WILL YOUR ADVANCE DIRECTIVE BE FOLLOWED?

A REPORT BY THE ROBERT POWELL CENTER FOR MEDICAL ETHICS

Originally Issued April 2005

Revised Edition Issued June 2017

ROBERT POWELL CENTER *for* MEDICAL ETHICS
AT THE NATIONAL RIGHT TO LIFE COMMITTEE

Will Your Advance Directive Be Followed?
A Report by the Robert Powell Center for Medical Ethics

Table of Contents

ROBERT POWELL CENTER for MEDICAL ETHICS
AT THE NATIONAL RIGHT TO LIFE COMMITTEE

512 10th Street, N.W.
Washington D.C. 20004
www.nrlc.org

key conclusions

In the wake of the 2005 Terri Schiavo case, many authorities urged Americans to complete advance directives. Every state authorizes these legal documents, which allow a person to specify whether and under what circumstances she or he wants life-preserving medical treatment, food or fluids when no longer able to make health care decisions.

However, the laws of all but twelve states may allow doctors and hospitals to disregard advance directives when they call for treatment, food, or fluids. Increasingly, healthcare providers who consider a patient's "quality of life" too low are denying life-preserving measures against the will of patients and families – and the laws of most states provide no effective protection against this involuntary denial.

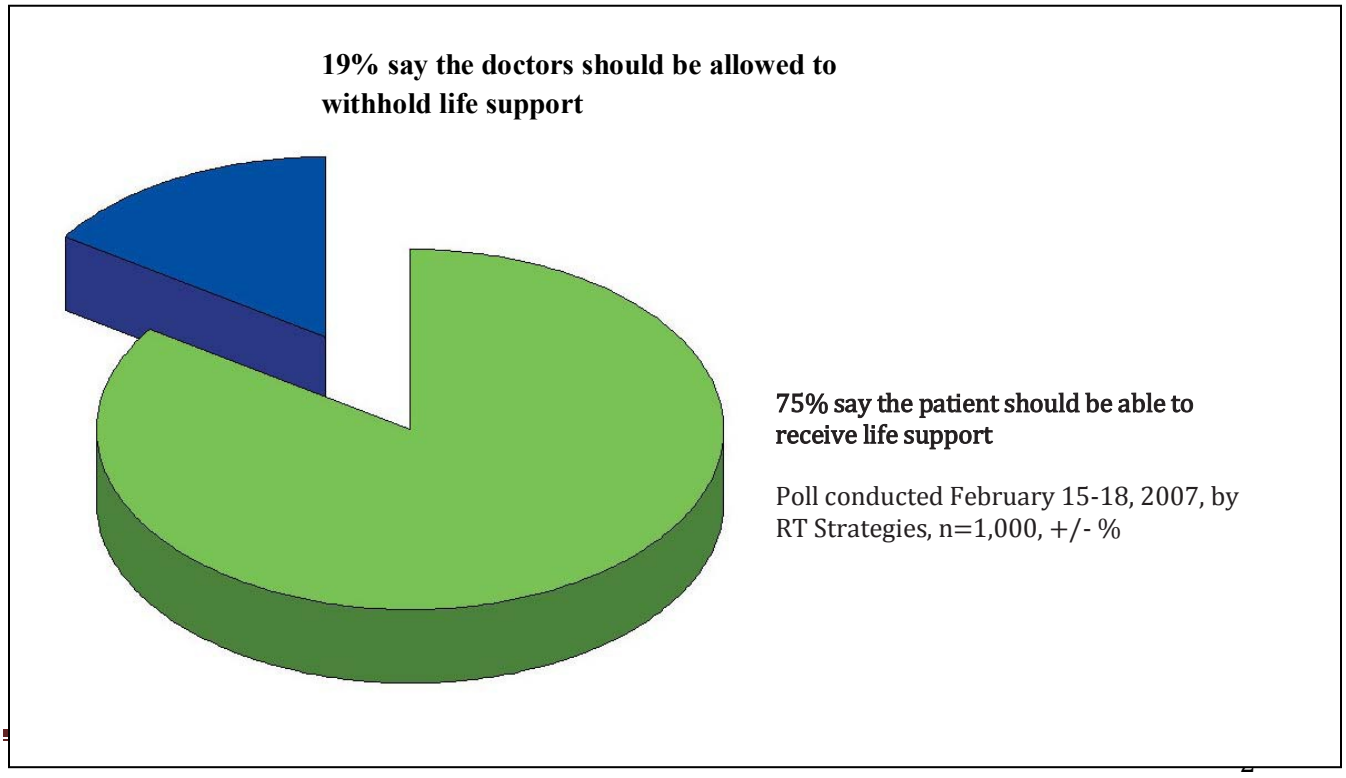
The result: **in most states, if you want life-saving treatment – or even food and fluids – there is no guarantee your wishes will be honored, even if you make them clear in a valid advance directive.**

Will Your Advance Directive Be Followed?

The Public Believes Patient and Family Choices for Life-Preserving Measures Should Be Respected, Even When Health Care Providers Disapprove

Americans overwhelmingly believe that when they or their families make the choice for food, fluids, or life support, those wishes should be respected – despite the contrary view of doctors who may think their quality of life too poor. A nationwide survey by RT Strategies, conducted February 15-18, 2007, found that by 75% to 19% the public believes that when a seriously ill patient's family wants life support for the patient, their wishes should be followed even though the doctor thinks the patient's quality of life is too low to merit food and fluids.[1]

A desire **for** life-saving measures is common. A study published in the *Journal of the American Medical Association* (JAMA) found that 48% of a national sample of seriously ill patients in Veterans Administration hospitals wished to "use all available treatments no matter what the chance of recovery" compared to 31% who did not.[4]



Health Care Providers Are Increasingly Denying Life-Preserving Measures in Contravention of Patient and Family Directives Choosing Them

A legal document generically called an "advance directive"† is the clearest way for someone to give directions concerning whether and under what conditions he or she would want food, fluids, or life-preserving medical treatment if no longer able to make and communicate health care decisions. The laws of every state and the District of Columbia, as well as U.S. territories, make provision for such advance directives.[3]

Increasingly, however, doctors and hospitals, often working through ethics committees, are asserting the authority to deny life-preserving measures against the will of patients and families – and implementing that authority in a growing number of cases. According to Dr. Lachlan Forrow, director of ethics programs at Boston's Beth Israel Deaconess Medical Center, "About 15 years ago, at least 80 percent of the cases were right to-die kinds of cases. Today, it's more like at least 80 percent of the cases are the other direction: family members who are pushing for continued or more aggressive life support and doctors and nurses who think that's wrong."[4] A study of policies at 26 California hospitals, for example, found that all but two of them specifically defined circumstances in which life-preserving treatments should be considered nonobligatory even if requested by a patient or patient representative.

Commonly, they would **deny treatment to patients with severe, irreversible dementia. This would presumably include people with Alzheimer's disease.** The authors of the study urged that health care providers "refuse to provide nonbeneficial treatment and then defend their decisions as consistent with professional standards."[5]

As one journalist has noted, this reflects "a turnabout in medical ethics, one in which doctors no longer want to employ all that medical science has to offer to keep patients alive and families find themselves fighting for their loved ones' right to live."[6]

A leading legal treatise lists nearly 40 appellate level court cases that have arisen from conflict between patients and their family members who want life-preserving measures and health care providers who wish to deny them.[7] This does not take into account countless ethics committee disputes or trial level cases that did not lead to appellate-level published opinions. The treatise authors note that "the development of medical professional standards about when it is appropriate and when it is not to provide life-sustaining medical treatment ... has been going on through the barrage of writings in the medical and ethical journals for more than a decade. More recently, formal efforts have been undertaken in a variety of places, with individual hospitals, groups of hospitals or other health care providers, and medical societies drafting 'futility guidelines.'"[8]

---

† The term "advance directive" includes durable powers of attorney for health care, living wills, health care declarations and instructions, and other documents with titles that vary from state to state.

Two examples of such guidelines:

The Society of Critical Care Medicine's Task Force on Ethics issued a "Consensus report on the ethics of foregoing life-sustaining treatments in the critically ill" which maintains that *even when a patient requests a particular therapeutic treatment*:

If a requested treatment entails, according to the norms of medical practice, loss of function, mutilation, or pain disproportionate to benefit, the physician and nurses are not obligated to provide it.[9]

The guidelines state, "Both preservation of life *and quality of life* must be weighed when making decisions concerning withholding and withdrawing life-sustaining treatments."[10] As one sympathetic medical commentator noted, under these guidelines, "Because treatment choices must be considered in relation to a patient's overall condition, a treatment offering a reasonable expectation of physiologic benefit may be withheld from terminally ill patients."[11]

The American Thoracic Society issued an official statement on "Withholding and Withdrawing Life-Sustaining Therapy" stating that life support "can be limited without the consent of the patient or surrogate when the intervention is judged to be futile." The paper defined "futile" as an intervention "that would be highly unlikely to result in a meaningful survival for the patient…. Survival in a state of permanent loss of consciousness…may be generally regarded as having no value for such a patient."[12]

In light of this, it is not surprising that a study published in the *Archives of Internal Medicine* in 2004 analyzing compliance with advance directives through a survey consisting of hypothetical cases found that the treatment decisions physicians said they would make were inconsistent with the patients' advance directives in 65% of cases. Among the factors likely to influence physicians' treatment decisions was the doctor's perception of the patient's "quality of life."[13]

Denial of Care as "Futile" Is Often Based on "Quality of Life" Rather than Physiological Grounds

While denial of life-saving measures against the will of patients or family members is frequently justified on the grounds that the treatment is "futile," it is important to distinguish between the narrow physiological and the broader value-laden use of the term. As described by the New York State Task Force on Life and the Law, "Some physicians use 'futile' narrowly, considering treatments to be futile if they would be physiologically ineffective or would fail to postpone death.... Many physicians embrace a broader, more elastic understanding of the term. ... [A] treatment might be seen as futile if it does not offer what physicians consider an acceptable quality of life. For example, in one survey, a majority of physicians agreed that for a severely demented patient with Alzheimer's disease, CPR [cardio-pulmonary resuscitation] would be 'so clearly inappropriate or futile on medical grounds that physicians should be permitted to institute DNR status based on clinical judgment, without obtaining consent.'"[14]

