EFILED Document
CO El Paso County District Court 4th JD
Filing Date: Feb 17 2005 6:07PM MST
Filing ID: 5173348
Review Clerk: Donna Maes

DISTRICT COURT, EL PASO COUNTY, COLORADO **El Paso County District Court** **20 E. Vermijo Ave., Colorado Springs, CO 80903-2209** **P.O. Box 2980, Colorado Springs, CO 80901-2980**	**▲COURT USE ONLY▲**
Plaintiffs: JOSEPH & LORRAINE LOVELESS, et al **v.** **Defendant: COLORADO SPRINGS MEMORIAL HOSPITAL, et al**	**Case Number: 04 CV 0790** Div.: 14
Chester H. Morgan, II, Atty. No. 31507 **Law Office of Chester H. Morgan, II** 1308 N. Cascade Ave Colorado Springs, Colorado 80903 Phone Number: 719-473-1986 Fax Number: 719-473-1965 (call first) chmorgan2d@yahoo.com	

JOSEPH AND LORRAINE LOVELESS' SUPPLEMENTAL RESPONSE TO DEFENDANT WEBB'S MOTION *IN LIMINE* RE: REQUIREMENT FOR WRITTEN "DO NOT RESUSCITATE" DIRECTIVES

Plaintiffs Joseph and Lorraine Loveless ("Mr. and Mrs. Loveless"), by and through counsel, Chester H. Morgan, II, submit the following in Reply to Defendant Webb's Motion in Limine re: "Do Not Resuscitate" Directives.

Facts Pertinent to Motion

Plaintiffs hereby incorporate by reference the "Facts Pertinent to Motion" in Plaintiffs' original Response to Defendant Webb's Motion *In Limine* re: Requirement for Written "Do

Not Resuscitate" Directives. In addition, Plaintiffs' offer the following which are germane to this Supplemental Response.

Neither Ron Brasch nor Patty Spencer corroborates Defendants' account of the issue. In an interview with Colorado Springs Homicide Detective Derrick Graham on 29 March 02, Brasch stated that he and Pat Spencer took Gary Loveless to Memorial Hospital "against his objections" and that Gary Loveless "repeatedly refused and said that he was not going to the hospital," that they "literally had to drag him kicking and screaming to get him to go to the hospital." [Exhibit 1, 29 Mar 02 interview of Ron Brasch by Detective Derek Graham, p. 16]. Brasch denied he had ever told anyone from Memorial Hospital that he had heard Gary Loveless "crying out in pain" while living in the neighborhood. *Id.* Although the affidavit from Brasch provided by Defendant Webb is silent on the subject of DNR, when Detective Graham specifically queried him on the issue, his report relates that Brasch "doesn't recall Gary ever specifically mentioning that he wanted to be a 'DNR'." Brasch "denied that he had ever told this to medical personnel at Memorial Hospital." *Id.*

Patty Spencer also contradicts Defendants' account of Gary Loveless's final moments in the Memorial Hospital ER. Present while Dr. Webb and Nurse Camarca were taking Gary Loveless' history, she related to Micheal Williams nothing about the alleged conversation between Dr. Webb and Gary Loveless concerning DNR in his 2 Apr 2002 interview with her:

> According to Ms. Spencer, Gary Loveless told Dr. Webb that he had terminal cancer and that he wanted something for the pain. Dr. Webb said he could give Gary something for the pain, but needed a history first. The nurse with Dr. Webb took the history in Dr. Webb's presence, with him asking the questions. After the history was completed, Dr. Webb left the room, and Gary sat up and again wanted to leave the hospital. [Exhibit 2, 28 Dec 04 Williams Affidavit, p. 6].

When Pat Spencer noticed that Gary Loveless was turning blue, she yelled "911" and asked for a nurse and help:

> According to Ms. Spencer, shortly after she asked for help three nurses along with Dr. Webb came in with the "crash cart." As they were working on Gary, Ms. Spencer told me that Dr. Webb turned to her and asked "is this man DNR?" She said she told him "No, it is not official and legal," or words to that effect. She said at that point Dr. Webb turned back to Gary and started to check his eyes, noticed that Gary was already deceased, and called the time of death. *Id.*

Earlier, just five days after Gary Loveless' death, Pat Spencer had given a somewhat sketchier account of the events in the Emergency Room to Detective Graham. Yet in respects material to the question at issue, she was entirely consistent. She has Dr. Webb asking *after* Gary Loveless was in terminal distress about a DNR, something Dr. Webb himself corroborates. And she relates that "she explained to Dr. Webb that Gary didn't have anything legally in regard to the DNR." [Exhibit 3, Interview of Pat Spencer by CSPD

Detective Derek Graham, p. 5]

Catherine Camarca, the nurse who took the intake information on Gary Loveless, Pat Spencer, and Ron Brasch, recalled no discussion of a DNR with Gary Loveless either with herself or with Dr. Webb. (Exhibit 4 - Deposition of Catherine Camarca, Nov 19, 2004, p. 60, line 8 – p. 61 line 25.). Micheal Williams related that Nurse Camarca told him in a 22 Apr 02 interview:

