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LEGAL MEDICINE

Legal Medicine Issues in the Aging – Part Two

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Part 1 presented an overview of elder law, physicians' fiduciary duties, capacity and competence, guardian, conservator, powers of attorney, informed consent and refusal, and the older driver. Part 2 comprises legal medicine issues at the End-Of-Life issues: Advance planning and directives, Pain Management, End-stage heart failure, Ventilator support, Hydration and nutrition, Palliative team care, DNR, POLST, CPR, Long-term care facilities, and Professional liability post-Covid-19 pandemic.

ADVANCE CARE PLANNING AND DIRECTIVES

Advance care planning helps patients prepare for current and future decisions about their medical treatment and place of care. In a systematic review of 150 peer-reviewed studies conducted in the United States and published from 2011 to 2016 (totaling 795,909 people), 37 percent of persons had completed an advance directive. Completion rates were higher for older Americans.

In 2014, Silveira and co-authors reported that 6,122 participants, who had died between 2000 and 2010 and were aged 60 and older at death, had a significant increase in advance directive rates of completion, from 47% in 2000 to 72% in 2010. Of note, the proportion who had died in the hospital decreased from 45% to 35%.

In 2007, Teno *et al* examined the role of advance directives 10 years after the Patient Self-Determination Act. Of 1,587 people who had died,

- 70.8% had advance directives.
- Persons who died at home with hospice or in a nursing home were more likely to have an advance directive.
- And those with advance directives were less likely to have a feeding tube (17% vs 27%) or *be placed on* ~~use~~ a respirator in the last month of life (11.8% vs 22.0%).

Advance Directives have been crucial during the Covid-19 pandemic. According to the Center for Disease Control and Prevention, the risk of getting severely ill from COVID-19 generally increases as one gets older. COVID-19-related deaths reported in the United States have been significantly higher among adults aged 65 years and older**.** The COVID pandemic has* heightened vulnerabilities and concerns pertaining to long-term care facilities (LTCFs), as noted below.

FAILURE TO COMPLY WITH PATIENT'S ADVANCE DIRECTIVE

It is medically unethical and legally unprofessional to disregard the patient's express wishes. The role of the medical professional is to fully inform, advise and recommend a medical course of action but *not* interfere, either intentionally or negligently, with an individual's right to accept or refuse medical treatment. Health care professionals should be particularly mindful of:

- Withholding or withdrawing life support;
- Providing unwanted life-prolonging treatment;
- Patient-requested but not provided life-sustaining treatment;
- Inadequately advising the patient about end-of-life issues;
- Improperly obtaining consent for an organ donation; and
- Insufficiently worded advance directives, if obtained by the medical facility.

When a medical provider fails to comply with a patient's advanced directive by providing unwanted treatment, the patient, or representative, may bring a civil action for damages under a variety of theories of recovery, including intentional assault and battery, medical negligence or wrongful life. The following are three examples that reached the appellate courts:

1. Patient Winter had chest pains and indicated that he wanted a do-not-resuscitate order to be on file. Despite that, a hospital nurse revived him. Two days later, he suffered a paralyzing stroke. Here the patient clearly limited the medical measure he was willing to undergo, and the health care provider disregarded such instruction. The consequences for that breach resulted in damages arising from the battery inflicted on the patient, as well as appropriate licensing sanctions against the medical professionals.

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2. The family of Brenda Young, acting as Miss Young's proxy, repeatedly told physicians that their daughter did not want life support. When the proxy requested that the life support be removed, the request went unheeded. The family sued and Miss Young's estate was awarded substantial damages.
3. A Geriatric Center kept a resident alive and on life support for six days of what her family described as unnecessary suffering, in violation of her living will. The jury found that the nursing home had failed to develop a plan for dealing with the patient's decline in the face of her advanced directives. Damages were awarded.

PAIN MANAGEMENT AT THE END OF LIFE

Aiding the dying patient is perhaps the only time when the medical professionals are asked not to save the patient but to comfort and ease the process of dying, with peace and dignity.

