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Law

Legal Briefing: New Penalties for Disregarding Advance Directives and Do-Not-Resuscitate Orders

Thaddeus Mason Pope

ABSTRACT

Patients in the United States have been subject to an ever-growing "avalanche" of unwanted medical treatment.[1] This is economically, ethically, and legally wrong. As one advocacy campaign puts it: "Patients should receive the medical treatments they want. Nothing less. Nothing more."[2] First, unwanted medical treatment constitutes waste (and often fraud or abuse) of scarce healthcare resources. Second, it is a serious violation of patients' autonomy and self-determination. Third, but for a few rare exceptions,[3] administering unwanted medical treatment contravenes settled legal rules and principles. This "Legal Briefing" describes a central and growing role for the law. Specifically, courts and agencies have increasingly imposed penalties on healthcare providers who deliberately or negligently disregard advance directives and DNR (do-not-resuscitate) orders. I group these legal developments into the following five categories:

1. Five Types of Unwanted Medical Treatment
2. State and Federal Duties to Follow Advance Directives
3. *Doctors Hospital of Augusta v. Alicea*
4. Other Lawsuits for Ignoring Advance Directives
5. Administrative Penalties for Ignoring Advance Directives

INTRODUCTION

There is significant evidence that physicians routinely ignore patients' preferences about life-sustaining treatment.[4] Alarmingly, in two separate recent surveys, one-third of respondents reported that clinicians did not carry out a patient's end-of-life wishes.[5] Contrast another recent study of 200,000 long-term care residents in four Canadian provinces that reports a remarkably high compliance rate with DNR orders. Only one in 2,500 residents with a DNR order was resuscitated.[6] One reason (although hardly the only reason) for this significant U.S. noncompliance is a widespread misperception among clinicians that one cannot get into legal trouble for doing "too much."[7] In 2013, I tried to bust this widespread myth and correct the misperception. I comprehensively collected and reviewed lawsuits and administrative sanctions to show that the risks of providing unwanted life-sustaining treatment are "not as rare, meager, and inconsequential as often depicted."[8]

Unfortunately, clinicians continue to believe that it is "safe" to err on the side of saving or prolonging life, notwithstanding a patient's own stated preferences.[9] For example, in its 2015 report, *Dying in America,* the Institute of Medicine (IOM) observed that "adherence to patients' advance directives" is negatively impacted by "concerns about malpractice liability."[10] Specifically, "physicians believe their liability risk is greater if they, mistakenly, do not attempt resuscitation than if they provide it against patient wishes."[11]

The IOM hastens to add that this "anxiety about being sued may not be based in fact."[12] I want to substantiate this point. In this "Legal Briefing," I up-

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date my research to report a persisting trend of civil and regulatory enforcement. Courts and administrative agencies have continued to impose penalties on healthcare providers who disregard advance directives and DNR orders. To be timely and relevant, I review significant legal developments from only the past 18 months.

1. FIVE TYPES OF UNWANTED MEDICAL TREATMENT

To adequately grasp the relevant context, it is useful to distinguish five relatively distinct types of unwanted medical treatment. In the first three, the treatment is probably unwanted because it has: (1) negative value—zero benefit but positive harm,[13] (2) zero value—no benefit and no harm,[14] or (3) low value—limited benefit and some harm.[15] With these three, the value of the treatment is measured clinically and scientifically. In contrast, in the fourth type of unwanted treatment, (4) unknown value, the worthwhileness of the treatment is preference-sensitive. It might have high value for some and low (or no) value for others. Here, treatment is probably unwanted, not because of its limited physiological effects, but because robust survey evidence indicates that most patients would not want it. In these instances, patients never actually decided to reject the treatment, because they did not understand the risks, benefits, and alternatives. But, had the informed-consent process been adequate, patients probably would have rejected the treatment.[16]

The fifth type of unwanted medical treatment is materially different. In contrast to the first four types, now we really know that the treatment is unwanted. Here, patients have already explicitly and specifically (5) refused and rejected it. I focus on this type of unwanted medical treatment. I focus on cases in which two conditions are satisfied. First, patients had a DNR order or an advance directive that clearly refused and rejected a medical treatment. Second, clinicians administered that same treatment, notwithstanding the patients' prior instructions. While there are sometimes reasons to override advance directives,[17] clinicians should normally follow them, especially when they are clearly applicable to patients' situations.