> Nurse Camarca said that she couldn't remember the exact words she used but asked Ron if Gary Loveless had a DNR order or a Power of Attorney for Mr. Loveless? She stated that [he] replied that he was "in charge," and told her "I am not prepared to provide that information at this time" or words to that effect. Although she saw Ron with a manila folder that appeared to have several papers in it, she did not see nor did Ron ever provide any documentation to her concerning a DNR order or any Power of Attorney for Mr. Loveless.
>
> . . . .
>
> Pat never mentioned the DNR order to her. Ron was the only person with Gary who stated he had the DNR order, o[r] Power of Attorney documentation, which was never produced. [Exhibit 2, p.4]

Of the five people still living who were present or nearby at the time Dr. Webb spoke with Gary Loveless while he was still conscious, only Dr. Webb claims that the topic of a DNR came up at all at that time, and his claim post-dates Gary Loveless' death. At that, his recollection of the alleged conversation sharpened dramatically at his deposition, taken more than two years after the events in question. By contrast, when he was first questioned on this topic by Mr. Williams on 5 Apr 02 he was more equivocal: Williams reported:

> I asked Dr. Webb when, if ever, the subject of a DNR (Do Not Resusciate) order first arose, and whether it was discussed with Gary Loveless himself, or the couple with Gary? Dr. Webb stated he could not remember. He then offered that once his report was completed he would be able to tell me what was exactly said and by whom. Dr. Webb did say that the subject of a DNR was mentioned; due to the fact all of the parties were discussing the terminal cancer, and Mr. Loveless wanting to die.
>
> I remember this portion of our conversation quite distinctly, because I was struck by the illogic of what Dr. Webb told me—that he couldn't remember distinctly about who said what about the DNR then, but would remember better later after his report was finished.
>
> Dr. Webb continued to relate that he exited the room and went to call Penrose Hospital to determine who the doctor was for Gary, and get the details of the treatment for his cancer. Dr. Webb further states he was out of Gary's room for approximately 10 to 15 minutes when the nurse summoned him informing him Gary was kind of "blue". Dr. Webb and the other nurses with the crash cart re-entered the room. Dr. Webb noticed Gary appeared to be deceased.

> Dr. Webb said that when he approached Gary to obtain vitals on him, he turned and asked the couple "Is this really a DNR?" He said they told him yes, this is what he wanted, he is happy now, he is in a better place. [Exhibit 2, p. 2.]

It is worth remarking that the timing of Dr. Webb's query, "Is this man DNR?" was while Gary Loveless was unconscious and slipping away and was directed at people without authority to make the call. Assuming the question was asked (and it is further worth noting that Patty Spencer corroborates both the language and the timing of the question) it is contextually puzzling if, as he now claims, Dr. Webb had already ascertained Gary Loveless' wishes personally earlier.

The first indication of Dr. Webb's position on the question came in the form of his report, presumably the one which was still incomplete on 5 Apr 02, when he spoke with Micheal Williams. In his undated typewritten notes, which were clearly dictated after Gary Loveless' death, Webb wrote: "Patient is adamant that he does not want any intubation, CPR, or any efforts to keep him alive." There is no contemporaneous (ante-mortem) entry in Gary Loveless' chart about any advance CPR directive nor about a DNR, even though Nurse Camarca indicated that had she known of a DNR order, she would have entered it in Gary Loveless' chart as "Patient states DNR, family has DNR.". [Exhibit 4 - Deposition of Catherine Camarca, p. 61, lines 4-25.]

At his deposition on October 18, 2004, Dr. Webb could not remember whether he had seen Gary Loveless while still conscious once or more times, but testified that "I believe there were others (beyond the single encounter documented in the hospital chart.). I just can't tell you how many." He related, however, that at one of those encounters he (Webb) had brought up the subject of resuscitation himself, in the context of a referral to hospice.

> You need to understand, if you are asking to go to hospice, that means that we do not resuscitate you, we do not make attempts to save your life, we do not intubate you. Do you understand all of these things? And he indicated that he did. And that's what he very much wanted, and this was told directly to me. [Exhibit 5, 18 Oct 04 Deposition of Dr. Webb, p. 21, lines 9-15.]

Applicable Statutory Law

Plaintiffs herein respectfully incorporate the statutory and regulatory law listed in their original brief, and add to those citations the following:

C.R.S. § 2-4-101: **Common and Technical Usage:**

C.R.S. § 2-4-201: **Intentions in the enactment of statutes**

C.R.S. § 2-4-203: **Ambiguous Statutes – aids in construction**

Legislative History

What is now Article 18.6 of Title 15, *"Directives Relating to Cardiopulmonary Resuscitation"* began as Chapter 3 of Senate Bill 92-3, introduced by Senators Wham and Allison in early 1992 and entitled *"A Bill for an Act Concerning Patient Autonomy in Regard to the Making of Medical Treatment Decisions."* (Hereinafter S. 92-3). It was referred to the committee on the Judiciary and reported out to the Committee of the Whole as amended by the Senate Judiciary Committee on April 1, 1992. 1992 Colorado Senate Journal Vol 2, p. 904 *et seq,* [hereinafter Sen. J. 2 p. ____. The bill as it emerged from the Senate Judiciary Committee is in most respects the version extant today and represents the most significant amendment of the original introduced by Senators Wham and Allison. There is, regrettably, no committee report on its reasoning or process by which it arrived at the amendment.