The successful and effective management of pain in the elderly and cancer patients, at the end of life, requires an interdisciplinary approach. Unrelieved pain may cause poor appetite, loss of sleep, anxiety, depression and a sense of hopelessness.

The terminally ill patient and the family need not be afraid of addiction to narcotics or induction of respiratory depression. It is perfectly legitimate for physician to administer sufficient amounts of opioids to patients for the purpose of relieving pain and suffering, even though the dying process may be hastened. This is referred to as the "double-effect." The intent of treatment is to alleviate pain, and not to cause the patient to die.

END-STAGE HEART FAILURE (ESHF)

The ESHF patient should be encouraged to choose in advance a person to assume legal authority (i.e. designated power of attorney or healthcare proxy) for health-care matters when the patient cannot be involved in decisions. Hospitalization and/or resuscitation may no longer be desired by the patient when the limitations imposed by heart failure alone or in combination with other severe conditions become intolerable.

It is inappropriate to perform aggressive procedures within the final days of life in patients with NYHA functional class IV symptoms who are not anticipated to experience clinical improvement from available treatments (including intubation and implantation of a cardioverter-defibrillator). Opioids are appropriate and recommended hospice care therapy for relief of suffering and symptom palliation for patients with heart failure at the end of life; inotropes and intravenous diuretics are optional. Greater attention needs to be devoted to the provision of comfort measures in the final days of life, including relief of pain and dyspnea. Hospice services provide compassionate care to patients dying of heart failure.

DISCONTINUATION OF VENTILATOR SUPPORT, HYDRATION AND NUTRITION

If a patient's desires cannot be ascertained by advance directives, then treatment decisions should be based on the patient's *best interests*. States can identify the level of proof (generally *clear and convincing*) required to ascertain a person's actual wishes when competent to effectuate those wishes when the patient is judged incompetent. Some difference exists in statutes and state court decisions regarding different forms of life-sustaining treatment, such as ventilator, nutrition and hydration support. The following are landmark cases involving absence of advance directives:

- ***In re Quinlan:*** Karen Ann Quinlan ceased breathing, became comatose then developed symptoms of a Persistent Vegetative State (PVS). She was intubated and fed via a nasogastric tube for years. Quinlan's father asked to be appointed guardian of his adult unmarried daughter. He stated his intent to cease all extraordinary medical procedures (ventilator support). The Trial Court refused. On appeal, the N.J. Supreme Court reversed and held that a competent adult has a constitutional right to privacy that allows him/her to refuse life-sustaining medical care and a guardian can assert that right on his/her behalf. Quinlan's father was an appropriate guardian. The court relied on the *substituted judgment* of a surrogate decision-maker. There is no civil or criminal liability if the guardian agreed to the withdrawal and a hospital ethics committee confirmed there is no reasonable possibility of the patient recovering a cognitive, sapient state.
- ***Cruzan v Director, Missouri Dept. of Health:*** Nancy Cruzan had an auto accident that led to transient cessation of cardiac and respiratory functions and cerebral contusions. She became comatose and evolved to a PVS. For years, nutrition and hydration were provided via a nasogastric tube. Cruzan's parents asked the hospital to terminate food and water. The hospital refused without a court order. The parents obtained such approval from a state trial court. The trial court held that substantive due process gives a competent person a federal constitutional right to refuse "death-prolonging procedures." Also, Nancy Cruzan had effectively exercised that right when she told a friend years-earlier that "if sick or injured, she would not want to continue her life unless she could live at least half way normally."

On appeal, the Missouri Supreme Court reversed and held that no person can assume that choice for an incompetent in the absence of the formalities required under Missouri's Living Will statutes or the "clear and convincing inherently reliable evidence absent here."

The case was appealed to the U.S Supreme Court. It recognized a substantive due process liberty interest under the 14th Amendment to refuse medical treatment including refusing nutrition and hydration in the manner Cruzan received them.

