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Legal Considerations in End-of-Life Decisionmaking in Louisiana

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ABSTRACT

End-of-life directives are among the most difficult decisions that a patient or a patient's family makes because of the many moral, ethical, legal, and practical considerations. This article addresses the basic legal framework in Louisiana for end-of-life directives. Although Louisiana law provides a framework for addressing end-of-life issues, the law does not dictate outcomes or decisions. The law is often the refuge of last resort, providing unsatisfactory results. End-of-life care decisions are generally most productive when they are based on discussions between patients, their families, and their care team regarding the patient's wishes.

INTRODUCTION

The right of an adult patient to consent to receive **or not to receive** medical treatment has long been recognized by common law and in the courts. This concept is derived from the United States constitutional right to privacy and the common law right of an adult person to control his or her person. For example, touching a person without his or her consent is a battery, a crime against that person under the common law (W. Keeton, D. Dobbs, R. Keeton & D. Owen, Prosser and Keeton on Law of Torts §9, pp. 39-42 [5th ed. 1984]). Because battery is a crime, we obtain written consent from patients prior to treatment. This legal concept is similar to the ethical principle of patient autonomy, that a patient has a right to make informed decisions about receiving or refusing medical care (AMA Code of Medical Ethics, Opinion 10.01 [2]).

Most states have laws supporting the right of adult patients to refuse care and to provide directives about end-of-life (EOL) care when the patient can no longer make decisions for himself or herself. In addition, the United States Supreme Court has recognized that the due process clause of the Constitution gives competent adults an interest in refusing unwanted medical treatment (*Cruzan by Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 [1990]). When an adult patient is not competent (the patient is unable to make his or her wishes known) or when the patient is a minor (under 18 unless married or emancipated), additional legal requirements apply, related to who may make informed consent and EOL decisions on behalf of the patient.

One of the leading cases on EOL decisionmaking is *Cruzan by Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990). In that case, the United States Supreme Court discussed the constitutional implications of a situation in which a patient is unable to communicate his or her wishes. This case established the right of a patient or patient representative to refuse treatment but recognized the state's interest in establishing parameters before such decisions can be made.

Nancy Cruzan was gravely injured in a car accident that rendered her in a persistent vegetative state. She did not have an advance directive document expressing her wishes, so her family directed her treatment. After several years, her family and medical team concluded that Ms Cruzan had no chance of a meaningful recovery and requested that her artificial feeding and hydration equipment be removed. At that time, Missouri had a law allowing a representative to direct that treatment be withdrawn in certain limited circumstances if the representative could show through clear and convincing evidence that the patient would have wanted the services withdrawn. The Missouri government determined that the Cruzan family had not shown clear and convincing evidence that their daughter would have wanted hydration and nutrition services withdrawn. The parents appealed to the United States Supreme Court to find out if the United States Constitution forbids a state from making conditions for the withdrawal of treatment when the patient is unable to state his or her wishes. The United States Supreme Court recognized

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the right of a patient to refuse treatment but refused to interfere with the state law requiring clear and convincing evidence of a patient's wishes. The parents bolstered their evidence, and eventually they were successful in withdrawing treatment.

Thus, although a patient has a right to make decisions about care, a state is also permitted to enact requirements that must be met when a patient refuses care or seeks withdrawal of treatment. Similarly, if a patient is unable to make decisions, because of either age or disability, many states, including Louisiana, impose additional precautions before a refusal of care or withdrawal of treatment decision can be carried out.

LOUISIANA LAW

Louisiana law clearly establishes the requirements of valid consent for medical treatment involving competent adults. More difficult are situations involving patients who cannot make decisions for themselves because they are either incapacitated or too young (under 18 unless married or emancipated) to consent for themselves. In these cases, the law allows family or legal representatives to make medical decisions on behalf of such patients.

While healthcare providers are generally very familiar with Louisiana law related to consent for medical treatment, a separate consent law addresses Declarations Concerning Life-Sustaining Procedures (La. R.S. 40:1299.58.1 *et seq*). This statute reaffirms that ''all persons have the fundamental right to control the decisions relating to their own medical care'' (*id*). This right includes the decision to withdraw or withhold ''life-sustaining procedures'' when the patient has a ''terminal and irreversible condition'' (*id*).