S. 92-3 was again amended and passed the second reading in the Senate on April 7, 1992 (Sen J. 2 p. 958). Among the various amendments, the only one relevant to this discussion is that what is now C.R.S. § 15-18.6-101 (2) was given its present verbiage:

> (2) "CPR DIRECTIVE" MEANS AN ADVANCE MEDICAL DIRECTIVE PERTAINING TO THE ADMINISTRATION OF CARDIOPULMONARY RESUSCITATION.

The bill as then amended was considered by the Colorado House of Representatives April 24, 1992, amended on the floor, passed, and returned to the Senate. 1992 Colorado House of Representatives Journal Vol. 2, pp. 1577-1579. Chief among the amendments pertinent to this discussion was the addition of the language now codified at C.R.S. § 15-18.6-108:

> (4) NOTHING IN THIS PART 5 SHALL BE CONSTRUED AS CONDONING, AUTHORIZING, OR APPROVING EUTHANASIA OR MERCY KILLING. IN ADDITION, THE GENERAL ASSEMBLY DOES NOT INEND THAT THIS PART 5 BE CONSTRUED AS PERMITTING ANY AFFIRMATIVE OR DELIBERATE ACT TO END A PERSON'S LIFE, EXCEPT TO PERMIT NATURAL DEATH AS PROVIDED BY THIS PART 5.

Refusing at first to recede to the House amendments, the Senate called for a conference committee, but ultimately reconsidered, accepted the bill as the House had amended it, and passed the bill which was ultimately signed by the governor and became effective June 4, 1992.

Article 18.6 has been thrice amended since 1992, once in 1994, once in 1998, and once in 2002. None of those amendments are relevant to or shed light upon the question at bar.

Discussion

From Its Inception the Colorado Patient Autonomy Act Has Required that Advance Directives Pertaining to CPR be Written

To begin with, it is important that any discussion of the issue proceed from a consistent frame of reference. The appropriate term for discussing the General Assembly's handling of a patient's

wishes respecting resuscitation is "CPR directive" as opposed to "DNR order." The first is the expression of a patient's wishes, the second is the manner in which a physician implements that advance direction in the medical record. *Compare* C.R.S. 15-18.6-105 (physician implements CPR directive as an order *with* C.R.S. 15-18.6.102 (". . . after a physician enters a "do not resuscitate" order . . .).

As first introduced, S. 92-3, chapter 3, structurally and substantively paralleled what is now Article 18 of Title 15, the "living will" section. The term used originally was "CPR Declaration" which was defined as "a declaration executed in accordance with this Part 3, *on the form contained herein."* (Emphasis added.) Subsection 15-18.5-303 of S. 92-3 stated:

> (1) A CPR declaration shall be executed in writing, through the use of a uniform statewide form set forth in section 15-18.5-304.
>
> (2) The CPR declaration must be personally signed by the declarant;
>
> (3) In the event that the declarant is physically unable to sign the declaration, it may be signed by some other person in the declarant's presence and at the declarant's direction; except that such person shall not be:
>
> (a) The declarant's attending physician or any other physician;
> (b) An employee of the attending physician or, if applicable, the health care facility in which the declarant is a patient;
> (c) A person who, at the time the declaration is signed has a claim against any portion of the estate of the declarant upon the declarant's death;
> (d) A person who, at the time the declaration is signed, knows or reasonably believes that such person is entitled, as a beneficiary under a will or as an heir at law, to any portion of the estate of the declarant upon the declarant's death;
> (e)
>
> (4) A CPR declaration shall be signed by a physician who certifies that such physician has:
>
> (a) Personally examined the declarant;
> (b) Evaluated the medical appropriateness of CPR for the declarant and informed the declarant of the risks and consequences of enforcing a CPR declaration;
> (c) Evaluated the understanding of the declarant in regard to the information provided in accordance with paragraph (b) of this subsection (4);
> (d) Determined that:
> (I) The declarant understands that as a result of signing the CPR declaration, CPR will not be administered to the declarant;
> (II) The declarant understand that death may result as a consequence of withdrawing or withholding CPR; and

(e) Based on the action taken in accordance with paragraphs (a) to (b) of this subsection (4), the declarant wishes to execute a CPR declaration.

(5) (a) A CPR declaration shall be witnessed by two persons, neither of whom may be any of the persons listed in paragraph (a) to (d) of Subsection (3) of this section.

(b) Each witness must sign the declaration stating that:

(I) Such person is not a person described in paragraph (a) of this subsection (5);

(II) The declarant at the time the declaration was executed, acted voluntarily and was under no constraint or influence by any other person; [Exhibit 6, A BILL FOR AN ACT CONCERNING PATIENT AUTONOMY IN REGARD TO THE MAKING OF MEDICAL TREATMENT DECISIONS]

From the foregoing it is easy to distill very specific conclusions concerning the intention of the original bill's sponsors: (A) The CPR declaration was to be written; (B) signed by the declarant; (C) using the statutorily prescribed form; (D) following a full disclosure of the consequences by the declarant's physician (informed consent); who (E) also was to sign the declaration and in so doing certify: (1) that he had personally examined the declarant; (2) believed a CPR directive was appropriate for the declarant's circumstances; (3) had briefed the declarant of the risks and consequences of a CPR directive; (4) assessed the declarant's understanding of those risks and consequences; and (5) ascertained that the declarant understood the immediate effect of a CPR should the declarant arrest (i.e., that no CPR would be administered), and that the consequences could well be death.