In a 2015 policy statement, "Responding to Requests for Potentially Inappropriate Treatments in Intensive Care Units", the American Thoracic Society states that medical futility ought to be defined as a value or "quality of life" judgment, not a medical one. The report writes, "The term 'potentially inappropriate' should be used, rather than futile, to describe treatments that have at least some chance of accomplishing the effect sought by the patient, but clinicians believe that competing ethical considerations justify not providing them."[15]

In a 2011 text, *Wrong Medicine: Doctors, Patients, and Futile Treatment*, the authors write, "If a patient lacks the capacity to appreciate the benefit of a treatment, . . . that treatment should be regarded as futile. . . . [W]e draw the line *at some point* between patients' rights to choose their own quality of health and life and the medical profession's obligation to achieve those ends."[16]

In a study published in the July 2010 *Journal of the American Medical Directors Association*:

> 71.8% of doctors surveyed considered mechanical ventilation futile for a "30-year-old quadriplegic patient with malignant melanoma who becomes unconscious"
>
> 65.9% considered hemodialysis futile for a "71-year-old diabetic patient in a persistent vegetative state who develops severe uremia" [17]

The study noted that, "Less experienced physicians (residents) were more likely to rate elder cases as futile compared with experienced physicians (attending/fellows)." [18]

One study, based on physician interviews, found that "Most often when futility arguments were invoked, they were used to support evaluative judgments based on quality of life considerations, only rarely to designate treatments that were medically inefficacious. Indeed, throughout the transcripts, physicians sought to frame value judgments as medical decisions."[19]

In another study, the authors complain, "[I]t is the physicians seeking to cease futile treatment . . . who have to live with the decision. For example, a judge who orders that a severely disabled child be kept alive rarely sees firsthand the long-term consequences of that decision, which remain a continuing vivid experience for the health professionals who must provide care for a child."[20]

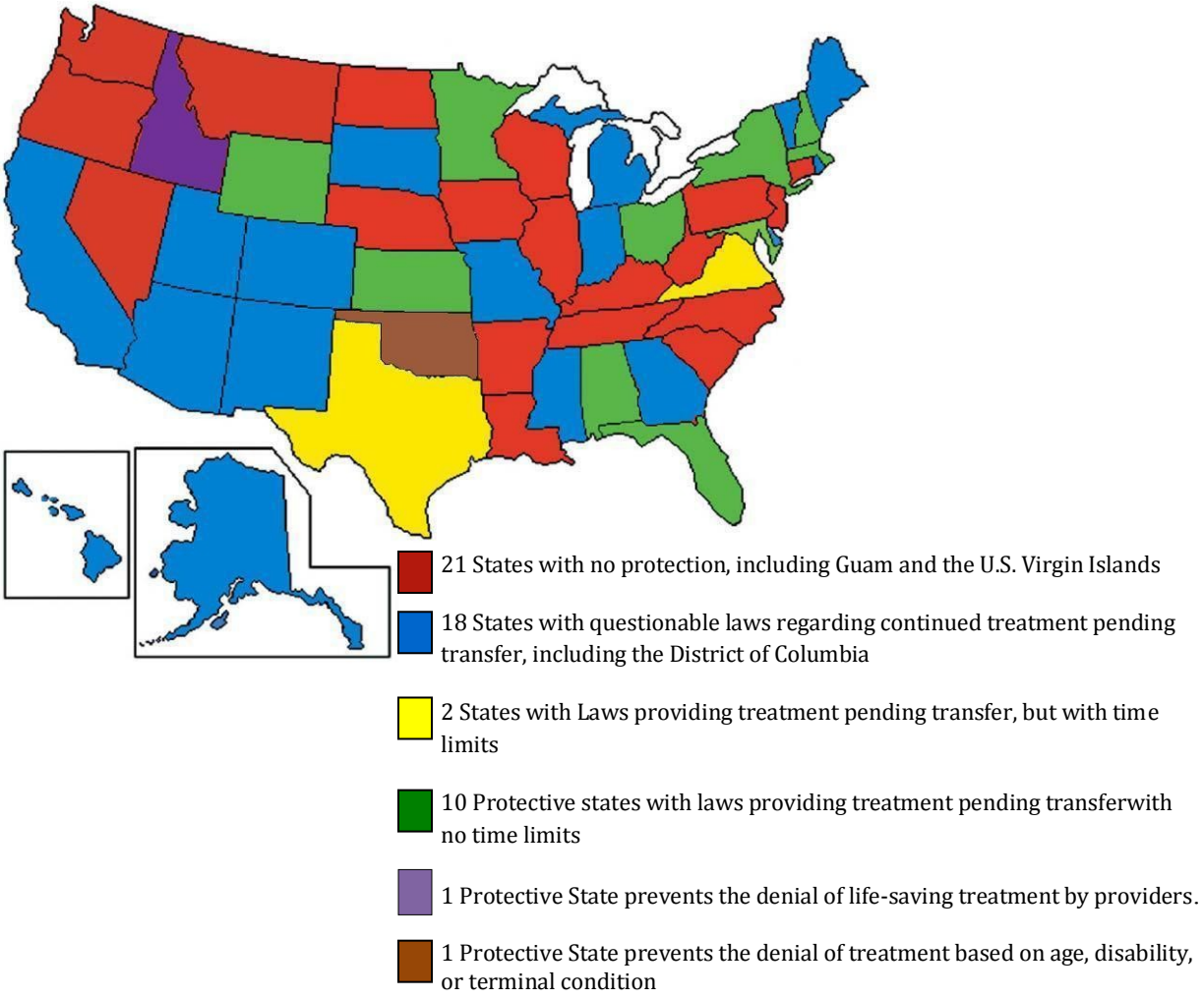
In 1991, the American Medical Association's Council on Ethical and Judicial Affairs criticized the use of this broader, "quality of life" view of futility to deny life-preserving measures against the will of patient or family:

> This approach to defining futility replaces a medical assessment (i.e., whether a reasonable potential exists for restoring cardiopulmonary function to the patient) with a nonmedical value judgment that is made by the treating physician (i.e., whether 1 day, 1 week, or 1 month of survival by the patient —perhaps in a severely debilitated state — is of value to him or her). This interpretation of futility is inconsistent with the principle of patient autonomy, which requires that patients be permitted to choose from among available treatment alternatives that are appropriate for their condition, particularly when such choices are likely to be influenced by personal values and priorities.
>
> ... Examples of some benefits that have been described as appropriate indications for CPR [cardio-pulmonary resuscitation] are a "meaningful existence" after resuscitation or an acceptable quality of life for the patient. These determinations, which attempt to define the types of treatment and the qualities of existence that constitute a benefit for the patient, undermine patient autonomy because they are based on the value judgments of someone other than the patient. These judgments of futility are appropriate only if the patient is the one to determine what is or is not of benefit, in keeping with his or her personal values and priorities.[21]

Decisions by providers unilaterally to deny treatment are far from uncommon. One study found that "14% of physicians in adult intensive-care units had withheld or withdrawn treatment they considered futile without informing the patient's family. More than 80 percent had withdrawn treatment over the family's objections."[22]

It is noteworthy that the value judgments of physicians are frequently at odds with those of patients. For example, the JAMA study cited earlier that found that 48% of seriously ill patients wanted to "use all available treatments no matter what the chance of recovery," compared with 31% of patients who disagreed, also found that among physicians, only 7% agreed with the pro-treatment position, compared to 81% who disagreed.[23]

Most State Laws Fail to Protect Patients and Families Who Want Food, Fluids, or Life Support When Health Care Providers Deny It on Quality of Life Grounds



Only twelve states have laws that essentially protect patients' directives for life-preserving measures.+

> *21 Unprotective Laws.* The relevant laws of twenty-one states and territories provide no effective protection of a patient's wishes for life-preserving measures in the face of an unwilling health care provider.
>
> Particularly striking is Connecticut's statute, which immunizes a physician who denies life support to any terminally ill or permanently unconscious patient; the physician need only have "considered the patient's wishes concerning the withholding or withdrawal of life support."[24]

+ Relevant provisions of all the states' laws, together with statutory citations, are provided in the appendix.

Most state statutes, in allowing health care providers to refuse to comply with a patient's advance directive for reasons variously described as ethics and judgments of medical inappropriateness, make some reference to providing an opportunity for the patient to transfer or be transferred to another, willing, health care provider. In some states, the unwilling provider must make a "reasonable" effort to bring about the transfer; in others, must simply cooperate with or not impede it. The critical point is that in these states there is nothing approaching *a duty to provide life-preserving measures while the patient is awaiting transfer*:*

It does the patient little good to be transferred already dead. It can by no means be assumed that unwilling health care providers will do so while the patient's family or others search around for another health care facility willing to accept and treat the patient. For example, representatives of Houston hospitals established a task force that developed a model protocol for denial of treatment in 1996. The protocol specified that if no transfer had been effectuated during a 72 hour period between notification of the family of the doctor's intent to deny treatment and an ethics committee meeting that ratified the doctor's position, treatment should generally be terminated promptly after the meeting. They wrote that they "firmly believe that professionals and institutions should not be required to provide treatments ... if patients cannot or will not arrange transfer."[25]

18 Questionable Laws. Eighteen states including the District of Columbia have statutes with language that might be cited to support a right to receive life-preserving measures specified in accordance with an advance directive, but either the language is ambiguous or it could be trumped by other provisions in state law.

