

The Patient Decided to “Die With Dignity” But Changed His Mind! What Now?

**By
Dan Groskruger, JD, MPH**

Your patient, a 67-year old retired meteorologist, suffers from advanced Amyotrophic Lateral Sclerosis (“ALS” or Lou Gehrig’s disease). His care is provided at home, but his condition continues to deteriorate. Anticipating that the end is near, you have arranged for hospice care and placed a do-not-resuscitate (“DNR”) order in the chart. Although he can no longer speak, he has a valid Durable Power of Attorney for Healthcare, naming his former wife as surrogate decision-maker. You both have candidly discussed end-of-life issues, and your patient’s wishes are known by his ex-wife and family. He has indicated, unequivocally, that he wishes to “die with dignity,” forgoing heroic measures. Despite his physical condition, your patient is highly intelligent and mentally alert.

The above situation represents planning and foresight beyond the norm. Many patients and families are uncomfortable discussing death and dying issues. Physicians too often procrastinate, or simply fail to bring up uncomfortable subjects. In any event, the above patient appears to be better prepared than most. You might expect that your efforts would ensure a relatively smooth and uncomplicated passing, while you concentrate on minimizing pain and suffering. If your patient was named Virgil Ray Noonkester, you would be dead wrong!

Lawrence Kline, M.D., a pulmonary specialist in San Diego, was sued by his patient, Noonkester, for failure to adequately explain options and for violating advance directives. In December 1993, the patient’s home health aide called “911” when Noonkester suddenly began gasping for breath. An ambulance brought him to the nearest emergency room. In the meantime, his ex-wife as surrogate decision-maker arrived and informed the doctors of Noonkester’s wishes. Despite actual notice of an advance directive, the physicians asked Noonkester if he wished to be intubated and placed on a respirator. Noonkester, who was conscious but unable to speak, gave a “thumbs up” in response. After he was stabilized, Noonkester was transferred to Kline’s hospital, and continued under Kline’s care for a year after the incident.

Lawrence Kline was stunned by the lawsuit which asked for money damages to pay for Noonkester’s round-the-clock nursing care. The complaint alleged that Noonkester was resuscitated and kept alive against his wishes. It was clear to Kline that, despite advance directives, his patient had simply changed his mind when confronting the prospect of choking to death. In fact, a jury ultimately agreed, and returned a defense verdict, finding that the patient changed his mind and decided to live. Unfortunately for Kline, the verdict came after widespread negative publicity, including coverage by the 1996 trial on Court TV. As a physician, Kline was embarrassed by the allegations of malpractice and violation

of patients' rights: "Even though my colleagues and the jury supported me some people will always think there's a presumption of guilt."

The lesson to be taken from all of this is that both physician and patient need to understand the purpose, and the limitations, of advance directives. The patient retains decision-making authority as long as he or she can give informed consent (Probate Code §4703). The patient may revoke a Durable Power of Attorney at any time, orally or in writing. Regardless of how clear an advance directive may be, the patient's choice is not irrevocable. Finally, many people cannot accurately predict exactly how they may react in an emergency. As Virgil Ray Noonkester wrote to Dr. Kline in a poignant letter of thanks (after the emergency but before filing suit), "I realize I am much more of a fighter for life than I ever imagined."