Dear Mary

by Mary Annas

Dear Mary is a monthly feature in which readers can ask about any nursing care issue that concerns them. Answers will be supplied by Mary Annas or a consulting nurse, physician, lawyer, or ethicist where appropriate. Readers are also invited to comment on the answers. Letters to Dear Mary may be handwritten. All inquiries should be addressed to Mary Annas, Nursing Law & Ethics, P.O. Box 9026, JFK Station, Boston, MA 02114.

Dear Mary,

I work on a fairly busy but small pediatrics ward in a large community hospital. We have a general policy of not allowing ventilators on the regular floors — the theory being that if a patient needs a ventilator, and thus close observation and monitoring, then the control of an ICU or CCU atmosphere is safest and best for the patient and the workers. An exception to this policy is made when a person will be on a respirator for an extended period of time, is fairly stable, and has what is usually accepted as a poor prognosis.

We recently had a patient who was eleven years old, who had undergone brain surgery twice, was comatose and terminally ill. He was on a respirator in the regular pediatrics unit (the tenth floor) while the ICU (where most of the staff familiar with the machine work) was on the second floor.

Many of the regular pediatric nurses were angry and felt put upon because of the lack of preparation they received before the patient was sent to the floor. This manifested itself in many ways including in-fighting among regular staff, overreacting to students' questions, a general fear and awe of the machine, and questions not only as to whether the boy should have been on the floor, but general ethical questions about quality of life, etc.

Jesse
Phoenix

Dear Jesse,

Having worked as a respiratory therapist I feel the fears of an unprepared staff that a machine will fail to function are justified, not because it often happens in a system that is properly set up, but because the aura and unfamiliarity of even a simple ventilator can produce fear in anyone lacking experience with it. The most scary thing can be the alarm system; it is often activated by something as simple as water in the tubing and need not signal pathological changes in the patient.

The best advice to someone in this situation is to remember that in most hospitals the system is backed up by an "ambu" (hand ventilator), which is the best physiological ventilator for the patient.

Two other points should be made. First, basic operating instructions for the ventilator should be reviewed with the nursing staff on the ward. Second, make use of other resources within the hospital. Perhaps someone from the respiratory therapy department could give a more extensive refresher course on ventilator use. In addition, the hospital may have a communications specialist or staff counselor to deal with this kind of situation. Calling on this person would give floor nurses an opportunity to constructively express their feelings and perhaps change policy.

Dear Mary,

We have a problem at our hospital. Some of our physicians refuse to write orders not to resuscitate. The nurses are no longer willing to take the responsibility of not resuscitating without a specific order.

I have found numerous articles stating that it is appropriate for the physician to write orders not to resuscitate in both the progress notes and the doctor's orders. I would like to know if you can refer me to some specific court cases involving "No Code" orders. I am more interested in cases where a code was never done than in cases involving discontinuing life support.

Gail
Rome, Georgia

Dear Gail,

Since this is a legal question I have referred it to one of my editors.

You are correct that good medical practice requires orders not to resuscitate, like all other important orders, to be documented both in the progress notes and in the doctors' orders. Authoritative medical commentary has uniformly insisted on this.[1] *Only two courts have dealt explicitly with the issue. In the first case, an intermediate appellate court determined that an order not to resuscitate was legally appropriate if the patient was incompetent and "in the terminal stages of unremitting, incurable, mortal illness." That same court cited articles from the medical literature indicating that such orders should be documented, and approved of the procedure of documentation both in progress notes and doctors' orders.*[2] *The second case was decided in early 1981 by a lower court in Minnesota, and the facts of that case are discussed in the* Health Law Notes *column of this issue.*

Nurses who follow verbal orders not to resuscitate run a risk because if a decision by the nurse not to resuscitate a patient is later challenged, the physician may deny ever issuing the order. This may leave the nurse in a legally untenable position — and if resuscitation was, in fact, medically indicated, the nurse could face discipline, malpractice, or criminal charges. Your nursing staff should insist that legitimate orders be properly documented to protect both you and your patients. I believe it important the order include a concise statement of the reasons it is given, so that its rationale can be challenged if the order is thought to be inappropriate.[3]

GJA

References

1. *E.g., Standards for Cardiopulmonary Resuscitation and Emergency Cardiac Care,* JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 227:796-97 (February 18, 1974) and *Standards and Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiac Care,* JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 244:505-06 (August 1, 1980).
2. *In the Matter of Dinnerstein,* 380 N.E.2d 134 (Mass. App. 1978).
3. *No Code Blue Guidelines,* JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 243:2339 (June 13, 1980).

