Legal Foundation for Crisis Clinical DNR Orders

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During a catastrophic pandemic, clinicians should not attempt resuscitation when these efforts will not prevent imminent death, will divert scarce resources that could save other lives, and will expose the code team to unnecessary infection risks. Pandemics can cause varying degrees of strain on healthcare resources. Catastrophic pandemics might require the enactment of "crisis standards of care." Some states have enacted regulations to recognize such crisis standards of care and protect clinicians from liability during the pandemic,[1] but these do not create effective legal grounds for writing orders to avoid medically ineffective resuscitation over patient or surrogate objection — what we will call "clinical DNR orders." Some states have statutes that protect clinicians who refuse to provide medically ineffective treatment during conventional care — including writing clinical DNR orders — but patient or surrogate objections trigger significant procedural requirements that are unfeasible during a crisis.

Explicit legal foundation for crisis clinical DNR orders is necessary to promote consistent medical practice, prioritize resource stewardship to save lives, and protect healthcare workers. During the COVID-19 pandemic, hospital systems are taking different approaches to crisis clinical DNR orders, creating disparate care across institutions. Hospitals are facing significant resource shortages including trained staff. Objections to clinician-initiated DNR orders are not common, but they are happening during the pandemic and are consequential for crisis resource allocation. Current evidence suggests that only 12% of COVID-19 related in-hospital cardiac arrest patients survive to discharge,[2] and staff are exposed to a greater risk of COVID-19 infection during resuscitation. By creating processes to ensure resuscitation is only performed when indicated and potentially life-saving, we help protect healthcare workers from unnecessary risk, reduce moral distress caused by providing medically ineffective care, and help save additional lives.

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Many states have laws protecting clinicians who forgo ineffective care during non-disaster scenarios.[3] These laws contain significant procedural requirements that help ensure consistent and fair care during conventional standards, but the safeguards are not reconcilable with optimizing crisis care. States without medical ineffectiveness laws have no clear legal grounds for clinical DNR orders, even with pandemic emergency regulations designed to protect clinicians. This leads to variable national practice, which is indefensible during crisis standards of care.

If a patient or surrogate disagrees with a clinical decision to forgo ineffective care, conventional safeguards in medical ineffectiveness laws require (1) ethics committee review; (2) facilitating patient transfer to a facility that would provide the treatment; and (3) continued care for the patient until a transfer is possible, determined impossible, or a specific time window elapses.[4] For DNR orders, this requires providing resuscitation until ethics committee review and transfer consideration are complete, despite a clinical determination that resuscitation would be ineffective. These conventional safeguards are untenable during any pandemic when hospitals are operating under crisis standards. Unless pandemic emergency regulations explicitly supersede, clinicians and institutions could be liable for not following these legal requirements.

Some states have promulgated pandemic immunities for clinicians, but it is unclear whether these immunities override existing rights and processes for DNRs in laws governing advance directives and surrogate decision-making. For example, Ohio now protects healthcare providers from liability for care during an emergency including injury or death arising from withholding treatment,[5] but still technically require transfer if the surrogate decision-maker objects to a withhold decision.[6] Other states like New York are largely silent on medical ineffectiveness, and New York COVID-19 pandemic immunities for clinicians are only afforded to those acting under applicable law or pursuant to an emergency rule.[7] Accordingly, clinicians who write DNR orders over patient or family objection might find themselves subject to malpractice claims and referrals to a disciplinary board. All states should implement legal protection for clinical DNR orders during crisis standards of care with practical procedural requirements to ensure patient and family involvement, fairness, and consistency.

Legal protection for clinical DNR orders must not exacerbate pervasive structural inequities that have caused

communities of color and disability to be disproportionately affected by the pandemic. Procedural safeguards must account for implicit biases that persist in healthcare delivery and for distrust in medicine among marginalized groups that leads to DNR order challenges. But these safeguards must also help reduce medically ineffective resuscitation efforts during crisis standards of care.

To justify clinical DNR orders during the pandemic, the definition of medical ineffectiveness must leave no room for disparate treatment or quality of life judgments. For present purposes, medically ineffective CPR should be defined physiologically in terms of imminent death; CPR that would be unable to restore cardiac or respiratory function or will lead to repeated arrest in a short time before death occurs. This definition should enable institutions to define the relevant medical criteria with input from diverse clinical stakeholders, and these criteria must adapt to the best available evidence regarding survival after arrest. If outcome predictions suggest death might not be imminent despite CPR, DNR decisions should remain subject to patient advance directives and shared decision-making processes.