Unlike the bulk of the states in the "unprotective" category, which merely give the patient the right to transfer from an unwilling provider, or at most require the unwilling provider to make a "reasonable effort" to bring about a transfer, five states+ specifically require an unwilling provider successfully to effectuate a transfer to a willing provider. This certainly suggests the intent of the state to ensure that the patient's advance directive is followed, since the right of the unwilling health care provider to deny life-preserving measures is coupled with the duty to find a provider willing and able to follow the advance directive. On the other hand, the statutes do clearly give the unwilling provider the right to refuse, and they specify nothing about life-preserving measures pending transfer.

---

* Many of the state statutes were enacted at a time, two decades or more ago, when the possibility that hospitals and doctors would cut off life-preserving measures against the will of the patient was not even being discussed, let alone implemented. The laws were generally written in contemplation of the opposite situation, in which a patient or the patient's family might want to reject treatment, food, or fluids in circumstances in which the health care provider would wish to continue them. Today, according to Chuck Ceronsky, co-chairman of the ethics review committee of Minneapolis' Fairview University, "The right-to-die families find a more receptive audience in the hospital, as opposed to years ago when a doctor might say, My job is not to end life." Quoted in Pam Belluck, "Even as Doctors Say Enough, Families Fight to Prolong Life," *N.Y. Times*, Mar. 27, 2005

+ Arizona, Indiana, Rhode Island, Utah, and the District of Columbia.

Eight states* require an unwilling health care provider to give "continuing care" to a patient pending the patient's transfer to a health care provider. While it might be argued that this means the patient must be given desired life-preserving measures while awaiting transfer, it is far from certain that it would be construed in this way by a court. The "care" that must "continue" is not defined. Hospitals unwilling to provide directed life-saving measures would argue that this does not mean they refuse to give "care" to the patient – they may provide palliative care, pain medication, and the like. It is also unclear what limit the word "continuing" may put on the obligation to give care pending transfer. Even if, for example, a hospital were to continue a ventilator the patient was already on, it might contend it has no obligation to provide *new* care – such as antibiotics if the patient develops an infection or CPR if the patient goes into cardio-pulmonary arrest.

Similarly, Colorado creates only "the duty to provide for the care and comfort of the [patient] pending transfer."[26]

Two states – Delaware and South Dakota – specify a duty to provide directed treatment, nutrition and hydration or life sustaining care pending transfer, but immunize health care providers for any violation of the act that is in accordance with "reasonable medical standards" or "generally accepted health-care standards." Given the profusion of articles in medical and bioethical journals that support involuntary denial of life-preserving measures on quality of life grounds, together with the pervasive prevalence of "futility protocols" at so many hospitals, it is not unlikely that a health care provider who refused to provide life-preserving measures pending transfer would be able to maintain the refusal was in accord with accepted medical standards.

Missouri and Michigan each present special cases. In Missouri, a health care facility may refuse to provide directed life-preserving measures pursuant to its "sincerely held moral convictions," but only if the facility had not "received a copy of the durable power of attorney for health care prior to commencing the current series of treatments or current confinement."[27] On the other hand, an individual physician or other health care professional who does not wish to comply has only the standard obligation of taking "reasonable steps" to transfer.

In Michigan, the health care provider is bound by the patient advocate's instructions. However, the provider is immunized so long as it adheres to "sound medical practice."[28] Additionally, in Michigan, the law requires healthcare facilities to automatically disclose their futility policies to guardians of minors, and to all other patients and surrogates if they request the policy.[29]

*Alaska, California, Georgia, Hawaii, Maine, Mississippi, New Mexico and Vermont.

2 Laws with Time Limits for Life-Preserving Measures. Two states require that unwilling health care providers give the life-preserving measures chosen in advance directives pending transfer of the patient to a willing health care provider, but establish time limits by which a successful transfer must be arranged and authorize denial of treatment, food or fluids if the time runs out. Virginia allows 14 days to arrange a transfer while life-preserving measures are provided. Texas allows 10 days, with a possible extension by court order if it can be shown there is a reasonable expectation that a willing provider will be found if there is an extension. [30]

12 Protective Laws. Only twelve states have laws that essentially protect the choice of a patient whose advance directive specifies that life-preserving measures should be provided in circumstances in which the doctor, hospital or other health care provider disagrees. Typically, the statutes in ten of these states^ allow the unwilling health care provider to transfer the patient to a provider willing to comply with the patient's advance directive ***but require that life-sustaining care be provided until the transfer can be completed.*** For example, the law in Ohio provides,

> "If the instruction of an attorney in fact under a durable power of attorney for health care ... is to use or continue life-sustaining treatment in connection with a principal who is in a terminal condition or in a permanently unconscious state, the attending physician of the principal who, or the health care facility in which the principal is confined that, is not willing or not able to comply or allow compliance with that instruction shall use or continue the life-sustaining treatment or cause it to be used or continued until a transfer as described in division."

Laws such as these, which require that health care providers unwilling to abide by the wishes of patients or family members who choose treatment must provide the treatment until the patient can be transferred to a willing provider, without a time limit, have wide public support. A February 2007 nationwide poll by RT Strategies asked:

> As you may know, under current law in some states such as Texas for example, a hospital committee can decide to deny life support against the will of a patient or the patient's family, who are then given ten days to try to find another hospital willing to give the patient life support. If they cannot, life support is then cut off and the patient is allowed to die. Do you support or oppose changing the law to require life support until the patient can be transferred to a willing hospital, without a time limit?

69% supported changing the law to require life support until transfer without a time limit, compared to 22% opposed and 8% unsure.

---

^Alabama, Florida, Kansas, Maryland, Massachusetts, Minnesota, New Hampshire, New York, Ohio, and Wyoming.

Oklahoma and Idaho laws work differently with protective results.

The Oklahoma Nondiscrimination in Treatment Act provides that if a patient or the patient's legal representative chooses life-preserving medical treatment, food or fluids, the patient's health care providers may not deny that treatment "on the basis of a view that treats extending the life of an elderly, disabled, or terminally ill individual as of lower value than extending the life of an individual who is younger, nondisabled, or not terminally ill." [31]

In Idaho, the statute simply prevents the involuntary denial of life-saving treatment, stating, "Assisted feeding or artificial nutrition and hydration may not be withdrawn or denied if its provision is directed by a competent patient."[32]

Under such laws, the choices of patients will be respected[#] unless the requested measures are physiologically futile.

[#] Even in these states there may not be an absolute guarantee that the wishes of the patient will be respected, as the case of Barbara Howe illustrates. The Massachusetts law, which we include in the protective category, provides, "If the facility or the agent … is unable to arrange … a transfer [to a willing provider], the facility shall seek judicial guidance or honor the agent's decision." Mass. Ann. Laws ch. 210D §15 (Law. Co-op. 2005). (New York has a similar option of resort to court.) Barbara Howe is a woman with Lou Gehrig's disease who made clear that she wanted a ventilator, and her daughter, who holds her health care proxy, has fought to maintain it against the wishes of Massachusetts General Hospital, which has argued that it should be terminated so that she dies. Ultimately, "judicial guidance" was sought. Nurses verified that Howe "wanted everything done to maintain her; including CPR, antibiotics, and ICU." While Probate and Family Court Judge John M. Smoot initially ruled in favor of the daughter's right to carry out her mother's wishes for treatment, in Spring 2004 he directed the daughter not to focus on her mother's wishes but on her "best interests" and recently brokered an agreement to terminate the ventilator so that Howe dies by June 30, 2005. Liz Kowalczyk, "Hospital, family agree to withdraw life support," *Boston Globe*, March 12, 2005.

Conclusion

Americans are being urged to set down their wishes concerning life-preserving medical treatment, food and fluids in advance directives to avoid the sort of debate over the wishes of a person no longer able to speak for herself that surrounded the case of Terri Schindler-Schiavo. To the extent those advance directives call **for** food, fluids, or life-preserving medical treatment in some or all circumstances, however, in the present state of medicine and the law there is no guarantee they will be honored in most states.

.

Endnotes

1. The exact poll question and results: A seriously ill patient is unconscious and has never expressed a desire for or against **life support** should they require it. If the patient's family wants life support for the patient, but the doctor thinks that the patient's quality of life is too low to merit life support, which of the following best describes your opinion: [ROTATE] the family of the patient should be able to get life support for the patient or the doctor should be allowed to withhold life support from the patient? **[N=1,000; Margin of error= +/- %]**

   75% THE FAMILY OF THE PATIENT SHOULD BE ABLE TO GET LIFE SUPPORT FOR THE PATIENT

   19% THE DOCTOR SHOULD BE ALLOWED TO WITHHOLD LIFE SUPPORT FOR THE PATIENT

   6% NOT SURE

2. Karen Steinhauser et al., "Factors Considered Important at the End of Life by Patients, Family, Physicians and Other Care Providers," *Journal of the American Medical Association* 284 (2000): 2476, 2480.

3. Michael Jordan, *Durable Powers of Attorney and Health Care Directives*, 4th ed. (n.p.:West, 2004), preface & 2-2.

4. Quoted in Pam Belluck, "Even as Doctors Say Enough, Families Fight to Prolong Life," *N.Y. Times*, Mar. 27, 2005.

5. Lawrence Schneiderman and Alexander Morgan Capron. "How Can Futility Policies Contribute to Establishing Standards of Practice?" *Cambridge Quarterly of Healthcarev Ethics* Vol. 9 (Fall 2000): pp. 524-531.

6. Ann Wlazelek, "Pendulum swings in life-saving efforts: Hospitals' policies on doing all they can to keep patients alive have changed," [Allentown, Penn.] *Morning Call*, June 13, 2004.

7. Alan Meisel & Kathy Cerminara, *The Right to Die: The Law of End-of-Life Decisionmaking*, 3rd ed. (New York: Aspen, 2004 & 2015 Supp.), §13.10 (Table 13.1, p. 13-44 to 13-47).

8. *Id*. at §13.09, p. 13-42.

9. Task Force on Ethics of the Society of Critical Care Medicine, "Consensus report on the ethics of foregoing life-sustaining treatments in the critically ill," *Critical Care Medicine* vol. 18, no. 12 (December 1990): pp. 1435, 1438.