2. STATE AND FEDERAL DUTIES TO FOLLOW ADVANCE DIRECTIVES

Overlapping and redundant laws require clinicians to follow patients' advance directives. First, healthcare providers have been increasingly subjected to civil liability for administering unwanted life-sustaining treatment.[18] Many of these causes of action have been based on common law theories, including: (1) battery, (2) inadequate informed consent, (3) negligence, (4) intentional infliction of emotional distress, and (5) breach of contract. Other lawsuits have been based on statutes such as healthcare decisions acts and POLST (Physician Orders for Life-Sustaining Treatment) laws. Second, in addition to private lawsuits for money damages, careproviders have also been subjected to disciplinary and criminal sanctions for providing treatment without appropriate authorization.

Furthermore, neither this civil nor regulatory law has remained static. U.S. states continue to refine their cases, statutes, and regulations to better assure compliance with advance directives. For example, a 2017 New York State bill seeks to ensure there will be remedies in appropriate cases by adding "punishment provisions" and by specifically allowing for the "recovery of damages" for disregard of valid directives.[19] In addition, the bill will prohibit careproviders from seeking and obtaining payment for such unwanted treatment.

A second 2017 New York State bill seeks to ensure that a surrogate's objection will not deter a careprovider from following the clearly expressed prior wishes of a patient.[20] The Family Health Care Decisions Act currently states that if a surrogate directs the provision of life-sustaining treatment, but the hospital or individual healthcare provider "does not wish to provide such treatment," then the hospital or individual careprovider nevertheless must either comply with the surrogate's decision, transfer the patient, or seek court review.[21]

While this provision is appropriate as applied to a dispute between a surrogate and a careprovider, it does not clearly or appropriately apply to a dispute between a surrogate and the patient, as evidenced by the patient's clear prior decision.[22] The proposed amendment clarifies that the dispute resolutions for careprovider-surrogate conflicts do not apply when the hospital or individual healthcare provider is carrying out a patient's own prior decision.

3. *DOCTORS HOSPITAL OF AUGUSTA V. ALICEA*

I recently argued that precedential appellate court rulings on end-of-life treatment matters are critically important, because they often cast a large "judicial shadow" on medical care. I called these "landmark" cases. While rare, these publicly avail-

able rulings with reasons may provide much-needed guidance to clinicians and institutions.[23] In July 2016, the Supreme Court of Georgia issued just such a published and precedential ruling in a case concerning advance directive compliance: *Doctors Hospital of Augusta v. Alicea*.[24]

Background

In November 2009, 89-year-old Bucilla Stephenson was living with her granddaughter, Jacqueline Alicea. When Stephenson completed an advance directive that month, she named Alicea her healthcare agent. The advance directive specified that Alicea be "authorized to make all health-care decisions for [Stephenson], including decisions to provide, withhold, or withdraw artificial nutrition and hydration, and all other forms of health care to keep [Stephenson] alive." The advance directive also directed, "I do not want my life to be prolonged if [among other conditions] I have an incurable and irreversible condition that will result in my death within a relatively short time."

Stephenson's advance directive did not specifically list or define the medical technology that she did or did not want used as part of her medical care. Yet, in addition to the written instructions, Stephenson repeatedly told her family members that "she was ready to go when the good Lord called her," and said "when it's my time, it's my time, don't prolong it." Stephenson told Alicea specifically that "she did not want . . . to rely on a machine to have to live," including a ventilator to breathe for her.

Hospital Admission

Stephenson completed her advance care planning documents and discussions just in time. Two years later, on 3 March 2012, she was admitted to Doctors Hospital of Augusta. She was suffering from pneumonia, sepsis, and acute renal failure. Since she lacked capacity, Alicea's agency was activated.