The requirement for the physician signature and certification was absolute. The requirement for the patient signature was likewise absolute, excepting only if the declarant were *physically unable* to sign. Under those circumstances, and only under those circumstances, a proxy could sign for the declarant, but only in the declarant's presence and at his direction. And not just anybody could sign for the declarant. The original bill was very careful to specify that the physician himself could not do so, nor could any employee of the medical treatment facility, nor even anybody who stood to gain (or thought to gain) from the declarant's death. (It is more than slightly ironic that Ron Brasch, one of those to whom Dr. Webb directed his inquiry "Is this man DNR?" believed himself to be the sole beneficiary of Gary Loveless' will.)

Had the legislation been adopted as above, it would be clear beyond cavil. Yet though the language was modified, the present language fully incorporates and accommodates the objectives of the legislature manifest in the original draft, only in different terms. And while the general assembly did ease the original statutory insistence upon one and only one prescribed form for an advanced CPR directive, it has *never* retreated from the requirement for a writing, much less from the public policy concerns which the requirement for a writing supports.

The CPR Directive Is Specifically Defined as a Written Document

At the heart of Defendant Webb's argument is the last sentence of C.R.S. § 15-18.6-103(1), "Nothing in this subsection (1) shall be construed to restrict any other manner in which a person may make a CPR directive." Defendant argues vociferously that this language serves to nullify any requirement for a writing. This is wrong for two reasons, the most obvious of which is the language of the subsection itself.

Statutory Rules of Construction Require the Court to Give Statutes the Meanings and Definitions Established by the General Assembly

C.R.S. § 2-4-101, **Common and technical usage,** codifies common sense rules of construction, requiring that words and phrases be read in context and, where they are given legislative definition, are to be "construed accordingly." A term which has been statutorily defined is required to be given its statutory definition whenever it appears in the statute. *R.E.N. v. City of Colorado Springs,* 823 P.2d 1359, 1364 (Colo. 1994). Quoting from C. Dallas Sands, *Statutes and Statutory Construction § 27.02* (4th Ed. 1985), the Colorado Supreme Court declared that "to ignore a definition section is to refuse to give legal effect to a part of the statutory law of the state. . . . Statutory definitions of words used elsewhere in the same statute furnish authoritative evidence of legislative intent." Indeed, the *R.E.N.* court, again quoting Sands, declared that "internal legislative construction is of the highest value and prevails over . . . other extrinsic aids." *Id. See also Sullivan v. Industrial Claims Appeal Office*, 22 P.3d 535, 2000 Colo. App. LEXIS 1803 (Colo. Ct. App. 2000); *Farmers Insurance Exchange v. Bill Boom, Inc* ., 961 P.2d 465, 1998 Colo. LEXIS 441 (Colo.1998) ("Statutory definitions of words used elsewhere in the same statute furnish authoritative evidence of legislative intent. Only in the absence of express definitions will statutory terms be construed according to the various interpretive rules governing the construction of statutes.")

Applying the foregoing interpretative prescription, the *R.E.N.* court construed the statute at issue by substituting the statutory definitions for the disputed terms ("court" and "juvenile court"). Adapting the Colorado Supreme Court's interpretive algorithm to this case yields a clear and inescapable result. The language of subsection 103(1) permits a person to make a "CPR directive" without requiring that the person use the specific protocols called for in 103(1). As adverted in Plaintiffs' earlier brief, "CPR directive" is specifically defined in C.R.S. §15-18.6-101(2) as an "advance medical directive pertaining to the administration of cardiopulmonary resuscitation." In turn, "advance medical directive" is defined in C.R.S. §15-14-505(2) as "any written instructions concerning the making of medical treatment decisions on behalf of the person who has provided the instructions. An advance medical directive includes . . . a declaration executed pursuant to article 18.6 of this title." Thus, using the statutorily required definition of "CPR directive" yields the following transcription of C.R.S. § 15-18.6-103(1): "Nothing in this subsection (1) shall be construed to restrict any other manner in which a person may make [any written instructions pertaining to the administration of cardiopulmonary resuscitation.] Following the mandatory rule of construction codified by C.R.S. § 2-4-101 and applied directly by the Colorado Supreme Court reveals conclusively that C.R.S. § 15-18.6-

103(1) does not offer an exception to the written requirement.

Creating an Exception to the Requirement for a Writing Would Undo the Clear Legislative Intent of Article 18.6 of Title 15

The Last Sentence of C.R.S. § 15-18.6-103(1) Is Limited in Application To Only that Subsection

The last sentence of C.R.S. §15-18.6-103(1) has only modest reach, one completely consistent with the remainder of the Article, and indeed of the entirety of the Colorado Patient Autonomy Act itself. It does no more than to relieve a would-be declarant from the requirement to use only the forms and protocols which are partially prescribed in §15-18.6-103 itself and which are to be further developed by the State Board of Health. Nothing more. By using the term "CPR directive" it explicitly does not relieve the declarant from articulating his or her wishes in writing. This is transparent not only from the above analysis concerning the statutory definition of CPR directive, but from the language of the last sentence of subsection 103(1) itself, ("Nothing *in this subsection (1)* shall be construed to restrict any other manner in which a person may make a CPR directive.) Since subsection (1) of section 103 is entitled "**CPR directive forms – duties of state board of health**" and is the unmistakable adaptation of the original language of S. 92-3 which not only required that all CPR declarations be in writing, but that they be on a form which the bill itself prescribed, the subsection is nothing more than an exception to the requirement to use the standard form. That exception expressly is not something which is available as a convenience to the physician—it is limited in application to the patient himself, who may produce a written CPR directive himself, much as an individual is permitted to avoid the Colorado requirements for written, sworn, notarized and witnessed wills by executing a holographic will. *See* C.R.S. § 15-11-502.

