Virtual Mentor. August 2004, Volume 6, Number 8.
doi: 10.1001/virtualmentor.2004.6.8.hlaw1-0408

Health Law

Words Count as Much as Deeds

Physicians must maintain strong communication lines and document discussions with patient surrogates to avoid confusion regarding end-of-life care and decisions for patients with irreversible brain damage.

Leah Eisenberg and Melissa Junge

Mrs. Milos was brought to the emergency department at Middlesex Hospital one evening, unconscious but breathing on her own. The 76-year-old woman had been transported there by ambulance from the skilled nursing facility where she had resided for the last 3 years. She moved into the facility after a stroke left her with neurological deficits that rendered her unable to speak or care for herself independently. She retained the ability to understand speech, and she enjoyed TV as well as being talked to or read to. Until the night she was taken to the ED, she still recognized her son, smiled at her fellow residents, and liked to be walked around the nursing facility in a wheelchair. However, on the night in question, Mrs. Milos had pressed the "panic button" in her room, and when an aide responded to her call, he found her unconscious on the floor and summoned the paramedics.

Shortly after arriving in the ED, Mrs. Milos went into cardiac arrest. Since she did not have any DNR orders, CPR was performed. The physicians treating her were able to restore her heartbeat in roughly twenty minutes, but Mrs. Milos remained unable to breathe on her own. Therefore, she was intubated before being transferred to the ICU in a deep coma.

The next morning, the attending physician, Dr. Mosher, called in Dr. Henry, a neurologist, to examine Mrs. Milos and to assess her neurological condition. Dr. Henry found Mrs. Milos to be unresponsive, with fixed, nonreactive pupils, no purposeful movement, and no spontaneous or reflex eye movements. Her son, George, was present during this examination, and Dr. Henry was not optimistic about Mrs. Milos's prognosis. He ordered a CT scan and left until the next morning. At that time, he found Mrs. Milos's condition to be unchanged. He told Dr. Mosher that Mrs. Milos was irreparably brain damaged and that there was no hope for neurologic recovery. He spoke to George Milos again, and told him that, based on the CT scan and the exam he had conducted, his mother had no remaining brain function. Most of this conversation took place between just the two of them, since Dr. Mosher was called away early on in the discussion.

Dr. Henry recommended a trial of patient-assisted ventilation in order to confirm his diagnosis. He explained to George that if Mrs. Milos made any attempt to breathe on her own, the patient-assisted ventilator would sense her efforts and deliver a breath for her. Should she fail to make such an attempt, however, the ventilator would not function, and then they could conclude that no brain function remained. George agreed that they should try the patient-assisted ventilation, and the ventilator settings were adjusted accordingly. Just then, Dr. Henry was called away from the ICU, and a nurse was left to observe the trial. The nurse did not see any evidence that Mrs. Milos was attempting to breathe on her own, but did not call a code. The nurse did call Dr. Mosher, and by the time he arrived, Mrs. Milos's heart rate and blood pressure had slowed. Twelve minutes later, she became asystolic, and Dr. Mosher declared her dead based on cardiac criteria. When he informed George that Mrs. Milos had just died, George was shocked. He said that he had only agreed to try the patient-assisted ventilation because Dr. Henry had led him to believe that his mother was already "brain dead" and that, if he had known she wasn't, he would never have agreed to change the ventilator settings. He was also furious that Dr. Mosher had done nothing to save his mother when he arrived and saw that she was failing to breathe on her own.

George Milos filed two lawsuits; he sued Dr. Mosher and Dr. Henry for fraud, and he sued Middlesex Hospital for malpractice.

Legal Analysis

The 2nd Circuit Court of Appeals addressed similar claims in the 2001 case of *Law v Camp* [1]. The basic facts in *Law v Camp* were similar to those in the Milos case—James Law sued the hospital where his mother died, as well as the physicians who treated her there, for malpractice and fraud, respectively. The 2 actions were later consolidated by the district court. In the *Law* case, as in the case above, a DNR was never signed, and part of the ruling discusses the implications of removing a patient from life support without such a directive. *Law v Camp* never went to trial, and the court focused more on procedural matters than on an adjudication of facts.

James Law asserted that the defendant physicians who cared for his mother, one of whom was Dr. Camp, violated a Connecticut statute when they withdrew Mrs. Law from life support before she had been declared brain dead, and that in so doing they also disregarded the hospital's own protocols, which established the medical standards for determining brain death. Mr. Law wanted these violations recognized as negligence *per se*, the negligence that arises automatically from the breach of a public duty. Since Mr. Law maintained that the statute prohibited the removal of a person from life support unless brain death had been established, and since Dr. Camp testified that he had not told James Law that his mother was brain dead, Mr. Law believed negligence per se was apparent. Therefore, he moved for summary judgment, a court decision made on the basis of pleadings, depositions, and other evidence presented for the record without a trial. Depriving a party of a trial violates the Constitutional guarantee of due process, so a court will only grant a motion for summary judgment when it determines that reasonable people could not differ as to their interpretation of the material facts in the case.

The district court ultimately rejected Mr. Law's motion for summary judgment. Key to its decision was the fact that Law failed to offer expert testimony supporting his interpretation of the Connecticut statute, while the defendant physicians offered an expert who stated that the standard of care does not demand a determination of brain death prior to placing a patient in Mrs. Law's condition on a patient-assisted ventilator. The fact that the defendant physicians presented an expert, while Law did not, sunk his claim of negligence per se and therefore his motion for summary judgment.