Alicea was a prompt and diligent healthcare agent. She provided the hospital with a copy of Stephenson's advance directive. She verbally instructed clinicians not to administer CPR (cardiopulmonary resuscitation), intubation, or mechanical ventilation. The hospital placed a copy of the advance directive in Stephenson's medical record, but not behind the admission tab where clinicians could more easily see and review it.

First Intubation

Two days later, on 5 March, cardio-thoracic surgeon Phillip William Catalano asked Alicea for consent to drain fluid from Stephenson's chest cavity through a surgical thoracentesis. Catalano had not read the advance directive or the progress notes stating there was to be no intubation without calling Alicea.[25] Moreover, Catalano did not mention that the surgical thoracentesis would require intubation. Alicea consented, and Catalano performed the procedure. Stephenson was later extubated and taken off the ventilator. Neither Catalano nor any other clinician told Alicea that they intubated Stephenson or put her on a ventilator.

Second Intubation

Two more days later, on 7 March, Stephenson was experiencing respiratory distress in the early morning hours. The nursing staff was concerned that she would progress to respiratory failure. Around 4 a.m., the nursing staff called Catalano at home. Again, notwithstanding the advance directive and progress notes, Catalano decided to have Stephenson intubated and put on a ventilator to prevent her from going into respiratory or cardiac arrest.

A nurse urged Catalano to call Alicea before ordering the intubation. However, he rebuffed her, saying, "I'm not going to call her at six o'clock in the morning and scare the hell out of her. I'll wait till, you know, she wakes up and then I'm going to call her and tell her what happened." Later, explaining his thought process, Catalano testified: "If the family does not want her on the respirator, we can just pull the tube out . . . we can always undo it." He further explained: "I really didn't go into any of the code/no code/do not intubate/resuscitate. Save the patient's life first and then we'll do whatever it takes to make the family and that patient whatever [*sic*], but we can't undo death."

Catalano knew that Stephenson had an advance directive. He knew that Alicea was the designated healthcare agent. Yet, without contacting Alicea for permission, Catalano directed the on-duty doctor to intubate Stephenson, explaining, "I don't want her to die." The on-duty doctor performed the intubation, and connected Stephenson to a ventilator. No clinician tried to contact Alicea before or after the intubation. Had they consulted Alicea before the intubation as she had directed, she would not have authorized the procedure.

When Alicea's husband stopped by the hospital later that morning to check on Stephenson, he was surprised to see her on a ventilator. He called Alicea, who was shocked by the news. He also told her that the nursing staff could not find the advance directive. Alicea left work as quickly as she could, got a copy of the advance directive from home, and headed to the hospital. It took the nursing staff 15 to

20 minutes of searching to locate the hospital's copy of the advance directive. One nurse remarked to Alicea's husband, "Boy, somebody has really messed up. I found it."

Subsequent Treatment

When she arrived at the hospital, Alicea showed the advance directive to the supervising critical care physician and told him that the hospital had failed to follow Stephenson's wishes by intubating her and placing her on a ventilator, but that "since they put her on it, they had to take care of her."

Perhaps surprisingly to some, Alicea declined to have Stephenson extubated and the ventilator removed at that point. Instead, she chose to continue treatment for Stephenson. She also consented to other procedures, including the placement of a feeding tube, a bronchoscopy to remove pus from the airway, and a tracheostomy to provide an airway and to remove lung secretions. Stephenson remained in the ICU (intensive care unit) from 7 March until 14 March. At that point, Stephenson's kidneys were shutting down. Alicea authorized the removal of Stephenson's ventilator and the provision of comfort measures only from that point forward. Stephenson died on 17 March.

