) could be made in such situations. Accordingly, we conclude that a California superior court lacks the jurisdiction to order or approve the withholding or withdrawing of extraordinary life support systems or procedures from a person made a ward or conservatee pursuant to the Probate Code.

