

# Legal Considerations for Palliative Care in Surgical Practice

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The current series on palliative care has discussed clinical and ethical considerations of the importance of relieving pain, managing other symptoms, and communicating with patient and family about end-of-life care decisions. Surgeons, however, often approach palliative care with more trepidation and uncertainty than necessary about the legal boundaries of end-of-life care. They are unsure about their own rights and obligations, or those of the patient and the (possibly conflicting) family. They may have worries about communicating with the wrong family member on end-of-life decisions. Aggressive pain management may be perceived as “intent to kill.” Surgeons may refrain from prescribing adequate analgesia, experiencing a conflict between a moral imperative to relieve suffering, and a sense of legal vulnerability from fear of hastening a patient’s death.

It is quite possible that ambiguity about legal consequences poses a significant barrier to optimal palliative care of surgical patients. The risks actually are few and the basic legal principles are fully consistent with medical ethics. The AMA’s ethical standards provide that “Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death.”<sup>1</sup>

The purpose of the following discussion is to elucidate the legal principles that apply to surgeons who wish to practice palliative care. In end-of-life clinical situations, who decides when the patient is unable? What are the legal risks of overtreating pain in the dying patient? And what are the potential liabilities of neglecting to treat pain at all?

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## CAPACITY AND SURROGACY: WHO CALLS THE SHOTS FOR THE PATIENT?

### Is the patient competent?

My mother is simply incompetent to tell you she doesn’t want this surgery. You know that if she doesn’t have it she will die soon. She is demented and can’t even take care of herself.

A competent patient has a constitutional right to refuse medical care in all but the most circumscribed matters. (Some states limit the ability of a pregnant woman to refuse medical care that would endanger the life of the unborn child.) The Uniform Health Care Decisions Act (“Uniform Act”) § I(3) defines capacity as “an individual’s ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health-care decision.”<sup>2</sup> Who decides whether the patient is competent? All states give the attending physician the right and the responsibility to determine whether the patient has capacity. This is both a legal and ethical obligation that the physician owes to the patient. The physician’s decision may be informed by ethics committee consultation, psychiatric consultation, sensitive observation of the patient, and discussions with the family.

Capacity is a sliding scale. A patient may have ample mental capacity to choose basic treatment alternatives even if unable to understand the complexity of more abstract issues. The question is whether the patient has the ability to understand her choices of the moment and to be reasonably consistent in reflecting her preferences. A person who is not fully able to understand all the risks and potential outcomes of surgery or a complex illness may well be competent to decide that she wants no more aggressive care, or that she wants “everything done.” A person does not have to be able to speak; a documented nod of the head will do. It is also important to keep in mind that capacity may vary from day to day and a person who once has appeared to lack capacity may well recover it as she improves. Administration of opioid analgesic or anxiolytic does not affect the patient’s compe-

tency as long as the above criteria are satisfied. In fact, it may be argued that opioid analgesia administered to a patient in severe pain will improve her capacity for medical decision making, vis-à-vis a patient who remains untreated.

### Who decides for the incompetent patient?

Mom was Dad's health-care power of attorney and he never got around to choosing one of us kids. The advance directive sought aggressive care because he wanted to be there for Mom. But that was before Mom died and he became so confused and lonely. I can't believe he would want to remain intubated now.

### Advance directives (living wills)

State legislatures created advance directives because of the inability of the common law to deal with self-determination in the interval between incapacity and death. They are not effective until the patient lacks capacity, and they most commonly come into play only if a patient is terminally ill.<sup>3</sup> It is up to the attending physician, often with concurrence of another physician, to determine that the patient is in the condition that triggers any advance directive requirement.<sup>4</sup> Although advance directives are based on the Uniform Health Care Decisions Act and are virtually identical in major concepts and rights, they vary somewhat from state to state, and a physician must know her own state's rules. Out-of-state advance directives are honored everywhere whether or not they conform to the law in the state in which the patient is located, unless they obligate a health-care provider to take an action that would be illegal in the state in which he must take action. This is a rare occurrence.