10. *Id*., p. 1435 (Emphasis added).

11. John M. Luce, M.D., "Withholding and Withdrawal of Life Support: Ethical, Legal, and Clinical Aspects," *New Horizons* 5 (February 1997): 30 – 37.

12. American Thoracic Society, "Withholding and Withdrawing Life-Sustaining Therapy," *American Review of Respiratory Disease* 144, no. 3 (Sept. 1991):726-31 (Section 3).

13. Steven B. Hardin, M.D. & Yasmin A. Yusufaly, M.D., "Difficult End-of-Life Treatment Decisions[:] Do Other Factors Trump Advance Directives?" *Arch. Intern Med.* 164 (2004): 1531-1533.

14. New York State Task Force on Life and the Law, *When Others Must Choose: Deciding for Patients Without Capacity* (New York: n.p., 1992), pp. 196-97, *quoting* N. Spritz, "Views of Our Membership Concerning the DNR Issue and the New York State DNR Law," in *Legislating Medical Ethics: A Study of New York's DNR Law*, ed. R. Baker and M. Strosburg, Philosophy and Medicine Series (Dordrecht: Kluwer Academic Publishers,).

15. Bosslet, Gabriel T., et al. "An Official ATS/AACN/ACCP/ESICM/SCCM Policy Statement: Responding to Requests for Potentially Inappropriate Treatments in Intensive Care Units." *American journal of respiratory and critical care medicine* ja (2015).

16. Lawrence J. Schneiderman and Nancy Ann Silbergeld. Jecker, *Wrong Medicine: Doctors, Patients, and Futile Treatment* (Baltimore: Johns Hopkins University Publications, 2011).

17. Cruz-Oliver, Dulce M., MD, David R. Thomas, MD, Jeffrey Scott, BS, Theodore K. Malmstrom, PhD, Wilfredo E. De Jesus-Monge, MD, MSc, and Miguel A. Paniagua, MD, "Age as a Deciding Factor in the Consideration of Futility for a Medical Intervention in Patients Among Internal Medicine Physicians in Two Practice Locations," *Journal of the American Medical Directors Association* (2010): 421-427 at 424, 425.

18. *Id.* at p. 423.

19. Mildred Z. Solomon, "How Physicians Talk about Futility: Making Words Mean Too Many Things," *The Journal of Law, Medicine & Ethics* vol. 21, no. 2 (Summer 1993): pp. 231, 232-33.

20. Lawrence Schneiderman and Alexander Morgan Capron, "How Can Futility Policies Contribute to Establishing Standards of Practice?" *Cambridge Quarterly of Healthcare Ethics* Vol. 9 (Fall 2000): 524, 529.

21. American Medical Association Council on Ethical and Judicial Affairs. "Guidelines for the Appropriate Use of Do-Not-Resuscitate Orders," *Journal of the American Medical Association* vol. 265, no. 14 (April 10, 1991): pp. 1868, 1870.

22. Cited in Patricia O'Donnell, "Ethical Issues in End-of-Life-Care: Social Work Facilitation and Practice Intervention" in *Living with Dying: a Handbook for End-of-Life Healthcare Practitioners*, ed. Joan Berzoff and Phyllis R. Silverman (New York: Columbia University Publications, 2004).

23. Karen Steinhauser et al., "Factors Considered Important at the End of Life by Patients, Family, Physicians and Other Care Providers," *Journal of the American Medical Association* 284 (2000): 2476, 2480.

24. Conn. Gen. Stat. §§ 19a-571; 19a580a (West 2007).

25. Amir Halevy, M.D. & Baruch Brody, Ph.D., "A Multi-institutional Collaborative Policy on Medical Futility," *Journal of the American Medical Association*, vol. 276 (August 21, 1996): p. 571.

26. Colo. Rev. Stat. § 15-14-507(5) (2007).

27. Mo. Rev. Stat. § 404.830 (2004).

28. Mich. Comp. Laws 700.5511 (3)(2007).

29. Mich. Comp. Laws § 333.20403 (2013).

30. In August 1996 the Journal of the American Medical Association published an article describing procedures then in effect in Houston hospitals. Under these procedures, if a doctor wished to deny a patient lifesaving medical treatment and the patient or the patient's surrogate instead steadfastly expressed a desire for life, the doctor would submit the case to the hospital ethics committee. The patient or surrogate would be given 72 hours notice of the committee meeting would be allowed to plead for the patient's life at it. During that short 72 hour period, the patient or surrogate, while preparing to argue for life, could also try to find another health care provider willing to give the lifesaving treatment, food or fluids.

If the ethics committee decided for death, under these procedures there was no appeal. There was no provision that the food, fluids, or lifesaving treatment be provided after the decision while the patient or family tried to find another hospital willing to keep the patient alive.

So under these procedures, the hospitals in Houston were denying life-saving

treatment, food and fluids against the wishes of patients and their families, when the hospital ethics committees said their quality of life was too poor. Patients and families were being given only 72 hours after being notified of the proposed denial to find another health care provider.

In 1997 then-Governor George W. Bush vetoed an advance directives bill because it would have given specific legal sanction to such involuntary denial of life-saving treatment. An effort in the Texas legislature to amend the bill to require treatment pending transfer to a health care provider willing to provide the life-saving treatment had been defeated.

With no legal protection at all under Texas law, and ongoing programs in Texas hospitals denying treatment with virtually no opportunity even to seek transfer, pro-life groups entered into negotiations with medical groups that finally resulted in a bill that:
1) formalized more protections for in-hospital review
2) gave patients 10 days of treatment while seeking transfer
3) authorized court proceedings to extend the 10 days for reasonable additional periods to accomplish transfer.

To advocates for the right to choose food, fluids, and life-preserving medical treatment, this was far from ideal, but represented an important advance over the existing situation of no legal requirement of treatment pending transfer. The votes were not there in the Texas legislature to accomplish a more protective bill. At their urging, Governor Bush signed the legislation as an imperfect but real improvement over the existing law.

31. 2013 Ok. ALS 160, 1 (2013), to be codified as 63 Okla. Stat. §§ 3090.1 to 3090.4.

32. Idaho Code § 39-4514 (2012).

APPENDIX: STATE STATUTES

21 STATES AND TERRITORIES THAT DO *NOT* SPECIFY LIFE-PRESERVING TREATMENT PENDING TRANSFER

arkansas

Ark. Code Ann. §§ 20-17-207, 20-17-210(f) (2017).

20-17-207: An attending physician or other health care provider who is unwilling to comply with this subchapter shall as promptly as practicable take all reasonable steps to transfer care of the declarant to another physician or health care provider

20-17-210(f): This subchapter does not require any physician or health care provider to take any action contrary to reasonable medical standards.

connecticut

Conn. Gen. Stat. §§ 19a-571; 19a580a (West 2016).

Sec.19a-571. Liability re removal of life support system of incapacitated patient. Consideration of wishes of patient.

(a) Subject to the provisions of subsection (c) of this section, any physician licensed under chapter 370, any advanced practice registered nurse liscensed under chapter 378 or any

licensed medical facility who or which withholds, removes or causes the removal of a life support system of an incapacitated patient shall not be liable for damages in any civil action or subject to prosecution in any criminal proceeding for such withholding or removal, provided

(1) the decision to withhold or remove such life support system is based on the best medical judgment of the attending physician or advanced practice registered nurse in accordance with the usual and customary standards of medical practice;

(2) the attending physician or advanced practice registered nurse deems the patient to be in a terminal condition or, in consultation with aphysician qualified to make a neurological diagnosis who has examined the patient, deems the patient to be

permanently unconscious; and

(3) the attending physician or advanced practice registered nurse has considered the patient's wishes concerning the withholding or

withdrawal of life support systems. In the determination of the wishes of the patient, the attending physician shall consider the wishes as expressed by a document executed in accordance with sections 19a-575 and 19a-575a, if any such document is presented to, or in the possession of, the attending physician at the time the decision to withhold or terminate a life support system is made. If the wishes of the patient have not been expressed in a living will the attending physician or advanced practice registered nurse shall determine the wishes of the patient by consulting any statement made by the patient directly to the attending physician or advanced practice registered nurse and, if available, the patient's health care representative, the patient's next of kin, the patient's legal guardian or conservator, if any, any person designated by the patient in accordance with section 1-56r and any other person to whom the patient has communicated his wishes, if the

attending physician or advanced practice registered nurse has knowledge of such person. All persons acting on behalf of the patient shall act in good faith. If the attending physician or advanced practice registered nurse does not deem the incapacitated patient to be in a terminal condition or permanently unconscious, beneficial medical treatment including nutrition and hydration must be provided.
(b) A physician qualified to make a neurological diagnosis who is consulted by the attending physician or advanced practice registered nurse pursuant to subdivision (2) of subsection (a) of this section shall not be liable for damages or subject to criminal prosecution for any determination made in accordance with the usual and customary standards of medical practice.
(c) In the case of an infant, as defined in 45 CFR 1340.15 (b), the physician, advanced practice registered nurse or licensed medical facility shall comply with the provisions of 45 CFR 1340.15 (b)(2) in addition to the provisions of subsection (a) of this section.