Lawsuit

In May 2013, Alicea filed a lawsuit against both Doctors Hospital of Augusta and Catalano. She alleged they contravened Stephenson's advance directive and acted contrary to the specific directions of her designated healthcare agent. The complaint further alleged that subjecting Stephenson to unnecessary procedures caused her pain, suffering, and emotional distress. Alicea asserted claims for (1) breach of contract, (2) inadequate informed consent, (3) ordinary negligence, (4) battery, (5) intentional infliction of emotional distress, and (6) breach of fiduciary duty. Notably, Alicea sought not only compensatory damages but also punitive damages, because the conduct was not merely negligent, but also egregious and unconscionable.

Trial Court

In April 2014, the defendants filed a motion for summary judgment, arguing that the Georgia Advance Directive for Health Care Act provided them immunity from liability. They contended that the GADHCA broadly immunizes healthcare providers for "failure to comply" with the directives of healthcare agents. Nevertheless, in May 2014, the trial court rejected the immunity argument and denied summary judgment.

The trial court held that immunity would apply on summary judgment only if all of the evidence (seven depositions and the medical record) showed that Catalano had acted in "good faith" compliance with the advance directive.[26] Instead, the evidence was far more mixed. It would also (if not better) support a finding that Catalano decided all by himself what was "right for the patient" and would only later check with the agent to tell her "what happened" and see if she wanted to "undo" the procedure already ordered. In short, Catalano was not acting in good faith reliance, in "honest dependence," on any decision that Alicea had made as Stephenson's healthcare agent. He made the treatment decision himself, exercising his own medical and personal judgment.

Court of Appeals

In June 2015, the Georgia Court of Appeals affirmed the trial court's denial of summary judgment to the defendants. The appellate court agreed that genuine issues of material fact existed regarding whether the defendants made a good faith effort to rely on the agent's directions and were thus entitled to statutory immunity.[27] The appellate court agreed that significant evidence showed that Catalano made the patient's healthcare decisions on his own, without relying in good faith on what the patient's agent (Alicea) directed.

Supreme Court

In July 2016, the Supreme Court of Georgia affirmed both lower court decisions denying the defendants' claims of immunity. Moreover, the court made two important observations. First, the court declared that a key animating purpose of the advance directive statute was to ensure that "it is the will of the patient or her designated agent, and not the will of the health care provider, that controls."

Second, the court determined that a core principle in the statute, reflected in many provisions, is that the patient and her agent may see a "real difference between passively allowing her life to slip away and requiring a loved one to make the affirmative decision to 'pull the plug' and halt life-sustaining measures like mechanical ventilation." Indeed, while it is a familiar refrain to bioethicists that there is no legal or ethical difference between withholding and withdrawing, the emotional and psychological differences have been well documented.[28]

When she arrived at the hospital on 7 March, Alicea did not direct that Stephenson's ventilator be withdrawn immediately. Had Catalano followed the advance directive and had Stephenson died,

Alicea "would have understood that it was her time and God took her." Yet, deprived of the opportunity to let nature take its course, Alicea consented to the continuing treatment until 14 March. Alicea drew a distinction between (1) never placing Stephenson on a ventilator and "let[ting] nature take its course," and (2) taking the affirmative step of removing her from the ventilator now that she was already on it. According to Alicea, she then "had to make the decision that [she] wasn't supposed to have to make."

On the other hand, a jury could find that Alicea failed to faithfully fulfill her duties as agent, thereby failing to mitigate damages caused by the hospital's breach. In other words, even if the hospital was wrong to intubate Stephenson and put her on a ventilator, that would have caused only a few hours of unwanted treatment. Instead, Stephenson was on a ventilator for more than a week because of decisions that Alicea made on her behalf, which were arguably inconsistent with Stephenson's wishes.

Back at Trial Court

While the supreme court judgment sent a loud and clear message about advance directive compliance, it had a limited impact on Alicea's lawsuit. It ruled on only one narrow issue that was presented procedurally in just one type of motion. The supreme court remanded the case to the Richmond County Superior Court, where it began. Alicea still had to establish liability on one or more of her claims.