Every state has a form for an advance directive, but use of the form is not mandatory; there are no magic words. The critical requirements are that the patient must be competent when he signs and that it is witnessed as required by state law. Hospitals funded by Medicare/Medicaid must offer an advance directive form to every patient at admission. They rarely, however, follow through with assistance or advice. Studies have shown that even with active intervention, patients avoid signing a directive.<sup>5-7</sup>

The most effective intervention occurs when the attending physician recommends an advance directive.<sup>8,9</sup> This does not require a physician to frighten a patient. He may state, for example, "We have to provide these

forms, but too many patients ignore them. I think it's important to have the form and it's easier to do it now when you aren't actually up against those decisions." Bear in mind that the advance directive serves the physician when important decisions must be made and there is no surrogate in sight. It also reduces the stress in families who have to make end-of-life decisions.<sup>10</sup> All states provide immunity for physicians who withdraw support and move to palliative care under the terms of an advance directive.<sup>11</sup> They also are determinative when relatives may not be able to agree on a decision. Advance directives allow a patient to direct for herself the full range of treatment options from "comfort care only" to "I want everything done." This does not require a physician to act in the face of medical futility, but would strongly confirm that any futility decision should be made with careful consultation only. State forms tend to be quite specific, with checkboxes for particular decisions, but they also provide space for more general statements of desires or further explanation.

An advance directive can be revoked by the patient orally, or by signing a different advance directive. It is important to understand that state laws expressly provide that the patient does not have to be competent to revoke. This appears counterintuitive in light of the insistence on formalities of signing the original advance directive, but it accurately reflects the overall goal of respecting patient autonomy at the end of life. An oral revocation must be communicated directly to a health-care provider in some states. In most, however, the decision can be received through a lay person and then communicated to the health-care provider. The provider then has a legal obligation to reflect the change in the patient's records. The change is not legally binding with a healthcare provider who is not aware of it until the records are updated.

### Health-care power of attorney

Health-care power of attorney is a simple and direct instrument that allows a physician to rely on the decisions of the surrogate decision maker when the patient lacks capacity. In most states, the surrogate has all the powers a competent patient would have to authorize or refuse care. In a few states, a surrogate may not direct that artificial feeding and hydration be discontinued unless the patient has included such a decision in an advance directive or has left other "clear and convincing"

evidence of his or her desires and the patient is terminally ill or in a persistent vegetative state.<sup>12,13</sup>

Unlike advance directives, the power of attorney is operative whether or not the incapacitated patient is terminally ill. This instrument should be of great interest to the surgeon, whose patients are certain to be unconscious for at least part of their care. Power of attorney has the advantage that its creation does not require a person to contemplate the details of his or her own terminal illness. For surgeons who perform procedures with high risk for critical illness or complications, it is in their self-interest to take an active role in advising all patients to execute a power of attorney before initiating their surgical care. But surgeons should not “require” execution of power of attorney (or advance directive) as a precondition of initiating treatment. That is a violation of federal and most state laws.<sup>14</sup>

Powers of attorney may be revoked orally or in writing under the same conditions that apply to advance directives under state law. In many states the health-care power of attorney comes packaged on the state form along with the advance directive; in other states these are separate documents. As with advance directives, they do not have to have any specific format as long as they are signed when the patient is competent and according to the state’s required formalities.

When a patient has both a health-care power of attorney and an advance directive, the directive overrides the surrogate’s ability to make decisions contrary to the directive. The legal role of the surrogate, whether or not the patient has an advance directive, is to act according to the patient’s wishes, if known, and otherwise “in the best interests of the patient.” This language appears in all surrogate decision-making statutes. The only route available to someone who believes that the surrogate is not acting within the patient’s best interests is to appeal to the Probate Court for a new surrogate or a directed decision. So in the case of the above quotation, the father’s advance directive will be operative, subject to concepts of medical futility or a court order. If the above surrogate is correct in assuming that the father’s wish has changed, then the example is a good argument for updating directives when life circumstances change. But the legal principle recognizes that the father’s wish may not have changed at all unless explicitly stated otherwise, and it protects his wish over the surrogate’s presumption.

It is important for surgeons to recognize that failure to honor valid DNR orders, advance directives, or the valid

instruction of a power of attorney constitutes battery. In *Leach v. Shapiro*,<sup>15</sup> for example, an Ohio Court of Appeals found that there had been harmful contact when a woman in a chronic vegetative state was placed on life support without her consent. A Michigan jury awarded surviving family members approximately \$16 million for mental anguish and past and future expenses for medical care after life-sustaining procedures were performed in direct violation of a surrogate’s instructions pursuant to a durable power of attorney for health-care. A limited number of state statutes go further to create a specific cause of action when a practitioner fails to honor an advance directive or a living will.<sup>16</sup> There is also good authority for payment denial when a procedure or treatment exceeds the physician’s authority.<sup>17</sup>

#### **No advance directive, no designated surrogate**

Despite the best efforts of the health-care community, most patients have neither advance directives nor a power of attorney. In these cases, surrogate decision-making power falls to relatives, and in some states, to close friends.<sup>18</sup> State law provides the order in which the relatives have the right to act. Spouse, followed by adult children, then parents, followed by siblings, and then siblings’ children is most common. Some states provide for a means to resolve intraclass disputes, either by majority rule or devolution of the choice to the next class. Surgeons should be aware of their own state’s rule. In practice, health-care providers seldom “skip” a class of adult children and will go to great lengths to help the class reach consensus for the treatment needed. Patient advocates, social workers, and the hospital’s ethics committee can be helpful in this process. When a single member of the surrogate class is available, other members of the class may delegate the power to him or her.