- ***In re Schiavo:*** In 1990, Terri Schiavo had a cardiac arrest and fell into a PVS. A state court appointed her husband as guardian. In 1998, the guardian husband petitioned the court to decide whether to discontinue the tube feeding. A conflict arose between the husband and Schiavo's parents who objected to ceasing nutritional and hydration support.

In 2003, a Florida state judge found that there was clear and convincing evidence that Schiavo was in a PVS. The feeding tube was removed. The Florida Supreme Court declined to review the case.

The parents sought and obtained state legislative authority to require reinsertion of the feeding tube. The law (2003-418) known as "Terri's Law" was signed by Governor Bush. In 2004, the Florida Supreme Court ruled it was unconstitutional since it violated the separation of powers. A law that permits the executive to interfere with the final judicial interpretation in a case is an invasion of the authority of the judicial branch. In 2005, The U.S. Supreme Court refused to hear an appeal brought by Governor Bush. The trial judge again ordered the tube removed. The parents again sought further judicial review. The trial and appellate courts refused to reopen the case.

Then new legislation was passed by the Florida House, but the Senate refused to agree noting it would again be found unconstitutional. The parents (and the Right to Life Lobby) then sought congressional relief. Congress passed P.L.109-3. This gave the Middle District of Florida jurisdiction to hear, determine, and render judgment on a suit or claim by or on behalf of Schiavo for the alleged violation of any right of Schiavo under the Constitution or laws of the U.S. relating to the withholding or withdrawal of food, fluids, or medical treatment necessary to sustain her life.

The parents filed a lawsuit under PL109-3 asking for a TRO (Temporary Restraining Order) requiring resumption of nutrition and hydration. The District Court denied the TRO. It also found no basis to sustain the parents' substantive or procedural due process claims under the 14th Amendment. The Eleventh Circuit agreed the P.L.109-3 did not alter the established rules under the Federal Rule for Civil Procedure 65 for granting a TRO.

PALLIATIVE CARE TEAM

The palliative care team includes a palliative care consultant, pain specialist, hospice medical director, hospitalist, or advanced practice nurse. Palliative care consultant services are available at many hospitals and hospice organizations. When conversing about impending death, the physician and/or the palliative care team might consider the following:

1. Reassure the patient repeatedly that he or she will continue to receive the best care possible.
2. Encourage the patient to complete important things left undone.
3. Urge the patients to draft, or review, their advance directives and a health-care proxies.
4. Encourage the patient to talk about the terminal illness. If the patient gives permission, include loved ones in the conversation.
5. Inform the patient that the illness is progressing, and at some point, people with this illness do die. Help the patient recognize the progression of disease and what might be expected to happen in the future.
6. Do not wait for the patient to bring up the subject of terminal illness.
7. Discuss a palliative care home program that is modeled after hospice programs, which provides more satisfaction for patients and family.
8. Allow time for the patient to ask if he or she is dying.
9. Explain the meaning of success versus futility in these situations, expectations about leaving the hospital, stabilizing the disease process, going to an extended care facility, ability to attend to one's self or live independently.
10. Deal openly and frankly with the ability or inability to make the patient better.
11. Physicians must communicate honestly with patients. This is also an important key risk management strategy.

DO NOT RESUSCITATE (DNR)

- An **inpatient DNR** order is signed by the physician while the patient is hospitalized. It applies to that facility and does not apply outside of that hospital. A patient who is transferred from one hospital to another must have a new DNR order.
- An **out-of-hospital DNR** order is also signed by the physician either during hospitalization or as outpatient. It is only necessary if the patient does not want to be revived by paramedics (first responders) in the event of a fatal accident outside of the hospital (car accident, heart attack, severe fall at home, etc.). The patient should have this document available at all times to give to the first-responder, otherwise they are legally obligated to use all resuscitative measures, which can be traumatic for both the patient and the family.
- **POLST** stands for *Physician's Orders for Life-Sustaining Treatment*. It is signed by the physician. In some states it is called by a different name such as **MOST** (*Medical Orders for Scope of Treatment*), **MOLST** (*Medical Orders for Life-Sustaining Treatment*), or **POST** (*Physician Orders for Scope of Treatment*). **POLST** is generally a one page, two-sided uniquely identifiable form. There is a *National POLST Form* but most states use their own state version of **POLST**.