Dear Mary,

We had an incident in the recent past with a patient who was projecting suicidal ideas, but no physician was available to initiate the order for suicide precautions. The patient was on an ambulatory unit and had voluntarily admitted himself for teaching concerning his diabetes. He left the unit and a staff nurse followed him to make sure he did not harm himself. Thus, the nurse was several blocks from the patient unit. Was the nurse responsible, by law, for the patient once he walked off the unit? I am interested in knowing if the law limits the physical area medical personnel must cover to protect a patient.

Eleanor
Portland, Maine

Dear Eleanor,

It is understandable that nurses become concerned when they believe a patient to be in danger of hurting him-

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Compassion *Continued*

framework of ethical principles while recognizing that answers will not come easily.

References

1. GARFIELD, C.A., PSYCHOLOGICAL CARE OF THE DYING PATIENT (McGraw-Hill, New York) (1978) p. 3.
2. FOX, M., A SPIRITUALITY NAMED COMPASSION AND THE HEALING OF THE GLOBAL VILLAGE, HUMPTY DUMPTY AND US (Winston Press, Minneapolis) (1979).
3. KITAMORI, K., THEOLOGY AND THE PAIN OF GOD (John Knox Press, Richmond, Va.) (1965) p. 98.
4. Hauerwas, S., *Reflections on Suffering, Death and Medicine*, ETHICS IN SCIENCE AND MEDICINE 6:229-37.
5. AMERICAN HOSPITAL ASSOCIATION, STATEMENT ON A PATIENT'S BILL OF RIGHTS (AHA, Chicago) (1972).
6. BEAUCHAMP, T.L. and CHILDRESS, J.F., PRINCIPLES OF BIOMEDICAL ETHICS (Oxford University Press, New York) (1979).
7. Stenn, F., *A Plea for Voluntary Euthanasia, Letter to the Editor*, NEW ENGLAND JOURNAL OF MEDICINE 303(15):891 (October 9, 1980).
8. KEYSERLING, K. and EDWARD W., SANCTITY OF LIFE OR QUALITY OF LIFE (Law Reform Commission of Canada, Ottawa) (1979) p. 13.
9. Shils, E., *The Sanctity of Life*. In LABBY D.H., editor, LIFE OR DEATH: ETHICS AND OPTIONS (University of Washington Press, Seattle) (1968) p. 19.
10. *Superintendent of Belchertown v. Saikewicz*, 370 N.E.2d 417, 426 (Mass. 1977).

Dear Mary *Continued*

self, especially when the nurses are not sure how far they can — or should — go to protect the patient. Striking a balance between the patient's rights and the nurse's responsibility can be a difficult task. I have referred your question to Barbara F. Katz, a member of *NLE's* Editorial Advisory Board and a hospital attorney.

A competent adult patient has the right to leave the hospital at any time he chooses. Attempts to restrain the patient against his will can form the basis for liability for false imprisonment. Following a patient after he has left the hospital is inappropriate. If it is the opinion of the hospital staff that the patient should not leave, he may be requested to sign a form indicating that he is leaving against medical advice. However, he cannot be required *to sign the form, and he may still leave even if he refuses to sign.*

It may be, however, that this particular patient is incompetent. If so, there may be other steps you could take. All states have statutes which permit the involuntary commitment of a mentally ill individual under certain circumstances. Generally one of those circumstances is if the mentally ill person is dangerous to himself, or suicidal. Accordingly, if the patient in question met these statutory criteria, an appropriate response would be to have the patient involuntarily committed. This process may be completed very quickly when necessary.

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