In cases when the surrogate is not obvious, as it would be with a patient’s spouse, how does a surgeon identify the members of the next surrogate class? Physicians are required to make reasonable inquiries but do not need to go to outlandish lengths. What is “reasonable” will depend somewhat on how emergent the situation is. In life-or-death “right now” emergency situations, the emergency room and other physicians are bound by advance directives and DNR orders that they know about either directly or from records available to them. In less dramatic situations, the usual definition of *reasonable* will require health-care providers to ask about other class members, but they are legally entitled to rely on what a

relative who is available tells them, unless they have actual knowledge to the contrary. Any such information should be very clearly documented before embarking on decision making with a next-class surrogate.

### **ALLEVIATING PAIN AND HASTENING DEATH: WHAT ARE THE RISKS?**

It is not always possible to palliate all symptoms of a terminal condition. It is very possible to alleviate most pain and to dramatically reduce other symptoms. Physician education on these topics is readily available.<sup>19,20</sup> To the extent that the patient or surrogate desires or requires it, there is the option of palliative sedation with an intent to alleviate patient suffering, even at the risk of hastening death. Based on the principles of double-effect and beneficence, the use of large doses of analgesics or anxiolytics do not incur medical or criminal liability if the intent for palliation is clinically indicated and clearly documented.

The Supreme Court has determined that palliative sedation is a fully acceptable medical act if no other means are available to relieve pain or other symptoms. The Supreme Court has also made it clear that there is no constitutional right to physician-assisted suicide, at least under circumstances where palliative measures are available without restriction. In so doing, the Court drew a clear line between euthanasia, which is illegal in every US jurisdiction, and physician-assisted suicide, which is available as a matter of state law in Oregon only. Importantly, it distinguished both acts from palliative sedation, which it emphasized is both legal and ethical.<sup>21,22</sup> All states that criminalize physician-assisted suicide have a clear immunity for physicians who intend to provide palliative care even though the care may hasten death.

Some states go further still. California has a “Pain Patient’s Bill of Rights” that entitles patients to pain management and requires physicians who are unwilling to provide it to refer the patient to one who will.<sup>23</sup> The same state also has recently required physicians to obtain continuing medical education in palliative care and pain management as a precondition to license renewal. Florida requires all physicians to discuss pain management and plan of care with the patient at the time of diagnosis and requires that pain be treated.<sup>24</sup>

Consistent with these developments, it is highly unlikely that a physician who intends palliative care after obtaining informed consent will be at risk either from

the medical board, malpractice, or criminal liability for aggressive pain management. Physicians’ fears along this line are exceedingly exaggerated. Between 1980 and the present, physicians have rarely been charged with a felony relating to efforts to provide palliative care at end of life.<sup>25,26</sup> More importantly, such cases will become even rarer because adequate palliation, including pain management, has become the standard of care and there is also better understanding that respiratory depression caused by opioids is much more unusual than previously believed.<sup>27</sup>

### **AN INCREASING RISK OF LIABILITY FOR FAILING TO PROVIDE PALLIATIVE CARE**

In the 1950s there was a reluctance to use opioids for pain management or control of dyspnea for even the dying cancer patient. The landscape has changed drastically since then, because clinical experience and studies have demonstrated the value of pain management on quality of life for those with serious painful diseases. Additional studies also have suggested the negative effects of pain on longevity and functional status of the patient. Perhaps equally important, it has been demonstrated that the great taboos—“she’ll die an addict” and “morphine will kill her”—are not grounded in fact. The role of opioids in the arsenal of physicians who treat the terminally ill (and for those who treat severe chronic pain) is clinically well established.

Nonetheless, health-care providers across all specialties still refrain from providing the greatest possible pain relief for their patients. The reasons for continued rationing of opioid analgesia include poor education for health-care providers in pain management, ungrounded fear of adverse license consequences or civil liability, and reluctance to embrace palliative care as a major goal for the patient.

The gap between clinical understanding and daily practice in many hospitals has given rise to the new Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards for pain assessment and treatment.<sup>28</sup> There also have been many other standards and guidelines for the management of pain in selected patient populations and elaborate on-line and in-person training programs to inform physicians about end-of-life-care.<sup>29,30</sup>

With this evolution in the standard of care has come the very real potential for civil liability for failing to provide pain management. Among the available causes

of action for the patient are medical malpractice, infliction of emotional distress (negligent and intentional), abandonment, and elder abuse.