Expert testimony is generally required in all medical malpractice proceedings in order to establish that the alleged negligence was the proximate cause of the injury in question. Law asserted that expert testimony was not needed in this case, and that the cause of his mother's death was not at issue, since it was "undisputed" that she was not brain dead before life support was removed, and that she died as a result of its removal. The court rejected his reasoning, holding that the cause of Mrs. Law's death was far from certain. Instead, it declared that, in order to find in Mr. Law's favor, the court would have to have evidence that Mrs. Law was not brain dead when life support was removed and that its removal was the proximate cause of her death. Since Mr. Law failed to offer expert testimony supporting a single claim against the defendant physicians, and since the defendant physicians backed up their own assertions, the district court granted the physicians' counter-motion for summary judgment.

Implications for Physicians

This case focuses on communication (or lack thereof) between the physician and the patient's decision maker. It is not an all or nothing situation of either no communication or completely accurate communication. The problem arises from the extent of the communication between the physician and the patient's family or surrogate.

First and foremost, physicians in situations similar to that of Dr. Camp must follow the hospital or health care institution's policy regarding the determination and confirmation of brain death. However, as exemplified in the case, much confusion can arise regarding the use of terminology such as "irreversibly unconscious," "brain death," "no brain function," and "persistent vegetative state." There are aspects of the terminology upon which even physicians disagree. [See this month's *VM* article, "Brain Death: At Once 'Well Settled' and 'Persistently Unresolved"] Determination of death by neurological criteria is definitely not a topic that is simple or straightforward for a patient's family or

surrogate to understand.

The *Code of Medical Ethics* provides guidance on the underlying issues of patient communication and informed decision making. Opinion 2.20, "Withholding or Withdrawing Life-Sustaining Medical Treatment," states that "Physicians should provide all relevant medical information…" [2]. Opinion 2.215, "Treatment Decisions for Seriously Ill Newborns" adds pertinent language which applies to an adult surrogate of a patient who is either brain dead or irreversibly brain damaged. It states that "Physicians must provide full information…regarding the nature of treatments, therapeutic options and expected prognosis with and without therapy, so that [surrogates] can make informed decisions for [the patient] about life-sustaining treatment" [3].

The challenge for physicians is to provide the information about the patient's condition and the implications of various treatment options in language that the family or surrogate can understand. In *Law v Camp*, it is quite obvious that there was a miscommunication or, at the very least, a misunderstanding between the patient's family member and the physician. Ultimately, a lack of communication and understanding leaves the family or surrogate feeling confused, frustrated, and potentially betrayed.

When speaking with the patient's family or surrogate, the physician should follow the guidelines of Opinion 8.081, "Surrogate Decision Making." Opinion 8.081 states that "Physicians should recognize the proxy or surrogate as an extension of the patient, entitled to the same respect as the competent patient. Physicians should provide advice, guidance, and support; explain that decisions should be based on substituted judgment when possible and otherwise on the best interest principle; and offer relevant medical information as well as medical opinions in a timely manner" [4]. After this discussion with the patient's family or surrogate, the physician should clearly document the discussion, including the information presented, implications discussed, and the family or surrogate's questions and decision(s).

Given the absence of a Do Not Resuscitate (DNR) order or advance directive, it is surprising that the absence of efforts to resuscitate Mrs. Law was not considered a material issue in the *Law v Camp* case. Generally, in the absence of a DNR order, efforts *are* made to resuscitate the patient, inasmuch as his or her preference to the contrary has not been expressed or documented. The *Law v Camp* case indicates that Dr. Camp discussed the absence of a DNR or an advance directive for Mrs. Law with her son. Her son replied that his mother would not wish to be kept alive in a state of irreversible brain damage. Perhaps this discussion sufficed to make clear that Mr. Law did not want efforts made to resuscitate his mother, should she "fail" the patient-assisted ventilator test. Nevertheless, a physician who has this type of discussion with the family should at least document the patient's preferences as expressed by the surrogate, if not establish the order accordingly. Preferably, the physician would take the next step and see that the DNR was entered into the patient's chart. Opinion 2.22, "Do-Not-Resuscitate Orders" provides guidance by stating that "[i]f a patient is incapable of rendering a decision regarding the use of [resuscitative efforts], a decision may be made by a surrogate decision maker, based upon the previously expressed preferences of the patient or, if such preferences are unknown, in accordance with the patient's best interests" [5]. The Opinion also states "[i]f, in the judgment of the attending physician, it would be inappropriate to pursue CPR, the attending physician may enter a DNR order into the patient's record."

In life-and-death situations, clear and complete communication, coupled with clear evidence that the surrogate understands the situation and treatment options will go far toward decreasing the number of cases such as *Law v Camp* where the patient's family or surrogate is left with confusion and frustration about the end-of-life care of the patient.

References

1. *Law v Camp* 116 F. Supp. 2d 295.
2. American Medical Association. Opinion 2.20 Withholding or withdrawing life-sustaining medical treatment. *Code of Medical Ethics*. Accessed July 9, 2004.
   Google Scholar
3. American Medical Association. Opinion 2.215, Treatment decisions for seriously ill newborns. *Code of Medical*

Ethics. Accessed July 9, 2004.
4. American Medical Association. Opinion 8.081, Surrogate decision making. *Code of Medical Ethics*. Accessed July 9, 2004.
5. American Medical Association. Opinion 2.22, Do-not-resuscitate orders. *Code of Medical Ethics*. Accessed July 19, 2004.