Moreover, the defendants could have still argued (and could even have won) immunity. Yes, the trial court, the court of appeals, and the supreme court all agreed that the defendants were not entitled to summary judgment, because the evidence indicated that there was at least a disputed issue of fact as to whether Catalano acted with good-faith reliance on a decision made by Alicea. It would be a jury's job to assess and weigh the conflicting evidence regarding Catalano's good faith. While it seems unlikely, a jury could find that the defendants were entitled to immunity under the GADHCA. But the case might never get that far. In February 2017, the parties were engaged in settlement negotiations.[29]

4. OTHER LAWSUITS FOR IGNORING ADVANCE DIRECTIVES

While the Georgia Supreme Court's decision in *Alicea v. Doctors Hospital of Augusta* is the most significant legal development from the courts, families have been litigating other lawsuits against healthcare providers for ignoring advance directives and DNR orders. Three representative cases are from Maryland, Oregon, and California.

Maryland

In June 2013, Beatrice Weisman suffered a stroke that left her in the hospital. After weeks of worsening results, her family determined that "repetitive, painful, and intrusive medical interventions only served to prolong what was otherwise becoming a decreased quality of life."[30] Therefore, on 7 August 2013, Weisman's healthcare agent completed a Maryland MOLST form indicating that she did not want clinicians to resuscitate her if she coded.

Maryland MOLST (Medical Orders for Life-Sustaining Treatment) is a portable and enduring medical order form signed by a physician, nurse practitioner, or physician's assistant.[31] It contains orders about CPR and other life-sustaining treatments. MOLST orders can be based either on the consent of the patient or, if the patient lacks capacity, on the patient's surrogate.[32] MOLST orders must be honored by EMS (emergency medical services) medics and healthcare personnel in all healthcare settings.

While Weisman's family prepared the right advance care planning documentation, Weisman's MOLST failed to protect her from unwanted treatment. Just four weeks later, on 29 August 2013, clinicians at Maryland General Hospital (now part of the University of Maryland) performed CPR despite her express DNR instructions and against her wishes. Clinicians administered chest compressions, defibrilated Weisman three times, and injected her with epinephrine. Weisman was transferred to the ICU and later discharged home.

In July 2016, Weisman's agent sued the hospital, asserting claims for: (1) assault, (2) negligence, (3) intentional infliction of emotional distress, (4) breach of contract, (5) breach of fiduciary duty, and (6) inadequate informed consent. The complaint alleges Weisman was "severely injured by the violent process." She suffered "painful medical intervention at the end of her life in violation of her express wishes to the contrary," and will "spend the remainder of her life in a condition repugnant to her values and wishes as to how and when she wanted to die."

The complaint also focuses on the financial implications of the unwanted CPR. First, the hospital "ultimately charged" Weisman for medical services that she specifically advised "she did not want or were otherwise occasioned by [hospital's] having ignored her express wishes." Second, Weisman's "artificially prolonged death" is "saddling her Estate as well as her extended family with enormous financial costs and other burdens." Her family now spends "significant time, energy and resources," alleged to amount to "tens of thousands of dollars per month" caring for Weisman because she cannot fully

care for herself. As of February 2017, the case is in an active discovery phase, with several depositions scheduled.

Oregon

The advance treatment instructions were clear and non-ambiguous in the Stephenson (Georgia) and Weisman (Maryland) cases discussed above. Yet, clinicians in those cases administered precisely the treatment that had clearly been specifically rejected. In contrast, the advance directive in a third case from Oregon was not so clear. Consequently, it was uncertain whether the patient's agent had the necessary warrant or mandate to make the healthcare decisions that he was making on the patient's behalf.

In June 2009, 56-year-old Californian Nora Harris was diagnosed with Alzheimer's disease. She drafted an advance directive directing that she did not want nutrition and hydration in an advanced state of dementia. Harris and her husband then moved to Oregon, because it had lower healthcare costs. In 2013, Harris's husband admitted her to Fern Gardens, a memory care facility.

In 2016, Harris's husband discovered clinicians at Fern Gardens were spoon-feeding Harris, contrary to her wishes (as he understood them). He tried to have the spoon-feeding stopped, but was overruled by the Oregon ombudsman for long-term care. So, he filed a lawsuit asking the court to order Fern Gardens to stop. He argued that "there was overwhelming evidence and testimony that she wouldn't want to be spoon-fed."