### Medical malpractice

Malpractice is professional negligence with four elements: (1) a duty to the patient, (2) a breach of that duty by providing care that is less than the community standard, (3) damages to the patient, which is (4) proximately caused by the breach.<sup>31</sup> With the new clinical standards, JCAHO guidelines, and clear ethical mandates, palliative care is clearly a duty of health-care providers, both individual and institutional. The same factors make it quite possible to establish a breach in the standard of care.

Damages are the most problematic part of the potential malpractice suit. Pain and suffering are historically outcomes of some other act of medical malpractice. In palliative care cases, it is the injury complained of. But courts have held that a plaintiff may maintain a negligence action by claiming only emotional distress damages if avoidance of emotional distress to the plaintiff is within the scope of the defendant's duty of care.<sup>32</sup> Moreover, pain itself is regarded as a physical injury in some cases.

### Infliction of severe emotional distress

The law recognizes two different kinds of infliction of emotional distress: negligent and intentional. Either could apply to a patient or to the family of a patient who experiences relievable pain. This is not to say, of course, that every stab of pain invokes a law suit—far from it. Where the line lies will have to be delineated as described below.

Intentional infliction of emotional distress has four elements: (1) The defendant must act intentionally or recklessly, (2) the conduct must be extreme or outrageous, (3) the conduct must be the cause of the emotional distress, and (4) the distress must be severe.<sup>33</sup> The severity of the distress must usually be proved by expert testimony. But it is quite possible to make a prima facie case for severity in the case of a person who dies in unnecessary pain just by the lay person's appreciation of the intense suffering such a situation would cause and by testimony concerning the patient's actions or complaints that evidenced pain. It would almost certainly be essential to provide expert testimony to show that the failure

to treat was outside the standard of care, as with malpractice.

Intentional infliction opens the field of plaintiffs to family members who witness the patient's suffering, whether or not that observer suffers bodily harm and to any other person who is present if bodily harm is proved.<sup>34</sup> It does not extend to those who hear about the pain from others, no matter how severely they may be affected.

Negligent infliction of emotional distress occurs when a person acts negligently, but severe emotional distress is a foreseeable outcome of the negligence involved. The cause of action usually requires expert testimony of the impact of the event on the plaintiff in terms of bodily harm. Bodily harm includes "sleeplessness, anxiety, and other emotional trauma if they are sufficiently strong to require care."<sup>35</sup> An example is *Lynch v. Bryant*, in which the Sixth Circuit affirmed a jury award on the basis of negligence and infliction of emotional distress when a woman's severely injured husband was left without any pain medication. The event occurred during a time when he had been discharged from a hospital but remained on the hospital premises while awaiting substantially delayed (more than 12 hours) helicopter transport to another hospital. It was proved that the attending physician passed through the transport area and was aware that the patient remained on the premises suffering from complex orthopaedic injuries incurred in an accident, but failed to treat his pain.<sup>36</sup>

### Failure to treat pain can constitute abandonment

Once a physician takes on the care of a patient, he or she has a duty to provide necessary care (or provide for it by referral) until the doctor-patient relationship is formally terminated. (Termination is covered by medical board rules or statute and usually requires a formal written notice and continuation of care until the patient has had a reasonable—sometimes defined in terms of 30 days—opportunity to obtain care elsewhere.) When a doctor agrees to treat a patient, that doctor has a duty to give the patient all necessary attention for as long as the patient needs it.<sup>37</sup> A physician who leaves a patient at a critical stage of treatment, without giving the patient adequate notice and time to choose another caregiver, has abandoned the patient.<sup>38</sup> Abandonment of a patient by his physician is a tort,<sup>39</sup> and a physician who does it is liable for damages. He or she may also have exhibited unprofessional conduct for the purposes of medical board li-

censing. In fact, the Oregon Medical Board penalized a physician for permitting a patient to die in severe pain despite repeated family pleas for pain relief.<sup>40</sup>

To prove abandonment, the patient must show four elements: (1) an established physician-patient relationship,<sup>41</sup> (2) that the physician terminated or neglected (3) without sufficient notice to allow the patient to choose another physician, and (4) the patient must have been injured as a result.<sup>42</sup>

Abandonment is a well-established cause of action. For example, an obstetrician who promised a patient that he would use anesthesia during delivery was away on a fishing trip when she went into labor. He had not relayed his promise to his substitute and anesthetic was not given by his partner physician. The court found that as long as the patient had not been given adequate notice, she had been abandoned, and the lack of help managing her pain during delivery was an injury.<sup>43</sup> The case of *Lynch v. Bryant*, discussed above in the context of severe emotional distress, is also an abandonment case and any of the cases discussed in the context of elder abuse below could have also been brought under an abandonment theory.

