The New Hawaii Comfort Care Only—Do Not Resuscitate Law

Gregory C. Gifford MD, JD

The new Hawaii law creating the Comfort Care Only-Do Not Resuscitate order allows terminally ill patients to be treated by ambulance personnel for comfort and pain control, and to not be resuscitated when they are near death.

There is a new law in Hawaii that is designed to resolve the pre-hospital dilemma of terminally ill patients who want access to medical care for physical comfort, but want to avoid undergoing attempted resuscitation when they start to die. Will the roles change for emergency medical services (EMS) personnel, first responders, and health care providers, including the terminally ill patients' private physicians under this new law?

This new Hawaii law was passed following years of consideration by legislators, EMS personnel, medical directors, religious and community groups, and the general public. It was signed into law in July 1994. Under this new Hawaii law, a patient can issue a "Comfort Care Only—Do Not Resuscitate" order if that patient is a competent adult and it has been certified by his or her physician to be terminally ill.

Competent adults have been held to have the legal right to refuse unwanted medical treatment by both Supreme Court decisions[1] and federal legislation.[2] This refusal can be expressed in advance of the unwanted treatment. The most effective inpatient mechanism to exercise this right in advance is the Living Will, an "advance directive" that says, in advance of an actual occurrence that could result in unwanted treatment, to withhold unwanted treatment.

The concept of Living Wills for inpatients in hospitals and nursing homes is accepted in this country and many others. The Patient Self-Determination Act (part of the Omnibus Budget Reconciliation Act of 1990[3] requires that written information regarding Living Wills be offered to patients during admission to facilities participating in Medicare or Medicaid funding (including hospitals, skilled nursing facilities, home health agencies, prepaid health care organizations, and hospice programs). However, the federal government has not addressed the pre-hospital situation.

The pre-hospital situation is unique in these two respects: The concept of presumed consent, and the extremely limited time to decide to resuscitate. It has long been legally presumed that patients want to be rescued and treated in an emergency setting if found unconscious or incompetent. An advance directive (Living Will) can overcome this presumption if it can be determined to be valid and applicable to that emergency setting and treatment—but how can its existence, applicability, and validity be determined in seconds?

Several states have tried to deal with this problem by enacting legislation to address the pre-hospital recognition of advance directives. Some states require time-consuming procedures, including reading and interpreting the documents themselves and then communicating with one or more physicians prior to honoring the advance directive. Other states, including Hawaii,[4] have enacted laws that allow for a method of immediate identification of terminally ill patients who choose not to be resuscitated. In Hawaii immediate identification is to be facilitated with a bracelet or necklace of a specified size and shape with "Comfort Care" engraved on one side, and the patient's name, date of birth, ethnic group, CCO number, and State of Hawaii engraved on the other side. Note that this CCO-DNR order is a different kind of advance directive than a Hawaii Living Will.[5] Living Wills allow individualized instructions for different patients, do not require illness, and do require two unrelated witnesses and notarization. Every Living Will must be read and interpreted before it can be honored. Since paramedics have only seconds to make decisions, some patients with Living Wills are undergoing attempted resuscitation. In contrast, a CCO-DNR order is between the patient, his or her physician, and one witness, and is more likely to be really private. The patient can wear a CCO-DNR necklace under his or her shirt and can keep his or her condition confidential; he or she is immediately identifiable as terminally ill and wanting comfort care only, not resuscitation.

Many EMS personnel say the Hawaii CCO-DNR law is long overdue. They have been forced to perform CPR on patients with terminal conditions whose families did not want resuscitation, they just wanted to be made comfortable and allowed to die in peace.

An information packet regarding the new CCO-DNR order has been prepared and includes information in both written and flow diagram formats. It also includes a sample CCO-DNR order and information regarding ordering the CCO-DNR bracelet or necklace and answers such questions as the following:

- What is a CCO-DNR order?
- Who can get a CCO-DNR order?
- Who can follow CCO-DNR orders?
- Guidelines for consideration by EMS personnel, first responders, and other health care providers (both individuals and organizations) when they see the CCO-DNR bracelet or necklace.
- Anticipated questions and answers.
- Revocation of the CCO-DNR order.