A **POLST** form is neither an advance directive nor a replacement for advance directives. An advance directive is a direction from the patient, not a medical order. In contrast, a **POLST** form consists of a set of medical orders that applies to a limited population of patients and addresses a limited number of critical medical decisions. The form is intended as a complement to advance directives in that it serves as a translational tool and a continuity of care assurance. Both advance directives and **POLST** forms are helpful advance care planning documents for communicating patient wishes when appropriately used.

CARDIO-PULMONARY RESUSCITATION (CPR)

During the Covid-19 pandemic, **CPR** has become hazardous. It involves multiple staff, and intubating and extubating the patient creates an opportunity for coronavirus transmission at a very high level. It is justified if the patient has an appreciable chance to recover and be discharged. For COVID-19 patients on ventilators, CPR is a very clear risk to health care workers and is most unlikely to be successful; CPR would be considered a futile effort.

LONG-TERM CARE FACILITIES (LTCFS)

Long-term care facilities include nursing homes, skilled nursing facilities (SNF), and assisted living facilities, *residential care homes* or *personal care homes*. There are about 15,600 nursing homes and 7,500 assisted living facilities in the U.S. About 2.1 million people live in LTCFs., of whom 1.3 million people live in nursing homes; 80 percent are white. Every year, between one to three million serious infections occur in LTCFs, including urinary tract infections, diarrheal diseases, antibiotic-resistant staph infections, upper respiratory infections and many more. In LTCFs, infections are a major cause of hospitalization and cause deaths of 380,000 people every year.

The COVID pandemic has revealed vulnerabilities and concerns pertaining to LTCFs.

- Eight out of 10 COVID-19-related deaths reported in the United States have been among adults aged 65 years and older**.** The greatest risk for severe illness from COVID-19 is among those aged 85 or older.
- LTCFs have accounted for 42% of the COVID-19 deaths in the U.S.
- Nursing homes with a significant number of African-American and Latino residents have been twice to three times as likely to be hit by COVID-19 as those where the population is overwhelmingly white.
- In May 2020, the Oklahoma State Health Department tested 35,800 at 265 LTCFs and found 3% (1,100) of the residents (714) and staff (428) were positive for COVID-19.

CONCERNS ABOUT LTCFS BUILDING STRUCTURES:

- Nursing homes often have long hallways with 40 rooms and 80 or more residents.
- Residents mingle in large dining rooms and share resident rooms with mostly two occupants per room, but some have 3-4 occupants.
- Some nursing homes house hundreds of residents.
- This makes it easier to transmit from person-to-person a highly contagious disease such as COVID-19.

LTCFS WORKERS:

- The LTCFs workers might be inadvertently carriers of COVID-19.
- They have had shortages of safety gear.
- They have had difficulty securing coronavirus test kits.
- Some of the nursing home workers fell ill, alongside their patients.
- Some nursing homes have been short-staffed, disorganized facilities that lack adequate protective gear amid the pandemic.
- Restricting visitor access, screening for symptoms anyone who enters, and following federal guidelines for personal protective equipment and patient isolation were delayed partly because of delayed response to COVID-19 by the government.
- There have been delays in receiving proper supplies, including face shields, medical-grade eye protection, masks and gowns.

LTCFS RESIDENTS

Nursing home and assisted living facility residents are generally older people with underlying health conditions. Infections, such as COVID-19, prey on such people. The diagnosis and treatment of COVID-19 infections has been difficult because it is a novel virus,* *and there has been* a lack of timely testing and lack of specialists and proper equipment in LTCFs, such as ventilators.