Sec.19a-580a. Transfer of patient when attending physician or health care provider unwilling to comply with wishes of patient. An attending physician or health care provider who is unwilling to comply with the wishes of the patient or sections 19a-570, 19a-571, 19a-573 and 19a-575 to 19a-580c, inclusive, shall, as promptly as practicable, take all reasonable steps to transfer care of the patient to a physician or health care provider who is willing to comply with the wishes of the patient and said sections.

guam

10 Guam Code § 91109 (2016).
An attending physician or other health care provider who is unwilling to comply with this chapter shall take all reasonable steps as promptly as practicable to transfer care of the declarant to another physician or health care provider who is willing to do so.

illinois

755 Ill. Comp. Stat. Ann. 35/3(d) (West 2016).
If the patient is able, it shall be the responsibility of the patient to provide for notification to his or her attending physician of the existence of a declaration, to provide the declaration to the physician and to ask the attending physician whether he or she is willing to comply with its provisions. An attending physician who is so notified shall make the declaration, or copy of the declaration, a part of the patient's medical records. If the physician is at any time unwilling to comply with its provisions, the physician shall promptly so advise the declarant. If the physician is unwilling to comply with its provisions and the patient is able, it is the patient's responsibility to initiate the transfer to another physician of the patient's choosing. If the physician is unwilling to comply with its provisions and the patient is at any time not able to initiate the transfer, then the attending physician shall without delay notify the person with the highest priority, as set forth in this subsection, who is available, able, and willing to make arrangements for the transfer of the patient and the appropriate medical records to another physician for the effectuation of the patient's declaration. The order of priority is as follows: (1) any person authorized by the patient to make such arrangements, (2) a guardian of the person of the patient, without the necessity of obtaining a court order to do so, and (3) any member of the patient's family.

iowa.

Iowa Code §144A.8 (2016).

1. An attending physician who is unwilling to comply with the requirements of section 144A.5, or who is unwilling to comply with the declaration of a qualified patient in accordance with section 144A.6 or an out-of-hospital do-not-resuscitate order pursuant to section 144A.7A, or who is unwilling to comply with the provisions of section 144A.7 or 144A.7A shall take all reasonable steps to effect the transfer of the patient to another physician.
2. If the policies of a health care provider preclude compliance with the declaration or out-of-hospital do-not-resuscitate order of a qualified patient under this chapter or preclude compliance with the provisions of section 144A.7 or 144A.7A, the provider shall take all reasonable steps to effect the transfer of the patient to a facility in which the provisions of this chapter can be carried out.

kentucky

Ky. Rev. Stat. Ann. §311.633(2) (2017).

(2) An attending physician or health care facility which refuses to comply with the advance directive or a medical order for scope of treatment made pursuant to KRS 311.6225 of a patient or decision made by a surrogate or responsible party shall immediately inform the patient or the patient's responsible party and the family or guardian of the patient of the refusal. No physician or health care facility which refuses to comply with the advance directive or medical order for scope of treatment of a qualified patient or decision made by a responsible party shall impede the transfer of the patient to another physician or health care facility which will comply with the advance directive or medical order for scope of treatment. If the patient, the family, or the guardian of the patient has requested and authorized a transfer, the transferring attending physician and health care facility shall supply the patient's medical records and other information or assistance medically necessary for the continued care of the patient, to the receiving physician and health care facility.

louisiana

La. R.S. §40:1151.6(B), (D) (West 2017).

B. Any attending physician who refuses to comply with the declaration of a qualified patient or declaration otherwise made pursuant to this Subpart shall make a reasonable effort to transfer the patient to another physician.

D. If the policies of a health care provider preclude compliance with the declaration of a qualified patient under this Subpart or preclude compliance with the provisions pertaining to a representative acting on behalf of a qualified patient, then the provider shall take all reasonable steps to transfer the patient to a provider with which the provisions of this Part can be effectuated.

montana

Mont. Code Ann. §50-9-203 (2017).

An attending physician, attending advanced practice registered nurse, or other health care provider who is unwilling to comply with this chapter shall take all reasonable steps as promptly as practicable to transfer care of the declarant to another physician, advanced practice registered nurse, or health care provider who is willing to do so. If the policies of a health care facility preclude compliance with the declaration of a qualified patient under this chapter, that facility shall take all reasonable steps to transfer the patient to a facility in which the provisions of this chapter can be carried out.

nebraska

Neb. Rev. Stat.§ 30-3428(1), (2) (Michie 2016).

(1) Nothing in sections 30-3401 to 30-3432 shall obligate a health care provider organization to honor a health care decision by an attorney in fact that the health care provider organization would not honor if the decision had been made by the principal because the decision is contrary to a formally adopted policy of the health care provider organization that is expressly based on religious beliefs or sincerely held ethical or moral convictions central to the operating principles of the health care provider organization. The health care provider organization may refuse to honor the decision whether made by the principal or by the attorney in fact if the health care provider organization has informed the principal or the attorney in fact of such policy, if reasonably possible. If the attorney in fact is unable or unwilling to arrange a transfer to another health care facility, the health care provider organization may intervene to facilitate such a transfer.

(2) Nothing in sections 30-3401 to 30-3432 shall obligate an individual as a health care provider to honor or cooperate with a health care decision by an attorney in fact that the individual would not honor or cooperate with if the decision had been made by the principal because the decision is contrary to the individual's religious beliefs or sincerely held moral or ethical convictions. The individual health care provider shall promptly inform the attorney in fact and the health care provider organization of his or her refusal to honor or cooperate with the decision of the attorney in fact. In such event, the health care provider organization shall promptly assist in the transfer of responsibility for the principal to another individual health care provider who is willing to honor the decision of the attorney in fact.

nevada

Nev. Rev. Stat. § 449.628 (Michie 2016).

An attending physician or other provider of health care who is unwilling to comply with NRS 449.535 to 449.690, inclusive, shall take all reasonable steps as promptly as practicable to transfer care of the declarant to another physician or provider of health care.

new jersey

N.J. Stat. Ann § 26:2H-65(a)(4)(West 2017).

a. In addition to any rights and responsibilities recognized or imposed by, or pursuant to, this act, or any other law, a health care institution shall have the following rights and responsibilities:

(4) In situations in which a transfer of care is necessary, including a transfer for the purpose of effectuating a patient's wishes pursuant to an advance directive, a health care institution shall, in consultation with the attending physician, take all reasonable steps to effect the appropriate, respectful and timely transfer of the patient to the care of an alternative health care professional or institution, as necessary, and shall assure that the patient is not abandoned or treated disrespectfully. In such circumstances, a health care institution shall assure the timely transfer of the patient's medical records, including a copy of the patient's advance directive.

north carolina

N.C. Gen. Stat. § 90-321(k) (2017).

(k) Notwithstanding subsection (c) of this section: (1) An attending physician may decline to honor a declaration that expresses a desire of the declarant that life-prolonging measures not be used if doing so would violate that physician's conscience or the conscience-based policy of the facility at which the declarant is being treated; provided, an attending physician who declines to honor a declaration on these grounds must not interfere, and must cooperate reasonably, with efforts to substitute an attending physician whose conscience would not be violated by honoring the declaration, or transfer the declarant to a facility that does not have policies in force that prohibit honoring the declaration.

north dakota

N.D. Cent. Code § 23-06.5-12(3) (2016).

(3) A health care provider who administers health care necessary to keep the principal alive, despite a health care decision of the agent to withhold or withdraw that health care, or a health care provider who withholds health care that the provider has determined to be contrary to reasonable medical standards, despite a health care decision of the agent to provide the health care, may not be subjected to civil or criminal liability or be deemed to have engaged in unprofessional conduct if that health care provider promptly took all reasonable steps to: a. Notify the agent of the health care provider's unwillingness to comply; b. Document the notification in the principal's medical record; and c. Arrange to transfer care of the principal to another health care provider willing to comply with the decision of the agent.

oregon

Or. Rev. Stat. § 127.625(2)(c) (2017).

(2)If a health care provider is unable or unwilling to carry out a health care instruction or the decisions of the health care representative, the following provisions apply:
(c) If the representative's authority or decision is not in dispute, the representative shall make a reasonable effort to transfer the principal to the care of another physician or health care provider;

pennsylvania

Pa. Stat. Ann. tit. 20§ 5424 (2016).

Notification by attending physician or health care provider. –If an attending physician or other health care provider cannot in good conscience comply with a living will or health care decision of a health care agent or health care representative or if the policies of a health care provider preclude compliance with a living will or health care decision of a health care agent or health care representative, the attending physician or health care provider shall so inform the principal if the principal is competent or the principal's health care agent or health care representative if the principal is incompetent.
Transfer.—The attending physician or health care provider under subsection (a) shall make every reasonable effort to assist in the transfer of the principal to another physician or health care provider who will comply with the living will or health care decision of the health care agent or health care representative.

south carolina

S.C. Code Ann. § 44-77-100 (2016).

... A failure by a physician to effectuate the declaration of a terminal patient constitutes unprofessional conduct if the physician fails or refuses to make reasonable efforts to effect the transfer of the patient to another physician who will effectuate the declaration. ....

tennessee

Tenn. Code Ann. § 32-11-108 (a) (2016).

Any physician or other individual health care provider who cannot in good conscience comply with the provisions of such living will, on being informed of the declaration, shall so inform the declarant, or if the declarant is not competent, the declarant's next of kin or a legal guardian, and at their option make every reasonable effort to assist in the transfer of the patient to another physician who will comply with the declaration. Any health care provider who fails to make good faith reasonable efforts to comply with the preceding procedure as prescribed by the attending physician shall be civilly liable and subject to professional disciplinary action, including revocation or suspension of license. The health care provider shall not be subject to civil liability for medical care provided during the interim period until transfer is effectuated.

virgin islands

19 V.I.C § 193 (2016).

An attending physician or other health-care provider who is unwilling to comply with this chapter shall, as promptly as practicable, take all reasonable steps to transfer care of the declarant to another physician or healthcare provider who is willing to do so.

washington

Wash. Rev. Code Ann. §70.122.060(2) (West 2016).