• Role of the base station physician.
• Role of the patient's physician

For this information packet explaining how the Comfort Care Only law can help your terminally ill patients, please call Jamie Go, (808) 733-9210 or write to the following address:

CCO-DNR Information
Hawaii EMSS Branch
3267 Kilauea Avenue, Room 102
Honolulu, Hawaii 96816

References

1. *Cruzan v. Director.* 110 S Ct 2841:1990.
2. Omnibus Budget Reconciliation Act of 1990. Pub L 101-508, §§ 4206,4751. 42 USC § 1395cc(f)(1) & 42 USC § 1396a(a) (Supp 1991).
3. OBRA § 4206a(2), 42 USC § 1395cc(f)(1)(a)(i),(ii).
4. Hawaii House Bill 2553, eff July 1994.
5. Hawaii Rev Statutes Ann. § 327D-2: 1991.

Age–Based Rationing of Health Care

Patricia Lanoie Blanchette MD, MPH

The U.S. has focused attention on the rising costs of health care coincident with the increasing age of the population. Arguments have been made to overtly ration care to older persons; however, general acceptance of the need to ration scarce resources, whether or not such a policy is actually formalized, can lead to covert rationing. Some overt rationing has already occurred, some of the data put forth to justify that rationing needs to be challenged, and ethical principles need to be applied to provide appropriate and perhaps less costly care.

Given the temporal relationship between the increasing numbers of older people and the nation's attention to the costs of health care, it seems evident that aging is the major determinant of increasing costs. The image of demented oldsters avariciously consuming the legacy of our children springs to mind. An incomplete and biased recitation of health care statistics appears to support this conclusion, leading to serious proposals to ration health care for older people.[1] A careful examination of the facts begins with an acknowledgment of the potential for bias, the willingness to question what appears obvious, and searching beyond those data which serve to support a predetermined conclusion. Decisions about health care must be guided by objective information and by illustrating the ethical and moral principles to enlighten decisions about limits on the public money allocated for people of all ages.

In considering the costs of health care it is easy to be baited into an inter–generational contest, pitting the costs of providing increasingly sophisticated care to increasingly younger, potentially chronically impaired neonates, against the costs of caring for the nation's elders. Although the potential life expectancy of babies as a whole is much longer than that of elders, this is often not true when individual lives are compared. It is also possible to make the argument that elders may have contributed to the public good for many years and are now more deserving of care. However, basing decisions on whether an individual is deserving of care presupposes a wisdom that we may not have yet achieved and is to be strenuously avoided.

The use of public monies or health insurance being used for infertility treatment in a country concerned with overpopulation is certainly questionable. Our culture is one that cherishes children and childhood, at least in the abstract. We are most likely to accept the costs of raising a child and seldom stop to total up the costs of the years of dependency. Are we less likely to appreciate the personal fulfillment, redefinition of productivity and inter–generational significance of old age. The importance of completing psychological development and the rooting of successive generations by the presence of elders is undervalued.

However, in considering the allocation of resources it is futile and intellectually inadequate to pursue the avenues of intergenerational conflict. It should be evident that people's lives are priceless at any age. A fully developed society should be guided by principles equally valid across an age spectrum. A consideration of the allocation of resources requires that we examine the quality of the data, understand the age prejudice that exists in our culture, and be primarily guided by the ethical grounds for limiting care at any age.

Population Aging and Costs

Is there a primary cause-and-effect relationship between the rapid aging of the population and health care costs? People over age 65 today comprise about 12% of the U.S. population and account for one–third of the nation's annual federal health care expenditures, or \$300 billion of an estimated \$900 billion in 1993.[2] By 2020, when baby boomers will be in their mid to late 70s, the population over 65 is estimated to be 20%, with the actual number of people over 65 doubling from today.

However, when examined closely, less than 10% of the

Professor of Medicine and Public Health
Director, Pacific Islands Geriatric Education Center
Chief, Division of Geriatric Medicine
Dept. of Medicine
John A. Burns School of Medicine