Counsel undersigned represents as an officer of the court that he contacted former Senator Dorothy (Dottie) Wham, one of the original two senatorial co-sponsors of S. 92-3. Although she declined the invitation to commit her recollections to writing, stating that former legislators are strongly discouraged from doing so, she did give permission to convey that the reasoning for the move from the rigidly prescriptive text of the original S. 92-3 to what emerged from the Senate Judiciary Committee was the belief that it was unnecessary for the General Assembly to itself prescribe the exact form, and that leaving the specifics to the Board of Health would allow doctors and related professionals to come up with a form which satisfied the policy concerns of the General Assembly without strait-jacketing the declarant. She was equally clear that there was never an intention to retreat from the requirement for a writing, but rather only from the original requirement that a single statutorily prescribed form was the only acceptable declaration.

Certainly the requirement for a written instrument has been clearly understood and carried over to other agencies of the Colorado government. The Colorado Department of Human Services has published "A Basic Guide to Understanding Guardianship, Conservatorship, Powers of Attorney, Medical Advance Directives, and Representative Payeeship, October 2003." [Exhibit 7]. The pamphlet repeats the statutory definition for a CPR directive and an advance medical

directive and, at p. 72, explains the "Procedure for Creating a CPR Directive" as follows:

> "(1) A CPR directive can be written, in any form, by a competent adult or by the person who has medical decision-making authority for an incapacitated adult . . . . The directive is typically done on official state forms furnished by the Department of Public Health and Environment and available through most physicians' offices.
>
> "(2) If a format other than the official form is used as the directive, there is **standard required information** that must be included about the adult for whom the CPR directive is written . . . .
>
> (3) The **adult must sign the completed CPR directive** with his/her legal signature or mark. . . .
>
> (4) The directive concerning the administration of CPR must be dated and **countersigned by the attending physician."**
>
> Emphasis in original.

Similarly, the Colorado Board of Health's Rules promulgated as ordered by the General Assembly in C.R.S. § 15-18.6-103, list a Declarant's responsibilities under section 4.2, to be, *inter alia,* making an informed decision concerning the refusal of resuscitative procedures and "signing the original form." Hence, patient autonomy is honored not impaired by virtue of having some written assurance that a patient was informed in making his choice, and we have objective reason to know that because he was willing to sign his name to that choice.

The Legislative Intent of the General Assembly in Enacting Article 18.6 of the Patient Autonomy Act Would Be Nullified if an Unwitnessed, Unsigned, Oral Declaration of a Patient to the Attending Physician Were Deemed Sufficient

It is to be presumed that a statutory enactment is intended to be effective, and constructions of statutory language which tend to frustrate an enactment are to be avoided

C.R.S. § 2-4-201 establishes the statutory presumption that a statute is intended to be effective and that a just and reasonable result is intended. Hence, courts are to act as to give "full force and effect" to the statute. *Colorado & S. Ry. V. District Court,* 493 P.2d 657, 659 (Colo. 1972), and should avoid construction that has the effect of defeating an obvious legislative intent. *Showpiece Homes Corp et al v. Assurance Company of America,* 38 P.3d 47, 51 (Colo. 2001), *R.E.N., supra, People v. Meyers,* 510 P.2d 430 (Colo 1973).

Plaintiffs respectfully submit that the language of Article 18.6, given its definition of CPR

directive is and should be dispositive of the question posed by the Court. But even if it weren't, even if the statute were "ambiguous" as to the requirement for a writing, rewriting the statute as Defendant Webb wishes would create an exception that would not only swallow the rule, but nullify the legislation and the directed Board of Health regulations both, making each physician a law unto himself.

Implicit in Defendant Webb's argument is that patient autonomy, the *raison d'etre* of the act itself, would somehow suffer were the Court to read the language for other than what it plainly requires—a writing. This misconceives the question. The purpose of the Colorado Patient Autonomy Act was to enable informed patient choice by providing a reliable and predictable mechanism for its articulation. In that regard, three very clear legislative purposes emerge from the outset of S.93 to the final version: (1) To have a reasonably reliable means whereby it could be *known* what the patient wanted; (2) To have some reassurance that the patient was competent at the time of making this decision; and (3) to provide a specific mechanism to ensure that the declarant's choice is an *informed* choice. The Act as written does all three; the Act as Defendant Webb would have this court endorse provides no assurance of any of the three. Thus patient autonomy is *facilitated* by the requirement for a writing, while Defendant's urged construction could well have the opposite effect. Since there is no objective evidence of the patient's intentions, we can never be sure of what a patient really wanted, whether he was fully informed, and even whether he was capable. Put another way, patient autonomy is not furthered if his wishes are whatever a doctor says they were after the patient's death.