FUTURE OF LTCFS

- Large nursing home populations should be divided into small, self-sufficient units with kitchens, private rooms and a dedicated staff.
- "Smaller-is-better" approach arose before COVID-19 out of concern for residents' privacy and dignity. COVID-19 infections and deaths in large nursing homes indicate that the smaller-is-better approach helps with infection control as well.
- Private rooms can make a big difference in controlling COVID-19 and keeping it at bay. A private room or even an entire 'household' can be closed off more easily, keeping out or confining viruses.
- Staff members who are focused on a small number of residents may be more likely to pick up on warning signs that someone is sick.
- The preparation of food and laundry in a household instead of a central facility eliminates some of the way diseases can infiltrate.
- Disease control should include scrutiny of air circulation and filtration when heating, ventilation and air conditioning systems are planned. Use of high-efficiency particulate air filters, commonly called HEPA filters, can trap bacteria and other particles.
- Adding ultraviolet light filters are effective in killing airborne viruses.
- Other considerations include easy-to-clean, nonporous surfaces; use of antimicrobial materials, like copper, for "high touch" areas like hand railings; voice - or sensor-activated controls for doors, lighting, curtains, faucets and toilets; solar and/or wind energy; battery back-up equipment; audio and video communications between residents and nursing staff; and telemedicine/telehealth equipment and trained presenters.
- Some nursing home designers may install modular walls so that resident rooms can quickly be reconfigured in a crisis. During a pandemic, the virus infected patient may not be moved to an isolation area, but the room may be changed into an isolation area.

EXAMPLES

- Private rooms have made a significant difference in the ability to control the virus at *Jewish Senior Services*, a four-story building for skilled nursing and assisted living in Bridgeport, Conn. There are 330 residents divided into 'households' of 14 residents each. When somebody

is diagnosed with COVID-19, their door is closed. Signs are posted and safety gear is placed outside the door so that staff know to suit up before entering. Eight of the 23 'households' had COVID-19 infections and 15 residents died.

- The *Green House Project* is a nonprofit organization that oversees 266 small-house nursing homes. Of the 243 projects that supplied data in early May 2020, eight reported having cases of Covid-19, and there were no deaths.
- The *Department of Veterans Affairs* began embracing a small-house model in 2011; now, 13 of its 134 nursing homes are organized around communities of 10 to 14 residents. In these settings, only a single veteran has tested positive for COVID-19.

The Centers for Medicare & Medicaid Services (CMS) and *the Centers for Disease Control and Prevention (CDC) issued Nursing Homes Guidance* on April 2, 2020 new recommendations to State and local governments and long-term care facilities to help mitigate the spread of COVID-19. These include,

- Addressing nursing homes in different phases of COVID-19 response;
- Assigning an individual to manage the facility's infection control program;
- New requirements for nursing homes to report to the National Healthcare Safety Network (NHSN);
- Creating a plan for frequent testing of residents and healthcare personnel for COVID-19;
- Providing clinical staff Information;
- Provide resident information;
- Implement prevention tools; and
- Workers infection prevention training.

MALPRACTICE LIABILITY POST-COVID-19 PANDEMIC

The Covid-19 pandemic is expected to affect the legal risks to physicians, hospitals and LTCFs, and to increase the malpractice premium. The potential legal risks include for example:

1. Telemedicine/telehealth malpractice caused by incomplete exam, missing a change in a patient's health status, or not following up with the patient in person, leading to a failure to diagnose action;
2. Issues involving medical record documentation, prescribing controlled substances, and interstate unlicensed practice;
3. Patient whose surgery was postponed due to prohibitions of elective surgery, but they prove subsequently to be necessary;
4. Claim that patients contracted Covid-19 at the physician's office.

To defend themselves, physicians and other health care providers should follow the CDC guidelines for Covid-19 safety.

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