The attending physician or health facility shall inform a patient or patient's authorized representative of the existence of any policy or practice that would preclude the honoring of the patient's directive at the time the physician or facility becomes aware of the existence of such a directive. If the patient, after being informed of such policy or directive, chooses to retain the physician or facility, the physician or facility with the patient or the patient's representative shall prepare a written plan to be filed with the patient's directive that sets forth the physician's or facilities' intended actions should the patient's medical status change so that the directive would become operative. The physician or facility under this subsection has no obligation to honor the patient's directive if they have complied with the requirements of this subsection, including compliance with the written plan required under this subsection.

west virginia

W. Va. Code § 16-30-12(a) (2016).

(a) HEALTH CARE FACILITIES: Nothing in this article shall be construed to require a health care facility to change published policy of the health care facility that is expressly based on sincerely held religious beliefs or sincerely held moral convictions central to the facility's operating principles. (b) HEALTH CARE PROVIDERS. Nothing in this article shall be construed to require an individual health care provider to honor a health are decision made pursuant to this article if: (1) The decision is contrary to the individual provider's sincerely held religious beliefs or sincerely held moral convictions; and (2) The individual health care provider promptly informs the person who made the decision and the health care facility of his or her refusal to honor the decision. In such event, the medical power of attorney representative or surrogate decision maker shall have responsibility for arranging the transfer of the person to another health care provider. The individual health care provider shall cooperate in facilitating such transfer, and a transfer under these circumstances shall not constitute abandonment.

wisconsin

Wis. Stat. Ann. § 154.07(1)(a) (West 2017).

(a) No physician, inpatient health care facility or health care professional acting under the direction of a physician may be held criminally or civilly liable, or charged with unprofessional conduct, for any of the following:

3. Failing to comply with a declaration, except that failure by a physician to comply with a declaration of a qualified patient constitutes unprofessional conduct if the physician refuses or fails to make a good faith attempt to transfer the qualified patient to another physician who will comply with the declaration.

17 STATES AND D.C. HAVE QUESTIONABLE TREATMENT PENDING TRANSFER STATUTES

alaska

Alaska Stat. § 13.52.060 (2017).

(e) A health care provider may decline to comply with an individual instruction or a health care decision for reasons of conscience, except for a do not resuscitate order. A health care institution or health care facility may decline to comply with an individual instruction or health care decision if the instruction or decision is contrary to a policy of the institution or facility that is expressly based on reasons of conscience and if the policy was timely communicated to the patient or to a person then authorized to make health care decisions for the patient.

(f) A health care provider, health care institution, or health care facility may decline to comply with an individual instruction or a health care decision that requires medically ineffective health care or health care contrary to generally accepted health care standards applicable to the provider, institution, or facility. In this subsection, "medically ineffective health care" means health care that according to reasonable medical judgment cannot cure the patient's illness, cannot diminish its progressive course, and cannot effectively alleviate severe discomfort and distress

(g) A health care provider, health care institution, or health care facility that declines to comply with an individual instruction or a health care decision shall (1) promptly inform the patient, if possible, and any person then authorized to make health care decisions for the patient that the provider, institution, or facility has declined to comply with the instruction or decision;(2) provide continuing care to the patient until a transfer is effected; and (3) unless the patient or person then authorized to make health care decisions for the patient refuses assistance, immediately cooperate and comply with a decision by the patient or a person then authorized to make health care decisions for the patient to transfer the patient to another health care institution, to another health care facility, to the patient's home, or to another location chosen by the patient or by the person then authorized to make health care decisions for the patient.

arizona

Ariz. Rev. Stat. Ann. § 36-3205 (C) (2016).

(C)A health care provider is not subject to criminal or civil liability or professional discipline for any of the following:

1. Failing to comply with a decision or a direction that violates the provider's conscience if the provider promptly makes known the provider's unwillingness and promptly transfers the responsibility for the patient's care to another provider who is willing to act in accordance with the agent's direction.

california

Cal. [Probate] Code § 4734, 4736 (2017).

Section 4734: (a) A health care provider may decline to comply with an individual health care instruction or health care decision for reasons of conscience.
(b) A health care institution may decline to comply with an individual health care instruction or health care decision if the instruction or decision is contrary to a policy of the institution that is expressly based on reasons of conscience and if the policy was timely communicated to the patient or to a person then authorized to make health care decisions for the patient

Section 4736: A health care provider or health care institution that declines to comply with an individual health care instruction or health care decision shall do all of the following:
(c) Provide continuing care to the patient until a transfer can be accomplished or until it appears that a transfer cannot be accomplished. In all cases, appropriate pain relief and other palliative care shall be continued.

colorado

Colo. Rev. Stat. § 15-14-507 (2), (5) (2016).
(2) A health care provider or health care facility shall provide for the prompt transfer of the principal to another health care provider or health care facility if such health care provider or health care facility wishes not to comply with an agent's medical treatment decision on the basis of policies based on moral convictions or religious beliefs.
(5) Nothing in this section shall relieve or exonerate an attending physician or health care facility from the duty to provide for the care and comfort of the principal pending transfer pursuant to this section.

delaware

Del. Code Ann. tit. 16 § 2508(g) (2017).
(g) A health-care provider or institution that declines to comply with an individual instruction or health-care decision shall:
(2) Provide continuing care, including continuing life sustaining care, to the patient until a transfer can be effected;

But:
Del. Code Ann. tit. 16 § 2510(a)(5)(2017).
(a) A health-care provider or institution acting in good faith and in accordance with generally accepted healthcare standards applicable to the health-care provider or institution is not subject to civil or criminal liability or to discipline for unprofessional conduct for: ...
(5) Declining to comply with a health care decision or advance health-care directive because the instruction is contrary to the conscience or good faith medical judgment of the health care provider or the written policies of the institution.

district of columbia

D.C. Code § 7-627 (b) (2017).
An attending physician who cannot comply with the declaration of a qualified patient pursuant to this subchapter shall, in conjunction with the next of kin of the patient or other responsible individual, effect the transfer of the qualified patient to another physician who will honor the declaration of the qualified patient. Transfer under these circumstances shall not constitute abandonment. Failure of an attending physician to effect the transfer of the qualified patient according to this section, in the event he or she cannot comply with the directive, shall constitute unprofessional conduct as defined in § 3-2926 [repealed].

georgia

Ga. Code Ann. § 31-32-8(2) (Michie 2016).

A health care decision made by a health care agent in accordance with the terms of an advance directive for health care shall be complied with by every health care provider to whom the decision is communicated, subject to the health care provider's right to administer treatment for the declarant's comfort or alleviation of pain; provided, however, that if the health care provider is unwilling to comply with the health care agent's decision, the health care provider shall promptly inform the health care agent who shall then be responsible for arranging for the declarant's transfer to another health care provider. A health care provider who is unwilling to comply with the health care agent's decision shall provide reasonably necessary consultation and care in connection with the pending transfer.

hawaii

Haw. Rev. Stat. § 327E-7 (e), (f), (g)(2) (2016).

(e) A health-care provider may decline to comply with an individual instruction or health-care decision for reasons of conscience. A health-care institution may decline to comply with an individual instruction or health-care decision if the instruction or decision is contrary to a policy of the institution which is expressly based on reasons of conscience and if the policy was timely communicated to the patient or to a person then authorized to make health-care decisions for the patient.
(f) A health-care provider or institution may decline to comply with an individual instruction or health-care decision that requires medically ineffective health care or health care contrary to generally accepted health-care standards applicable to the health-care provider or institution.
(g) A health-care provider or institution that declines to comply with an individual instruction or health-care decision shall: (2) Provide continuing care to the patient until a transfer can be effected;

indiana

Ind. Code Ann. § 16-36-4-13 (2017).

(e) An attending physician who refuses to use, withhold, or withdraw life prolonging procedures from a qualified patient shall transfer the qualified patient to another physician who will honor the patient's living will declaration or life prolonging procedures will declaration unless:
(1) the physician has reason to believe the declaration was not validly executed or there is evidence that the patient no longer intends the declaration to be enforced; and
(2) the patient is presently unable to validate the declaration.
(f) If the attending physician, after reasonable investigation, finds no other physician willing to honor the patient's declaration, the attending physician may refuse to withhold or withdraw life-prolonging procedures.

maine

Me. Rev. Stat. Ann. Tit. 18-A § 5-807 (G) (2017).

(G)A health-care provider or institution that declines to comply with an individual instruction or health-care decision shall:
(2) Provide continuing care to the patient until a transfer can be effected or a court of competent jurisdiction issues a final order regarding the decision;

michigan

Mich. Comp. Laws § 700.5511(3) (2017).

A person providing care, custody, or medical treatment to a patient is bound by sound medical practice or if applicable, mental health treatment practice and by a patient advocate's instructions if the patient advocate

complies with sections 5506 to 5515, but is not bound by the patient advocate's instructions if the patient advocate does not comply with these sections.

Mich. Comp. Laws § 333.20403 (2017)
Life-sustaining or nonbeneficial treatment; policies of heath facility or agency; disclosure to patient or resident; patient as minor or ward.
(1) Upon the request of a patient or resident or a prospective patient or resident, a health facility or agency shall disclose in writing any policies related to a patient or resident or the services a patient or resident may receive involving life-sustaining or nonbeneficial treatment within that health facility or agency.
(2) If the patient or resident or prospective patient or resident is a minor or ward, the health facility or agency shall upon request provide in writing the policies described in subsection (1) to a parent or legal guardian of the patient or resident or prospective patient or resident.

mississippi

Miss. Code Ann. § 41-41-215 (7) (2017).
(7) A health-care provider or institution that declines to comply with an individual instruction or health-care decision shall: (b) Provide continuing care to the patient until a transfer can be effected; and

missouri

Mo. Rev. Stat.§ 404.830 (2017).
1. No physician, nurse, or other individual who is a health care provider or an employee of a health care facility shall be required to honor a health care decision of an attorney in fact if that decision is contrary to the individual's religious beliefs, or sincerely held moral convictions.
2. No hospital, nursing facility, residential care facility, or other health care facility shall be required to honor a health care decision of an attorney in fact if that decision is contrary to the hospital's or facility's institutional policy based on religious beliefs or sincerely held moral convictions unless the hospital or facility received a copy of the durable power of attorney for health care prior to commencing the current series of treatments or current confinement.
3. Any health care provider or facility which, pursuant to subsection 1 or 2 of this section, refuses to honor a health care decision of an attorney in fact shall not impede the attorney in fact from transferring the patient to another health care provider or facility.