Any adult may make a declaration directing that life-sustaining procedures be withheld or withdrawn if he or she has a terminal and irreversible condition (La. R.S. 40:1299.58.3). Such a declaration is often referred to as a living will. This declaration should be in writing and signed in the presence of 2 witnesses. However, an adult can also make an oral or a nonverbal declaration (such as hand gestures, nod of the head, etc) in the presence of 2 witnesses. The directives expressed in this declaration can still be followed when the patient is unconscious or unable to express his or her wishes at that time. The Secretary of State is ordered to maintain a registry of declarations. The patient or family members/designee are responsible for informing physicians about the existence of such a declaration. The declaration may be revoked at any time by executing a written revocation, by obliterating or defacing the original declaration, or by an oral or nonverbal expression of intent to revoke. If the declaration was filed in the Secretary of State's registry, a written revocation may be filed there as well.

In addition to this statutorily authorized declaration, an adult patient may designate another person as his or her durable power of attorney for healthcare decisions. A healthcare power of attorney (HCPOA) may be made by an adult who possesses medical decision-making capacity. If, in the judgment of the healthcare provider, the patient does not possess medical decision-making capacity, an HCPOA cannot be created. An HCPOA overrides the rights of other individuals to make decisions on behalf of the patient. The HCPOA must be in writing and signed by the patient and must specify the person(s) who will be permitted to make healthcare decisions and declarations for the patient. The document does not need to be notarized, but notarization is preferable. The HCPOA does not automatically confer the right to withhold or withdraw life-sustaining measures. This right must specifically be described in the HCPOA for it to be permissible.

If an adult patient with a terminal and irreversible condition has not executed a living will or HCPOA, the law provides that a representative may make decisions when the patient is comatose or unable to make decisions for himself or herself (La. R.S. 40:1299.58.5). As in medical consents, the law establishes a hierarchy of representatives who can make decisions:

1. Someone whom the patient has previously designated in writing as the medical decisionmaker (either by declaration before 2 witnesses or through a written HCPOA)
2. The judicially appointed curator or tutor
3. The patient's spouse, not judicially separated
4. An adult child of the patient
5. The parents of the patient
6. The patient's sibling
7. The patient's other relatives

When more than one person is in a group, such as in the case of multiple adult children, the declaration should be made by the members of that group available for consultation. When the healthcare team is aware of multiple people within a certain group, a good faith effort must be made to locate and consult with all members of the group. After a good faith effort has been made, all identified members of the group who wish to be involved must agree with the declaration and 2 witnesses must be present when the declaration is made. A member of the healthcare team can be a witness to the declaration.

LEGAL ISSUES RELATED TO THE CARE OF A DYING PATIENT

One of the biggest problems related to EOL issues involves situations in which the patient is incapacitated and his or her wishes are not known to the family

and/or representatives. The family or legal representatives are often either uncomfortable making a decision or cannot agree on what decisions should be made. To avoid these situations, our institutional policy strongly encourages that conversations about EOL decisions occur in the clinic setting to ascertain, when appropriate, whether or not a patient already has or would like to have an advance directive. However, because patients (and in some cases providers) are often uncomfortable having such conversations in the clinic setting, patients are also asked about the existence of advance directives whenever they are admitted to a hospital.

Despite these efforts, not every patient admitted to an Ochsner hospital will have a living will or HCPOA to address EOL decisions if they arise. When the patient possesses medical decision-making capacity, the issue is relatively straightforward. A patient has a right to consent to or refuse treatment. If a competent adult patient does not want treatment, regardless of whether he or she has a terminal and irreversible condition, the patient's wishes will be respected. In the context of EOL decisions, a provider can request to transfer the care of the patient to another provider or facility if the provider feels he or she cannot honor the patient's wishes.

Questions often arise regarding the appropriate way to handle patients who no longer have decision-making capacity. In such cases, the provider must consider 2 preliminary questions: (1) does the patient have a terminal and irreversible condition, and (2) does the patient have an advance directive? Once a patient no longer has decision-making capacity, a decision to withhold or withdraw life-sustaining measures can only be made once 2 physicians, one of whom is the attending physician, certify that the patient has been examined and has a condition that is terminal and irreversible. A ''terminal and irreversible'' condition is defined by Louisiana law as

> [A] continual profound comatose state with no reasonable chance of recovery or a condition caused by injury, disease, or illness which, within reasonable medical judgment, would produce death and for which the application of life-sustaining procedures would serve only to postpone the moment of death (La. R.S. 40:1299.58.2).

Once 2 physicians establish that the patient's condition is terminal and irreversible, the treating physician must determine if the patient has made his or her wishes known through a living will or HCPOA. If a valid advance directive exists, it should be followed. Sometimes, despite a valid advance directive, family members disagree and want the healthcare team to act contrary to the advance directive. In such cases, it is appropriate to request an ethics consult from the Bioethics Committee.