Critical to Patient Autonomy is Reasonable Assurance that the Patient's Wishes Are Actually and Reliably Known

A first step to patient autonomy is to have some objective way of actually knowing what the individual wants in the first place. *See* La Puma, J. *Ádvance Directives in Managed Care: Are They Inspired by Love or Money?"* Managed Care Magazine, October 1996) found at www.managedcaremag.com/archives/9610/MC9610.ethics.shtml. Dr. La Puma relates that "Several studies demonstrate that physicians are not better than chance at guessing their patients' preferences for life-sustaining treatment. Family members and proxies are only a little better than physicians." Implicit in these studies is that the best evidence of a patient's wishes is that which we know he expressed himself.

As originally written S.92-3 contained not only substantial mechanisms for the reliable ascertainment of a patient's wishes, but contained specific prohibitions against individuals with an actual or even perceived conflict of interest from having any role in a CPR declaration. Categorically, attending physicians were excluded *even from witnessing* a proxy signing a CPR declaration where the declarant was *physically unable* to sign. This prohibition is codified when it comes to living wills covered in Article 18, which is a part of the Colorado Medical Treatment Decision Act, enacted in 1985. Not only does Article 18 require a writing for a "Declaration as to Medical or Surgical Treatment" (hereinafter living will) but it contains the same prohibitions as S. 92-3 as to who may witness a proxy signing if a patient is unable to sign, viz, the witnesses cannot be (1) the attending physician or any other physician; (2) an employee of the attending

physician or health care facility in which the declarant is a patient; (3) a person having or believing himself to have any claim to a portion of the estate of the declarant upon his death. C.R.S. § 15-18-105.

The reason for the above prohibitions is not hard to pin down—the individuals named have, or might seem to have, a conflict of interest. Focusing on the physicians and other employees of the health care facility first, the plain fact is that cardio-pulmonary resuscitation costs money. Dr. La Puma writes: "The real danger of advance directives in managed care is that they will be used to limit needed, useful, expensive treatment under the guise of ethics. In a system that prizes cost containment, quality and increasingly service beyond nearly all else, this treachery can subvert even the best intentions." *Id.*

In the case at bar, Dr. Webb has a significant, not to say profound financial stake in offering his own version of a conversation with Gary Loveless, though for different reasons than those posited by Dr. La Puma. Since it was not recorded in a writing, was unwitnessed, and Gary Loveless is deceased, there is no evidence that it took place at all, much less what was said, other than Dr. Webb's say-so. It might well be said that the General Assembly had precisely this concern in mind when it specified that as a minimum a CPR had to be in writing to shield a practitioner from civil or criminal liability.

As discussed in Plaintiffs' original brief on the subject, the Colorado General Assembly has specified that certain decisions regarding important matters, such as a will, be committed to writing. One can scarcely conceive of a decision more important than one to refuse potentially life-saving treatment.

The General Assembly has also legislated on the question of hearsay itself with the so-called Dead Man's Statute, C.R.S. § 13-90-102. Although designed primarily for will and probate contests, the underlying public policy objectives to "guard against perjury by prohibiting living interested witnesses from testifying when the deceased cannot refute the testimony" applies *a fortiori* in this case. See, e.g., *DeLeon v. Tompkins,* 576 P.2d 563 (1977), rev'd on other grounds, 595 P.2d 242 (1979); *Berger v. Coon,* 606 P.2d 683 (1980) (purpose is to maintain equality between parties at trial through limitations upon admissibility of evidence, thereby promoting justice). If the General Assembly does not permit on the basis of the Dead Man's Statute Dr. Webb to testify that Gary Loveless had told him that in the event he died he wanted Dr. Webb to have his car, it follows that it would not permit him to testify as to a hearsay statement of a deceased that he did not want life-saving cardiopulmonary resuscitation, where both declarations redound decisively to the benefit of Dr. Webb himself.

Wisely, the General Assembly anticipated the very problems of proof as to Gary Loveless' intent that can, and this case most certainly have, arisen post-mortem, by requiring a written advance directive, and Defendants should not be permitted to profit from their failure to get one by testifying without fear of contradiction concerning an alleged statement made by him.

A Written Directive Gives Some Assurance Not Only of What the Declarant's Desires Are, But of his Decision-Making Capacity

From S. 92-3 through the final evolution of Article 18.6, the General Assembly paid careful attention to a would-be declarant's capacity, a judgment which was to be originally certified in writing by the physician. S. 92-3 required the physician to personally certify that he (a) had personally examined the declarant; (b) evaluated the medical appropriateness of CPR and informed the declarant of the consequences of enforcing a CPR declaration; and (c) evaluated the understanding of the declarant in regard to the information provided and (d) (1) determined that the declarant understood the result(s) of signing the declaration.

Other than the situation where a declarant presents his own CPR declaration, the duties of the attending physician outlined above carried over in material part to the final Act through the Board of Health's implementing Rules established in obedience to the General Assembly's mandate of C.R.S. §15-18.6-103. Those rules, found at 6-CCR-1015-2 and appended to Plaintiffs' original brief on this issue, require an attending physician "who is assisting a declarant" to ensure that the declarant:

1) receives an explanation of the expected consequences of withholding or withdrawing CPR;
2) is informed that if the CPR directive or bracelet or necklace is not apparent and immediately available, or has been altered, CPR will be initiated by emergency medical services personnel;
3) receives an explanation of how and by whom the CPR Directive may be revoked; and
4) signs the CPR Directive.