On 13 July 2016, Jackson County Circuit Court Judge Patricia Crain refused to issue the injunction.[33] The judge refused to order the nursing home to stop spoon-feeding Harris because the state ombudsman's office said that not helping her eat would be a violation of state law. Importantly, Harris's advance directive addressed only artificial nutrition and hydration. The advance directive never explicitly mentioned food and fluid by mouth. Therefore, the court never reached the question of whether the facility had to honor Harris's wishes. It was simply unclear what her wishes were. She now lacked capacity to express them. And Harris's advance directive was too vague to convey whether she would want help eating in her current state.

California

A fourth case was not brought against clinicians or facilities. Yet it involves a published appellate opinion that provides helpful guidance on advance directive compliance.

In 2011, Dick Magney completed an advance healthcare directive appointing his wife, Judith, as his agent. In 2015 Magney was hospitalized with a serious heart infection. In consultation with the attending physician, Magney and his wife concluded that further treatment would not give him an acceptable quality of life. So, they pursued a palliative care treatment plan.

However, someone reported possible caretaker abuse to Humboldt County (California) Adult Protection Services. After a brief investigation, the County APS and public guardian sought to override Magney's advance directive by removing his wife as his designated agent and compelling medical treatment. The superior court granted the county's petitions. But two weeks later, the county withdrew its petition, after Magney's family presented a more complete medical picture.

The case concerns the family's entitlement to attorney's fees for having to litigate to enforce Magney's advance directive. The California Probate Code specifically provides that, in a proceeding under the Health Care Decisions Act commenced by a person other than the agent or surrogate, "the court may in its discretion award reasonable attorney's fees" to the agent or surrogate, "if the court determines that the proceeding was commenced without any reasonable cause."[34] The superior court denied these fees. But the court of appeal reversed.[35]

The court of appeal concluded that the county lacked reasonable cause to commence the proceeding because its allegations of neglect were unsubstantiated. It observed that the county made an "appallingly inadequate evidentiary showing" and even deliberately misled the trial court. Furthermore, the court concluded that the county brought the petition because it determined that further medical treatment was in Magney's best interest. The court chastised the county for losing "sight of the fact that the Health Care Decisions Law does not provide a forum to debate the wisdom of a particular individual's health care choices." Absent a showing an advance directive is invalid or terminated, its instructions are controlling.

The language in the court of appeal's opinion was so strong, the Humboldt County attorney tried to have the opinion "de-published." But in January 2017 the Supreme Court of California denied this request.[36]

5. ADMINISTRATIVE PENALTIES FOR IGNORING ADVANCE DIRECTIVES

Just as individual clinicians have duties to honor patients' treatment refusals, most healthcare facilities also have statutory and regulatory duties under U.S. state law to honor advance directives and re-

fusals of treatment. Furthermore, while state governments oversee the licensing of nursing homes, the U.S. federal government also has a significant role, because substantial Medicare and Medicaid dollars are used to cover nursing home care and services for the elderly and disabled. The U.S. Centers for Medicare and Medicaid Services contract with the states to monitor those nursing homes that want to be eligible to provide care to Medicare and Medicaid beneficiaries.

The states, usually through their health departments or departments of human services, have the responsibility for certifying a facility's compliance or noncompliance with quality and performance standards in Medicare and Medicaid regulations. Failure to comply with these duties can lead to fines and other sanctions. Three recent enforcement actions come from Connecticut, Florida, and Wisconsin.

Connecticut

In November 2015, the Connecticut Department of Public Health fined Miller Memorial Community for administering unwanted CPR.[37] Miller Memorial is a skilled nursing and rehabilitation therapy facility in Meriden, Connecticut. Its 93-year-old resident was admitted after a hospitalization for acute kidney injury. Upon admission, the resident and family members had requested a DNR order. However, employees did not enter the order into the nursing home's computerized physician ordering system. On 5 June 2015, clinicians found the resident without respiration or a heartbeat. They performed CPR and called 911. Shortly thereafter, paramedics intubated the resident and transported her to the hospital where she remained on advanced life support until she died.