Even when clinical DNR orders are considered during crisis standards, goals of care conversations should start on admission and involve the patient, appropriate patient-designated stakeholders, and the primary team. Palliative care should help facilitate communication and support when a clinical DNR order is being considered. Procedurally, we propose a clinical DNR order receive concurrence from a second physician before being submitted to the triage committee. Such committees, ideally with ethics and legal expertise, are designed to support triage decisions and have received support for implementation during crisis standards of care.[8] Swiftly reviewing clinical DNR decisions should pose minimal additional burden and should seamlessly integrate into the triage committee's existing workflow of continuous resource allocation.

If approved, the primary service would be responsible for communicating a clinical DNR decision to the patient or their family members. If the patient/surrogate continues to object, the disagreement should be documented in the patient's chart. If the primary team feels conflicted asking for a clinical DNR, the facility chief medical officer or a designee not on the triage committee can make the request. Clinical DNR orders during the pandemic should be subject to post-audit by the facility's chief medical officer and by the institution's ethics committee.

Although clinicians can always make bedside assessments for when resuscitation is not appropriate, delaying a decision about code status until the moment of arrest might lead to a medically ineffective resuscitation attempt, especially during crisis care, subjecting an imminently dying patient to ineffective treatment, and posing unnecessary risk and distress to staff. When resource limitations subside and crisis standards are no longer utilized, clinicians must engage with patients and their families as they would during conventional standards, including meeting all requirements specified in existing medical ineffectiveness laws.

Crisis standards necessitate a shift in care from focusing on individual patient values and well-being to public health. Clinical DNR orders must support this shift, but they must also remain transparent and patient-centered, involving the patient/surrogate early and continuously. Legal protection for such orders recognizes the moral mandate to allocate resources effectively and protect clinicians from unjustifiable infection risk. These decisions must be limited to imminently dying patients and subject to oversight that will ensure consistency and fairness. Public health ethics demand consistent state policies to guide effective and fair resuscitation assessment during crisis standards of care.

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REFERENCES

1. **Koch VG**. Crisis Standards of Care and State Liability Shields. San Diego Law Review, Forthcoming. Published online June 27, 2020. Accessed December 2, 2020. https://papers.ssrn.com/abstract=3636918.
2. **Hayek SS, Brenner SK, Azam TU, et al.** In-hospital cardiac arrest in critically ill patients with covid-19: multicenter cohort study. BMJ. 2020;371:m3513.
3. Wyoming Health Care Decisions Act, Section 35-22-401 et seq. 2005; New Mexico Uniform Health Care Decisions, Section 24-7A-1 et seq. 1995; New Hampshire Written Directives for Medical Decision Making for Adults Without Capacity to Make Health Care Decisions, Section 137-J:1 et seq. 2006; Maine Uniform Health Care Decisions Act, Section 5-801 et seq. 2017; Idaho Medical Consent and Natural Death Act, Section 39-4501 et seq. 2005; Delaware Health-Care Decisions, Section 2501 et seq. 1995; Connecticut Removal of Life Support Systems and Medical Orders for Life-Sustaining Treatment, Section 19a-570 et seq. 1985; Arkansas Rights of the Terminally Ill or Permanently Unconscious Act, Section 20-17-201 et seq. 1987; Alaska Health Care Decisions Act, Section 13.52.010 et seq. 2004.
4. California Probate Code, Section 4735. Uniform Health Care Decisions Act. Vol 4.7. 1999; Texas Health and Safety Code, Section 166.046. Procedure If Not Effectuating a Directive or Treatment Decision. 2015.
5. **Grendell D.** (Ohio) Grant Immunity to Essential Workers Who Transmit COVID-19, Bill 606; 2020.
6. Ohio Uniform Commercial Code, section 1337.16. Duties of Healthcare Providers. 1998.
7. New York Public Health Law, section 3080. Emergency Disaster Treatment Protection Act. 2020.
8. **Chuang, Elizabeth, Pablo A. Cuartas, Tia Powell, and Michelle Ng Gong**. "We're not ready, but i don't think you're ever ready." Clinician perspectives on implementation of crisis standards of care. AJOB Empir Bioethics 2020;11(3):148-159.

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