Obviously, none of this can be done in the absence of a written directive, and to decide that there is no such requirement is to completely relieve the attending physician of very specific requirements. The entire architecture of Article 18.6 simply collapses where a physician's say-so is sufficient to establish a deceased's person's wishes.

A Written Directive Can Provide Some Evidence of a Declarant's Capacity

Capacity, of course, was among the issues at the forefront of the development of Article 18.6. As originally conceived, the attending physician had a statutory duty to certify not only that he had assessed a declarant's capacity, but was satisfied that the declarant did indeed understand and appreciate the ramification of refusing CPR. To be sure, somebody can lack capacity and still sign his name, but it becomes more difficult if the written declaration does not come on the Board of Health form, but is the holographic exception of C.R.S. § 15-18.6-103(1). Writing out ones wishes gives at least some clue as to the author's lucidity and purpose, even if indirectly.

In this particular case, there is only one instrument in the 16 March 2002 medical record having Gary Loveless' signature in the medical record—the treatment and consent form "signed" in the bottom right hand corner. [Exhibit 8]. It is difficult from that form to even know that there is a

signature, much less that it is Gary Loveless'. While one may very well lack capacity and still have a legible signature, where the signature is not even identifiable as such, we have at least some clue that there may be something amiss, including the possibility of such gross intoxication as to significantly impair even fine motor control. Had there been a similar signature on a written CPR directive, it might have shed at least some objective light on Gary Loveless' condition at the time of his alleged conversation with Dr. Webb.

A written directive is some evidence to document the discharge of the physician's obligation to ensure that a patient's decision is a medically informed decision

At the heart and soul of all medical decision-making by a patient is the requirement for *informed consent.* That concern permeates the entirety of the Colorado Patient Autonomy Act, the Colorado Medical Decision Act, and the Colorado Department of Public Health and Environment's "Rules Pertaining to Implementation and Application of Advance Medical Directives for Cardiopulmonary Resuscitation (CPR) By Emergency Medical Services Personnel." The original S. 92-3 required a physician's signed certification that the declarant had been fully informed of the consequences of a CPR declaration. Although the final version of Article 18.6 and its implementing rules does not use the term certification, as discussed above it does require the physician to brief the declarant, *and to countersign the instrument itself.* The Board of Health and Environment's form itself must contain "a statement indicating that the declarant has been informed of the expected consequences of withholding CPR," (6-CCR-1015-2, Para. 3.2c)) along with the signature of the attending physician who has undertaken his statutory and regulatory responsibilities. Cumulatively these provide at least some evidence of the physician's cognizance of and compliance with his legal obligations in treating with a declarant.

As noted in Plaintiffs' earlier brief, Dr. Webb at his deposition admitted that he was, in 2002, unaware of any statutory or regulatory requirements with respect to CPR directives whatsoever, and implied that he did not think it important that he learn of them. As noted in Plaintiffs' earlier brief:

> Q. So to your knowledge in March of 2002, did the hospital, Memorial Hospital, have a written policy about requiring a written DNR from a competent patient?
>
> A. I couldn't tell you what the policy was or if there were a policy. [Webb depos. p. 29 line 5 – p. 30 line 2]
>
> .....
>
> Q. Are you aware—and don't include anything Mr. Bronfin might have told you—were you aware in 2002 that Colorado had a law concerning DNR orders?
>
> A. I'm not a lawyer, so I really don't keep track of laws. I couldn't tell you if there was or wasn't.

Q. Are you aware as we sit here today that Colorado has a law concerning the form and format of DNR orders to make them valid?

A. I don't know what it is, if there is.

Q. Is it your position, as practicing emergency medicine in this state, that if there is a law requiring the DNRs to be in writing that you have an obligation to know that?

MR. BRONFIN: Form and foundation.

A. I have no idea. I mean in emergency medicine, we ask people, if we can, what their wishes are, and we assume that that supersedes anything they have done before, because we have access to that person. So we try, to the best of our ability, to do what that patient actually wants.

Q. When you left the room the first time, you didn't expect him to die imminently, did you?

A. No, I did not. [Webb Depos, p. 35, line 16 – p. 36 line19].

Given Dr. Webb's admission that he didn't even know that he had any statutory or regulatory responsibilities as an attending physician to a would-be CPR declarant, much less what they were, his recollection at the deposition that he happened to discuss the consequences of a refusal of CPR with Gary Loveless seems, to put it mildly, very lucky—for Dr. Webb. Inasmuch as Gary Loveless did not have a holographic declaration of his own under C.R.S. §15-18.6-103(1) when he presented, his alleged desires respecting CPR were to be documented in the state-approved form. (6-CCR-1015-2 para 4.1), a specific responsibility of the attending physician. This was not, of course, done.

In short, the General Assembly's three-fold concerns manifested in the original S. 92-3, and carried forward in the final Act itself, *viz*: (1) having reliable evidence as to a declarant's intentions; (2) ensuring that a declarant was competent to make such a grave decision; and (3) having some indication that a declarant's choice is an informed one, are all furthered by the written requirement, and frustrated if not obliterated by allowing the circumvention of all attending physician duties through the simple expedient of a post-mortem hearsay declaration by the physician himself.