#### **Failure to provide palliative care may be elder abuse**

Older Americans are disproportionately represented in the sick and dying and receive less pain care than younger patients.<sup>44</sup> Demented elderly patients receive less pain care than their more competent contemporaries.<sup>45</sup>

Federal law requires every state to provide protection from abuse for the elderly. Combining these facts with the JCAHO pain standards applicable to hospitals and nursing homes and the American Geriatric Society's guidelines for the management of pain in the elderly,<sup>46</sup> failure to manage an elderly or incapacitated person's pain has been labeled elder abuse.

In June 2000, a California jury awarded \$1.5 million to the family of an elderly man with metastatic lung and bone cancer.<sup>47</sup> He was prescribed intravenous meperidine 25–50 mg as needed while he was hospitalized. Hospital records showed that throughout the hospitalization his pain was rated between 7 and 10 on an assessment scale and at some point during every day, he rated his pain as 10. On discharge, although his pain was still rated a 10, he was prescribed oral acetaminophen/hydrocodone, which he could not swallow, supple-

mented later with a low dose of transdermal fentanyl and a meperidine injection. His doctor refused to prescribe anything stronger despite requests from the patient and the family. After several days another doctor prescribed higher doses of morphine, which brought immediate relief. The jury was not convinced by the physician's defense that the patient had refused definitive diagnosis of terminal lung cancer and that he had not believed by his clinical assessment that the patient was in severe pain.

This case is significant because it directly addresses the issue of pain, and also because the California elder abuse statute<sup>48</sup> requires proof (by a preponderance of the evidence) of "reckless and malicious" behavior to find liability. Many states' elder abuse statutes set a less stringent standard. In addition, in a number of states, the elder abuse statute allows the plaintiff to recover punitive and compensatory damages and allows the cause of action to survive the patient's death.<sup>49</sup> This case has had wide attention among patient advocates and has inspired additional litigation.

Not all states, however, provide a private right of action for elder abuse. In states that do not, the agency implementing the elder abuse statute must take action. This is a far more cumbersome process and in those states it may well be that the patient and family rely on negligence, abandonment, and infliction of emotional distress as cause for legal action.

In conclusion, we have entered into a period in which surgeons should have little fear about providing aggressive palliative care. Encouraging patients to execute advance directives and powers of attorney is very much in their interest as well as their patients'. Current legal structures support the idea that aggressive pain management stands on firm legal ground. Surgeons should have little fear of civil or criminal liability for palliative treatment of pain at the end of life. On the other hand, neglecting to treat pain, particularly the pain of dying or elderly patients, will increasingly become an arena of potential legal liability. Surgeons want to do their best for their patients, and patients will increasingly demand that pain management be addressed at all stages of severe disease, but most assuredly at the end of life.

It is incumbent on surgeons to learn the basics of palliative care and its legal ramifications. The fundamental principles are simply that one must offer choices and act based on the informed consent of the competent patient or surrogate. Comfort care must be provided to relieve pain and other symptoms of severe suffering. And

all decisions must be sufficiently documented that a reviewer will understand the surgeon's palliative treatment intent and recommendations, see the basic treatment plan, and know that the patient or surrogate had enough information on which to base the decision. There are ample legal precedents to support, even "protect" the surgeons who choose to provide intensive palliative care to their patients.

## Appendix

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4. Knight et al v. Beverly Health Care Bay Manor Health Care Center (AL 2001). This case upholds implementation of living will on the basis of physician determination that the patient was in a vegetative state. The case also applies the general rule that if such decisions are contested, they must be resolved by "clear and convincing evidence," which is a higher standard than usually applied in civil law.
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  41. *Heraud v. Weissman*, 714 N.Y.S.2d 476 (N.Y. App. Div. 1<sup>st</sup> Dept., 2000).
  42. *Manno v. MacIntosh*, 519 N.W.2d 815, 1994.
  43. *Miller v. Dore*, 154 Me. 363, 148 A.2d 692 (1959).
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  47. *Bergman v. Eden Medical Center*, No. H-205732, 2000 WL 519345 (Cal. Supl. Ct. Alameda City).
  48. Cal. Welfare & Institutions Code § 15600 et seq.
  49. See, eg, *Ten. St. § 71-6-120* (2000) (punitive damages applicable if the defendant is a physician or other health care provider or institution).