The Bioethics Committee exists to provide information, guidelines, and advice to the medical staff, hospital personnel, patients, and/or patients' representatives to support the basis for informed decisionmaking on bioethical issues. An ethics consult can be requested by contacting a chaplain or the Office of Legal Affairs and Risk Management. The opinions and recommendations of the Bioethics Committee relative to the consultation are strictly advisory and nonbinding. However, an ethics consult often provides guidance in and resolution of many EOL decisions.

When the patient no longer has medical decision-making capacity and has no advance directive, the healthcare team should look to the legal hierarchy described above to determine who should make decisions on behalf of the patient. Once that person(s) is identified, the team members should encourage the representative(s) to use the substituted judgment standard by asking the representative(s) what the patient would have wanted had he or she been able to make the decision.

CONFLICTS WITH THE PATIENT OR PATIENT REPRESENTATIVE'S CHOICE

In certain cases, a conflict may arise between a patient, the patient's family or representative, and a healthcare provider regarding appropriate medical care, including the futility of further care. In such cases, the physician should take time to carefully explain to the patient and the patient's family or representative the nature of the patient's condition, prognosis, and options. If the physician is unsuccessful, the physician or any healthcare provider may request (1) assistance from another physician to provide a second opinion, (2) a palliative care consult, (3) a consult from other support staff (including social workers and Pastoral Care), or (4) a recommendation from the Bioethics Committee.

Such conflicts arise when the representative(s) either does not know the patient's wishes or cannot abide by them if the patient's wish was to withhold or withdraw treatment. In some cases, especially those involving multiple adult children, not all of them may agree on the appropriate course of action. If a representative does not want to make the decision or multiple representatives disagree on the decision, a useful strategy is to request an ethics consult to help the care team and the patient's representative(s) come to an agreement about how best to proceed.

In a small number of cases, a representative may inform the healthcare team that he or she wants aggressive treatments or therapies implemented that the healthcare team feels would be futile or even harmful

to the patient. If such a situation arises, transferring the patient to another provider or even another facility may be appropriate. However, a healthcare provider is not obligated to provide futile care to a patient. In such circumstances, requesting an ethics consult is appropriate.

HOW DOES A DO NOT RESUSCITATE ORDER FACTOR IN TO EOL DECISIONS?

A do not resuscitate (DNR) order provides instructions about how the healthcare team should carry out the EOL decisions of a patient through either the competent patient's own wishes or an advance directive that already exists. From a legal perspective, there is no distinction between withholding and withdrawing life-sustaining procedures/support. When a patient possesses medical decision-making capacity, the physician should discuss the DNR decision with the patient and document the discussion in the patient's medical record. A patient who has medical decision-making capacity need not have a terminal and irreversible condition to request that a DNR order be entered and carried out if the patient's condition deteriorates. When the patient lacks medical decision-making capacity but has an advance directive, a DNR order can be written after certain requirements are met. The attending physician must reach a conclusion, based on ordinary medical standards, with a reasonable degree of medical certainty that (1) the patient's condition is terminal and irreversible, (2) the patient's death is imminent, and/or (3) based on the patient's medical condition, a DNR order is appropriate.

When the patient lacks medical decision-making capacity and the patient has no advance directive or has not made his or her wishes clear, the physician should consult with the patient's family and/or representative(s) about issuing a DNR order. Before a DNR order can be written under such circumstances, the following requirements must be met. Two physicians—one of whom is the attending physician with primary responsibility for the treatment and care of the patient at the time the DNR order is being considered—must concur based on ordinary medical standards with a reasonable degree of medical certainty that (1) the patient's condition is terminal and irreversible, (2) the patient's death is imminent, and/or (3) a DNR order is appropriate based on the patient's condition and the wishes of the patient, family, and/or representative(s).

CONCLUSIONS

Issues relating to EOL decisionmaking frequently arise in the hospital setting. Although the law provides a framework to allow a substitute to make decisions when the patient can no longer do so, the law does not dictate what decisions the substitute should make. Very often, the family members are forced to make very serious decisions with insufficient information about the patient's wishes. At times, family members are also unwilling or troubled by the burden of making such important decisions for a loved one. Thus, to avoid such situations, it is important to have frank discussions with patients about their wishes while they still have the ability to do so. When the patient does not have decision-making capacity, the healthcare team must be mindful of the legal parameters within which others can make decisions on behalf of a patient. It is also important to remember that the law, while helpful, cannot be interpreted in a vacuum. Using resources such as the Bioethics Committee can help healthcare providers and patients' families work through these difficult decisions.

This article meets the Accreditation Council for Graduate Medical Education and American Board of Medical Specialties Maintenance of Certification competencies for Patient Care, Medical Knowledge, and Systems-Based Practice.