Florida

The Florida Agency for Healthcare Administration imposed a $16,000 fine on Jacaranda Manor nursing home after workers resuscitated a 75-year-old resident who had a DNR order.[38] The resident suffered from nearly 20 medical conditions, including chronic airway obstruction, a kidney disorder, and dementia. After being resuscitated and transported, the resident was placed in an ICU and had chest tubes inserted in his lungs.[39]

Wisconsin

The Wisconsin Department of Health imposed a fine on Rock Haven nursing home in Janesville, Wisconsin.[40] A resident with an advance directive and DNR order was found on his bedroom floor, nonresponsive. Facility staff initiated CPR despite the resident's wishes for no CPR. They called 911, but the paramedics were unable to revive the resident.

CONCLUSION

In one famous unwanted treatment case, a court observed that "unless health care providers . . . face consequences for ignoring or failing to follow a patient's directives, the public policy favoring these directives stands to be undermined."[41] In this "Legal Briefing," I have aimed to establish that the prospect for enforcement and consequences is not as dismal as often depicted. At least when an advance directive is clear and pertinent, sanctions are more severe and more frequent than is commonly thought. This is one important starting point for changing clinicians' perceptions, and, consequently, clinicians' behavior.

NOTES

1. A. Gawande, "Overkill," *New Yorker,* 11 May 2015.

2. Campaign to End Unwanted Medical Treatment, "About Us," *http://endumt.org/about-us/.*

3. There are several exceptions to the normal requirement of informed consent. But most of these (like emergency and therapeutic privilege) are still premised on the notion that the administered treatment probably would be "wanted" by the patient. Some others (like conscience-based objection) are not.

4. T.M. Pope, "Clinicians May Not Administer Life-Sustaining Treatment without Consent: Civil, Criminal, and Disciplinary Sanctions," *Journal of Health and Biomedical Law* 9, no. 2 (2013): 213-96, 221-26; D.C. Leven, "Unwanted Medical Care and Treatment—Things You Can Do to Get Only the Care and Treatment You Want and to Which You Are Entitled," *NYSBA the Senior Lawyer* 8, no. 2 (Fall/Winter 2016): 15-21.

5. D.K. Heyland et al., "The Prevalence of Medical Error Related to End-of-Life Communication in Canadian Hospitals: Results of a Multicentre Observational Study," *BMJ Quality and Safety* 25, no. 9 (2016): 671-9; F.J. Freyer, "When You Die, Will Your Wishes Be Known?" *Boston Globe,* 12 May 2016.

6. S. Perry and C. Lawand, "A Snapshot of Advance Directives in Long-Term Care: How Often Is 'Do Not' Done?" *Healthcare Quarterly* 19, no. 4 (2017): 10-2.

7. Pope, "Clinicians May Not Administer Life-Sustaining Treatment without Consent," see note 4 above, pp. 248-59.

8. Ibid., 260-96.

9. R.S. Martin et al., "The Effects of Advance Care Planning Interventions on Nursing Home Residents: A Systematic Review," *Journal of the American Medical Directors Association* 17, no. 4 (2016): 284-93; C.M. Burkle et

al., "Physician Perspectives and Compliance with Patient Advance Directives: The Role External Factors Play on Physician Decision Making," *BMC Medical Ethics* 13, no. 31 (2012).

10. Institute of Medicine, *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life* (Washington, D.C.: National Academy Press, 2015), 133.