Mo. Rev. Stat. § 459.030 (2017).
459.030. 1. An attending physician who is unwilling to comply with the requirements of section 459.025 or who is unwilling to comply with the declaration of a patient in accordance with section 459.015 shall take all reasonable steps to effect the transfer of the declarant to another physician.
2. If the policies of a health care facility preclude compliance with the declaration of a patient under sections 459.010 to 459.055, that facility shall take all reasonable steps to effect the transfer of the declarant to a facility in which the provisions of sections 459.010 to 459.055 can be carried out.

new mexico

N.M. Stat. Ann.§ 24-7A-7 (E), (F), (G) (Michie 2017).
(E) A health-care practioner may decline to comply with an individual instruction or health-care decision for reasons of conscience. A health-care institution may decline to comply with an individual instruction or healthcare decision if the instruction or decision is contrary to a policy of the health-care institution that is expressly based on reasons of conscience and if the policy was timely communicated to the patient or to a person then authorized to make health-care decisions for the patient.
(F) A health-care provider or health-care institution may decline to comply with an individual instruction or

health-care decision that requires medically ineffective health care or health care contrary to generally accepted health-care standards applicable to the health-care practioner or health-care institution. "Medically ineffective health care" means treatment that would not offer the patient any significant benefit, as determined by a health-care practitioner .
(G) A health-care practioner or health-care institution that declines to comply with an individual instruction or
health-care decision shall: (1) promptly so inform the patient, if possible, and any person then authorized to make health-care decisions for the patient; (2) provide continuing care to the patient until a transfer can be effected; and (3) unless the patient or person then authorized to make health-care decisions for the patient refuses assistance, immediately make all reasonable efforts to assist in the transfer of the patient to another health-care practioner or health-care institution that is willing to comply with the instruction or decision.

rhode island

R.I. Gen. Laws § 23-4.10-6 (2016).
An attending physician or health-care provider who refuses to comply with the durable power of attorney of a patient pursuant to this chapter shall make the necessary arrangements to effect the transfer of the patient to another physician who will effectuate the durable power of attorney of the patient.

R.I. Gen. Laws § 23-4.10-8(a) (2016).
§ 234.10-8 (a) Failure of a physician to transfer a patient pursuant to § 23-4.10-6 shall constitute "unprofessional conduct" as that term is used in § 5-37-5.1.

south dakota

S.D. Codified Laws § 34-12D-12 (Michie 2016).
If an individual's declaration contains a directive to provide treatment or artificial nutrition and hydration under any circumstances, any health care provider who has responsibility for the treatment and care of the individual must provide the directed treatment or artificial nutrition and hydration in those circumstances so long as it is technically feasible. A health care provider who objects to providing such treatment may instead transfer the individual to a health care provider willing to honor the declaration, but must continue to provide the treatment or care until the transfer is effectuated.

BUT:
S.D. Codified Laws § 34-12D-19 (Michie 2016)
This chapter does not require a physician or other health care provider to take action contrary to accepted medical standards.

utah

Utah Code Ann. § 75-2a-115(4) (2016).
(4)(c) A health care provider or health care facility that declines to comply with a health care decision in accordance with Subsection (4)(b) must:
(i) promptly inform the adult and any acting surrogate of the reason for refusing to comply with the health care decision;
(ii) make a good faith attempt to resolve the conflict; and
(iii) provide continuing care to the patient until the issue is resolved or until a transfer can be made to a health care provider or health care facility that will implement the requested instruction or decision.

vermont

Vt. Stat. Ann. Tit. 18 § 9707(b) (2017).

(b)(3) because of a moral, ethical, or other conflict with an instruction in the advance directive or given by the agent or guardian, a principal's provider, or an employee thereof is unwilling to follow that instruction, in which case the provider shall promptly: (c) provide ongoing health care until a new provider or employe has been found to provide the services.

2 STATES REQUIRING LIFE-PRESERVING TREATMENT PENDING TRANSFER - TIME LIMIT

texas

Tex. Code Ann. § 166.046 (Vernon 2016).

Procedure if Not Effectuating a Directive

(a) If an attending physician refuses to honor a patient's advance directive or a treatment decision made by or on behalf of the patient, the physician's refusal shall be reviewed by an ethics or medical committee. The attending physician may

not be a member of that committee. The patient shall be given life-sustaining treatment during the review.

(e) If the patient or the person responsible for the health care decisions of the patient is requesting life-sustaining treatment that the attending physician has decided and the ethics or medical committee has affirmed is inappropriate treatment, the patient shall be given available life-sustaining treatment pending transfer under Subsection (d). The patient is responsible for any costs incurred in transferring the patient to another facility. The physician and the health care facility are not obligated to provide life-sustaining treatment after the 10th day after both the written decision and the patient's medical record required under Subsection (b) is provided to the patient or the person responsible for the health care decisions of the patient unless ordered to do so under Subsection (g). except that artificially administered nutrition and hydration must be provided unless, based on reasonable medical judgment, providing artificially administered nutrition and hydration would: (1) hasten the patient's death;

(2) be medically contraindicated such that the provision of the treatment seriously exacerbates life-threatening medical problems not outweighed by the benefit of the provision of the treatment; (3) result in substantial irremediable physical pain not outweighed by the benefit of the provision of the treatment;

(4) be medically ineffective in prolonging life; or (5) be contrary to the patient's or surrogate's clearly documented desire not to receive artificially administered nutrition or hydration.

(e-1) If during a previous admission to a facility a patient's attending physician and the review process under subsection (b) have determined that life-sustaining treatment is inappropriate, and the patient is readmitted to the same facility within six months from the date of the decision reached during the review process conducted upon the previous admission, subsections (b) through (e) need not be followed if the patient's attending physician and a consulting physician who is a member of the ethics or medical committee of the

facility document on the patient's readmission that the patient's condition either has not improved or has deteriorated since the review process was conducted.
(g) At the request of the patient or the person responsible for the health care decisions of the patient, the appropriate district or county court shall extend the time period provided under Subsection (e) only if the court finds, by a preponderance of the evidence, that there is a reasonable expectation that a physician or health care facility that will honor the patient's directive will be found if the time extension is granted.

virginia

Va. Code Ann. § 54.1-2987 (Michie 2017).
An attending physician who refuses to comply with (i) a patient's advance directive or (ii) the health care decision of a patient's agent or (iii) the health care decision of an authorized person pursuant to § 54.1-2986 shall make a reasonable effort to transfer the patient to another physician and shall comply with § 54.1-2990. This section shall apply even if the attending physician determines the health care requested to be medically or ethically inappropriate.

Va. Code Ann. § 54.1-2990 (Michie 2017).
§ 54.1-2990. Medically unnecessary health care not required; procedure when physician refuses to comply with an advance directive or a designated person's health care decision; mercy killing or euthanasia prohibited

A. Nothing in this article shall be construed to require a physician to prescribe or render health care to a patient that the physician determines to be medically or ethically inappropriate. However, in such a case, if the physician's determination is contrary to the request of the patient, the terms of a patient's advance directive, the decision of an agent or person authorized to make decisions pursuant to § 54.1-2986, or a Durable Do Not Resuscitate Order, the physician shall make a reasonable effort to inform the patient or the patient's agent or person with decision-making authority pursuant to § 54.1-2986 of such determination and the reasons for the determination. If the conflict remains unresolved, the physician shall make a reasonable effort to transfer the patient to another physician who is willing to comply with the request of the patient, the terms of the advance directive, the decision of an agent or person authorized to make decisions pursuant to § 54.1-2986, or a Durable Do Not Resuscitate Order. The physician shall provide the patient or his agent or person with decision-making authority pursuant to § 54.1-2986 a reasonable time of not less than fourteen days to effect such transfer. During this period, the physician shall continue to provide any life-sustaining care to the patient which is reasonably available to such physician, as requested by the patient or his agent or person with decision-making authority pursuant to § 54.1-2986.
B. For purposes of this section, *"life-sustaining care"* means any ongoing health care that utilizes mechanical or other artificial means to sustain, restore or supplant a spontaneous vital function, including hydration, nutrition, maintenance medication, and cardiopulmonary resuscitation.
C. Nothing in this section shall require the provision of health care that the physician is physically or legally unable to provide, or health care that the physician is physically or legally unable to provide without thereby denying the same health care to another patient.

10 STATES REQUIRING LIFE-PRESERVING TREATMENT PENDING TRANSFER - NO TIME LIMIT

alabama

Ala. Code § 22-8A-8(a)(2017).

(a) A health care provider who refuses to comply with a living will or the directions of a duly designated proxy or a duly appointed surrogate or who refuses to honor a portable physician DNAR order executed in compliance with the directives of this chapter and using the form designated by the State Board of Health pursuant to this chapter shall promptly so advise the declarant and any individual designated to act for the declarant, shall not be liable for such refusal, but shall permit the patient to be transferred to another health care provider. Such health care provider shall reasonably cooperate to assist the declarant, or any individual designated to act for the declarant, in the timely transfer of the declarant to another health care provider that will follow the directions of the living will, health care proxy, or surrogate. During the time for the transfer, all life-sustaining treatments, including artificially provided nutrition and hydration, shall be properly maintained.

But:

Ala. Code § 22-8A-9(d)(2017).

(d) Nothing in this chapter shall impair or supersede any legal right or legal responsibility which any person may have, under case law, common law, or statutory law, to effect the withholding or withdrawal of life-sustaining treatment or artificially provided nutrition and hydration in any lawful manner. In such respect the provisions of this chapter are cumulative.

florida

Fla. Stat. Ann. § 765.1105 (1) (2017).

A health care provider or facility that refuses to comply with a patient's advance directive, or the treatment decision of his or her surrogate or proxy, shall make reasonable efforts to transfer the patient to another health care provider or facility that will comply with the directive or treatment decision. This chapter does not require a health care provider or facility to commit any act which is contrary to the provider's or facility's moral or ethical beliefs, if the patient:

(a) Is not in an emergency condition; and

(b) Has received written information upon admission informing the patient of the policies of the health care provider or facility regarding such moral or ethical beliefs.