The Presumption of Consent to CPR in the Absence of a Valid CPR Directive Does No More than to Return the Issue of CPR to the Standard of Care Applicable to a Given Situation

If there is consensus on a single issue in this case, it is that the only reason *not* to have administered CPR to Gary Loveless on March 16, 2002, was the oral declaration he allegedly

gave to Dr. Webb, and Dr. Webb's direction to cease efforts. [Exhibit 4, pp. 30-31; Exhibit 9, 22 Nov 04 Deposition of Gloria Oakland p. 48 line 17 – p. 49 line 11.]

The implementing Rules from the Board of health are more specific. "If a CPR Directive is revoked, EMS personnel shall perform full resuscitation and treatment of the patient." And, "If there is reasonable question about the validity of a CPR Directive or bracelet or necklace, or the identity of the patient, resuscitation shall be initiated." 6-CCR-1015-2, paras 4.4 d), 4.4. f)3).

The American College of Emergency Room Physicians, in a Policy Resource and Education Paper entitled "'Do Not Attempt Resuscitation' Orders in the Out-of-Hospital Setting," discussing the principle of futility (certainly not applicable in this case), stated that "Despite public and professional agreement regarding the low likelihood of success in such situations, medicolegal (sic) compact to attempt resuscitation, in the absence of a valid DNAR decision, continues to be sanctioned by society and supported by EMS providers as the standard of care." American College of Emergency Room Physicians Police Resources and Education Papers, "'Do Not Attempt Resuscitation' Orders in the Out-of-Hospital Setting," October 2003, available online at http://www.acep.org/3,437,0.html. Defendants have never suggested an alternative reason for not performing CPR in this case (such as medical futility or impossibility), but have instead relied exclusively on the claim that Gary Loveless told Dr. Webb that he did not want it.

Complying with Article 18.6 prescriptions for a CPR directive does no more than to shield a physician in Dr. Webb's shoes from civil, regulatory and criminal sanctions. C.R.S. §15-18.6-104. It would be a monumental irony should non-compliance with that statute have precisely the same effect.

Finally, the General Assembly was emphatic that nothing in Article 18.6 was to be viewed or used as the condonation of physician assisted suicide or euthanasia, which is proscribed both in the civil and criminal realm. Yet, by permitting a physician to completely circumvent the prescriptions for a valid CPR directive, with all the protections they embody, there is nothing to prevent a suicide pact between physician and patient in the guise of an oral CPR declaration. This represents yet another way that the interpretation urged on this Court by Defendant would serve to undo the clear legislative intent of the General Assembly.

Summary

Since its inception as S. 92-3 through passage and codification as Article 18.6 of Title 15 **"Directive Relating to Cardiopulmonary Resuscitation"**, the General Assembly has manifestly required a writing for a CPR directive to be valid, defining it *always* as a written instrument. Courts are required by statute and Supreme Court precedent to use the statutory definition in interpreting any enactment unless to do so would be absurd and contrary to a clear legislative intent. C.R.S. § 15-18.6-103(1), which enables a declarant to deviate from the format and protocols to be developed by the Colorado Board of Health and Environment, uses the term "CPR directive" which means that a declarant who does not use the form must at a minimum express his choices in writing. Patient autonomy is not impaired by requiring a writing, but

rather enhanced since a writing provides some reassurance and evidence as to what the declarant's wishes really are; whether the patient's choice was medically informed; and some indication as to the declarant's physical, if not cognitive, condition. For the Court to rule that a CPR directive need not be in writing would have the legal effect of nullifying the careful prescriptions of Article 18.6 and the Board of Health and Environment's statutorily mandated rules which, *inter alia*, prescribe very specific duties of an attending physician who is faced with a declarant who expresses a desire to refuse CPR, but has no CPR directive, bracelet, or necklace. Thus, an attending physician could "opt out" of his duties and requirements merely by subsequently declaring an oral CPR directive communicated to him.

Permitting an oral CPR directive to be enforced is contrary to well-understood other enactments of the General Assembly which safeguard and verify important decisions through the requirement for a writing. It is further contradicted by timeless principles of the common law and Colorado statute relating to the admissibility of hearsay evidence, particularly where the declarant is deceased and there is no witnessing of the alleged declaration by an objective observer. Finally, although the General Assembly does not mandate CPR in the absence of a valid CPR directive, it eliminates the absolute defense for failure to administer it that would otherwise be available and leaves open the question of what the standard of care would require assuming there were no CPR directive. Hence, principles of medical futility or impossibility are accommodated by the General Assembly's not mandating CPR, without derogating from its requirement that if CPR is refused on the ostensible basis of patient wishes, there be a complying CPR directive to prove it.

Prayer

WHEREFORE, in reliance on the argument and supporting facts set forth above, Mr. and Mrs. Loveless respectfully reiterate their request to the Court to deny defendant Webb's motion in limine and to rule that CRS 15-14-502(2), CRS 15-18.6-101 *et seq* and regulations duly published and promulgated pursuant to the mandate of CRS 15-18.6-103, impose statutory and enforceable obligations on defendants.

DATED this 17th day of February 2005.

Respectfully Submitted,

Law Office of Chester H. Morgan, II

By: Chester H. Morgan, II, Atty. No. 31507
1308 N. Cascade Ave
Colorado Springs, Colorado 80903
Tel: 719-473-1986
Fax: Call voice first
(*Original printed signature available for inspection w/filing party*)