11. Ibid.

12. Ibid., 323.

13. Negative value treatment entails risk and harm with no corresponding medical benefit. This is often the result of intentional fraud for profit, for example, administering chemotherapy when the patient does not even have cancer. U.S. Department of Justice, "Detroit Area Doctor Sentenced to 45 Years in Prison for Providing Medically Unnecessary Chemotherapy to Patients," 10 July 2015, *https://www.justice.gov/opa/pr/detroit-area-doctor-sentenced-45-years-prison-providing-medically-unnecessary-chemotherapy.*

14. E.g., H.G. Prigerson et al., "Chemotherapy Use, Performance Status, and Quality of Life at the End of Life," *JAMA Oncology* 1, no. 6 (2015): 778-84.

15. E.g. *Medical Board of Australia v. Siow* [2016] SAHPT 1.

16. T.M. Pope, "Certified Patient Decision Aids: Solving Persistent Problems with Informed Consent Law," *Journal of Law, Medicine and Ethics* 45, no. 1 (forthcoming 2017); T.M. Pope, "Controlling the Misuse of CPR through POLST and Certified Patient Decision Aids," *American Journal of Bioethics* 17, no. 2 (2017): 35-7.

17. C.R. Bruce et al., "Navigating Ethical Conflicts Between Advance Directives and Surrogate Decision-Makers' Interpretations of Patient Wishes," *Chest* 149, no. 2 (2016): 562-7; E.K. Vig et al., "Responding to Surrogate Requests that Seem Inconsistent with a Patient's Living Will," *Pain and Symptom Management* 42, no. 5 (2011): 777-82.

18. See Pope, "Clinicians May Not Administer Life-Sustaining Treatment without Consent," note 4 above.

19. *N.Y. A.B.* 4274 (2017) (Gottfried).

20. Surrogates cannot update or amend a patient's advance directive. But when an advance directive is unclear or not clearly applicable to the present circumstances, the surrogate has discretion to interpret it.

21. *N.Y. Pub. Health L.* § 2994-f.

22. *N.Y. A.B.* 4019 (2017) (Pretlow).

23. G. Bosslet, M. Baker, and T.M. Pope, "Reason-Giving and Medical Futility: Contrasting Legal and Social Discourse in the United States with the United Kingdom and Ontario, Canada," *Chest* 150, no. 3 (2016): 714-21.

24. *Doctors Hospital of Augusta v. Alicea,* 788 S.E.2d 392, 299 Ga. 315 (2016).

25. Clinicians have a duty to check the chart for consent just as they have a duty to check the chart for contraindications to medications. E.g. *Parsons v. Northwestern Memorial Hospital and Northwestern Hospital Faculty Foundation,* 27 *Nat. J.V.R.A.* 5:C4, 2011 WL 10550300 (Cook County Judicial Circuit, Illinois 6 July 2011) ($5 million jury verdict).

26. *Ga. Code Ann.* § 31-32-10.

27. *Doctors Hospital of Augusta v. Alicea,* 774 S.E.2d 114, 332 Ga. App. 529 (2015).

28. G.S. Chung et al., "U.S. Physicians' Opinions on Differences Between Withholding and Withdrawing Life-sustaining Treatment," *Journal of Religion and Health* 55, no. 5 (2016): 1596-606; M. Solomon et al., "Decisions Near the End of Life: Professional Views on Life-sustaining Treatment," *American Journal of Public Health* 83, no. 1 (1993): 14-23.

29. *Alicea v. Doctors Hospital of Augusta,* No. 2013-RCCV-00275 (Richmond County Superior Court, Georgia 13 February 2017) (offer of settlement).

30. *Weisman v. Maryland General,* No. 24-C-16-004199 (Baltimore County Circuit Court, Maryland 25 July 2016) (complaint).

31. "Maryland MOLST," *http://marylandmolst.org/index.html.*

32. *Code of Maryland Regulations* § 10.01.21.04.

33. *In re Harris,* No. 13-017-G6 (Jackson County Circuit Court, Oregon 13 July 2016) (order).

34. *Cal. Probate Code* § 4771.

35. *Humboldt County Adult Protective Services v. Superior Court,* 4 Cal. App. 5th 548, 208 *Cal. Rptr.* 3d 666 (2016).

36. *Humboldt County v. Superior Court,* No. S239048 (Cal. 25 Jan. 2017).

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