(2) A health care provider or facility that is unwilling to carry out the wishes of the patient or the treatment decision of his or her surrogate or proxy because of moral or ethical beliefs must within 7 days either:

(a) Transfer the patient to another health care provider or facility. The health care provider or facility shall pay the costs for transporting the patient to another health care provider or facility; or

(b) If the patient has not been transferred, carry out the wishes of the patient or the patient's surrogate or proxy, unless the provisions of s. 765.105 apply.

kansas

Kan. Stat. Ann. § 65-28,107(a) (2017).

An attending physician who refuses to comply with the declaration of a qualified patient pursuant to this act shall effect the transfer of the qualified patient to another physician. Failure of an attending physician to comply with the declaration of a qualified patient and to effect the transfer of the qualified patient shall constitute unprofessional conduct as defined in K.S.A. 65-2837, and amendments thereto.

maryland

Md. Code Ann., [Health-General] § 5-613 (a)(2017).

A health care provider that intends not to comply with an instruction of a health care agent or a surrogate shall:
(1) Inform the person giving the instruction that:
(i) The health care provider declines to carry out the instruction; (ii) The person may request a transfer to another health care provider; and (iii) The health care provider will make every reasonable effort to transfer the patient to another health care provider;
(2) Assist in the transfer; and
(3)Pending the transfer, comply with an instruction of a competent individual, or of a health care agent or surrogate for an individual who is incapable of making an informed decision, if a failure to comply with the instruction would likely result in the death of the individual.

massachusetts

Mass. Ann. Laws ch. 201D § 14, 15 (Law. Co-op. 2016).

Section 14. Notwithstanding any provisions herein to the contrary, nothing in this chapter shall be construed to require a physician to honor an agent's health care decision that the physician would not honor if the decision had been made by the principal because the decision is contrary to the moral or religious views of the physician; provided, however, that the patient is transferred to another physician in the same facility, or in an equivalent facility that is reasonably accessible to the patient's family, who is willing to honor the agent's decision. If the physician or the agent is unable to arrange such a transfer, the physician shall seek judicial relief or honor the agent's decision.

Section 15. Notwithstanding any provisions herein to the contrary, nothing in this chapter shall be construed to require a private facility to honor an agent's health care decision that the facility would not honor if the decision had been made by the principal because the decision is contrary to a formally adopted policy of the facility that is expressly based on religious beliefs and the facility would be permitted by law to refuse to honor the decision if made by the principal, provided:
(a) the facility has informed the patient or the health care agent of such policy prior to or upon admission, if reasonably possible; and
(b) the patient is transferred to another equivalent facility that is reasonably accessible to the patient's family and willing to honor the agent's decision. If the facility or the agent is unable to arrange such a transfer, the facility shall seek judicial guidance or honor the agent's decision

minnesota

Minn. Stat. §145C.15 (2016).

145C.15 Duties of health care providers to provide life-sustaining health care.
(a) If a proxy acting under chapter 145B or a health care agent acting under this chapter directs the provision of health care, nutrition, or hydration that, in reasonable medical judgment, has a significant possibility of sustaining the life of the principal or declarant, a health care provider shall take all reasonable steps to ensure the provision of the directed health care, nutrition, or hydration if the provider has the legal and actual capability of providing the health care either itself or by transferring the principal or declarant to a health care provider who has that capability. Any transfer of a principal or declarant under this paragraph must be done promptly and, if necessary to preserve the life of the principal or declarant, by emergency means. This paragraph does not apply if a living will under chapter 145B or a health care directive indicates an intention to the contrary.

(b) A health care provider who is unwilling to provide directed health care under paragraph (a) that the provider has the legal and actual capability of providing may transfer the principal or declarant to another health care provider willing to provide the directed health care but the provider shall take all reasonable steps to ensure provision of the directed health care until the principal or declarant is transferred.
(c) Nothing in this section alters any legal obligation or lack of legal obligation of a health care provider to provide health care to a principal or declarant who refuses, has refused, or is unable to pay for the health care.

new hampshire

N.H. Rev. Stat. Ann. §137-J:7 (II)(2016).

An attending physician or ARNP who, because of personal beliefs or conscience, is unable to comply with the advance directive or the surrogate's decision pursuant to this chapter shall, without delay, make the necessary arrangements to effect the transfer of a qualified patient and the appropriate medical records that document the qualified patient's lack of capacity to make health care decisions to another physician or ARNP who has been chosen by the qualified patient, by the qualified patients agent or surrogate, or by the qualified patient's family, provided that pending the completion of the transfer, the attending physician or ARNP shall not deny health care treatment, nutrition, or hydration which denial would, within a reasonable degree of medical certainty, result in or hasten the qualified patient's death against the express will of the qualified patient, the advance directive, or the agent or surrogate.

new york

N.Y. [Public Health] Law § 2984(3) (Consol. 2016).

(3) Not withstanding subdivision two of this section, nothing in this article shall be construed to require a private hospital to honor an agent's health care decision that the hospital would not honor if the decision had been made by the principal because the decision is contrary to a formally adopted policy of the hospital that is expressly based on religious beliefs or sincerely held moral convictions central to the facility's operating principles and the hospital would be permitted by law to refuse to honor the decision if made by the principal, provided:
(b) the patient is transferred promptly to another hospital that is reasonably accessible under the circumstances and is willing to honor the agent's decision and pending transfer the hospital complies with subdivision five of this section. If the agent is unable or unwilling to arrange such a transfer, the hospital may intervene to facilitate such a transfer. If such a transfer is not effected, the hospital shall seek judicial relief in accordance with section twenty-nine hundred ninety-two of this article or honor the agent's decision.
(4) Notwithstanding subdivision two of this section, nothing in this article shall be construed to require an individual as a health care provider to honor an agent's health care decision that the individual would not honor if the decision had been made by the principal because the decision is contrary to the individual's religious beliefs or sincerely held moral convictions, provided the individual health care provider promptly informs the health care agent and the hospital of his or her refusal to honor the agent's decision. In such event, the hospital shall promptly transfer responsibility for the patient to another individual health care provider willing to honor the agent's decision. The individual health care provider shall cooperate in facilitating such transfer of the patient and comply with subdivision five of this section.

N.Y. [Surr. Ct. Proc. Act] Law § 1750 – b (7)(d)(Law. Co-op 2015).

(d) Notwithstanding the provisions of any other paragraph of this subdivision, if a guardian directs the provision of life-sustaining treatment, the denial of which in reasonable medical judgment would be likely to result in the death of the <1> the person who is intellectually disabled, a hospital or individual health care provider that does not wish to provide such treatment shall nonetheless comply with the guardian's decision pending either transfer of <2>the person who is intellectually disabled to a willing hospital or individual health care provider, or judicial review.

ohio

Ohio Rev. Code Ann. § 1337.16 (B) (2)(b) (Anderson 2016).

If the instruction of an attorney in fact under a durable power of attorney for health care that is given under division (A) of section 1337.13 of the Revised Code is to use or continue life-sustaining treatment in connection with a principal who is in a terminal condition or in a permanently unconscious state, the attending physician of the principal who, or the health care facility in which the principal is confined that, is not willing or not able to comply or allow compliance with that instruction shall use or continue the life-sustaining treatment or cause it to be used or continued until a transfer as described in division (B)(2)(a) of this section is made.

wyoming

Wyo. Stat. Ann. §35-22-408 (g) ii (Michie 2016).

(g) A health care provider or institution that declines to comply with an individual instruction or health care decision shall:(ii) Provide continuing care, including continuing life sustaining care, to the patient until a transfer can be effected; and (iii) Unless the patient or person then authorized to make health care decisions for the patient refuses assistance, immediately make all reasonable efforts to assist in the transfer of the patient to another health care provider or institution that is willing to comply with the instruction or decision.

1 STATE REQUIRES LIFE-PRESERVING TREATMENT

idaho

Idaho Code § 39-4514 (2017)

(3) Withdrawal of care. Assisted feeding or artificial nutrition and hydration may not be withdrawn or denied if its provision is directed by a competent patient in accordance with section 39-4503, Idaho Code, by a patient's health care directive under section 39-4510, Idaho Code, or by a patient's surrogate decision maker in accordance with section 39-4504, Idaho Code. Health care necessary to sustain life or to provide appropriate comfort for a patient other than assisted feeding or artificial nutrition and hydration may not be withdrawn or denied if its provision is directed by a competent patient in accordance with section 39-4503, Idaho Code, by a patient's health care directive under section 39-4510, Idaho Code, or by a patient's surrogated decision maker in accordance with section 39-4504, Idaho Code, unless such care would be futile care as defined in subsection (6) of this section. Except as specifically provided in chapters 3 and 4, title 66, Idaho Code, health care, assisted feeding or artificial nutrition and hydration, the denial of which is directed by a competent patient in accordance with section 39-4503, Idaho Code, by a patient's health care directive under section 39-4510, Idaho Code, or by a patient's surrogate decision maker in accordance with section 39-4504, Idaho Code, shall be withdrawn and denied in accordance with a valid directive. This subsection does not require provision of treatment to a patient if it would require denial of the same or similar treatment to another patient.

1 STATE PREVENTS THE DENIAL OF TREATMENT BASED ON AGE, DISABILITY, OR TERMINAL CONDITION

oklahoma

2016 Ok. ALS 160, 1 (2013), to be codified as 63 Okla. Stat. §§ 3090.3.

A health care provider shall not deny to a patient a lifepreserving health care service the provider provides to other patients, the provision of which is directed by the patient or a person authorized to make health care decisions for the patient:

1. On the basis of a view that treats extending the life of an elderly, disabled, or terminally ill individual as of lower value than extending the life of an individual who is younger, nondisabled, or not terminally ill; or
2. On the basis of disagreement with how the patient or person authorized to make health care decisions for the patient values the trade-off between extending the length of the patient's life and the risk of disability.