House
Legislative
Analysis
Section

Olds Plaza Building, 10th Floor
Lansing, Michigan 48909
Phone: 517/373-6466

CPR IN NURSING HOMES

House Bill 5013 as passed by the House
Sponsor: Rep. Michael J. Bennane

House Bill 5150 as passed by the House
Sponsor: Rep. Perry Bullard

Committee: Public Health
Second Analysis (8-28-92)

THE APPARENT PROBLEM:

Some nursing homes have written policies which state that they do not perform CPR (cardiopulmonary resuscitation), and reportedly some nursing homes require applicants to sign so-called "do not resuscitate" orders as a condition of being admitted to the nursing home. The nursing home industry offers several reasons for such policies. One is that since nursing homes are not acute care facilities (that is, hospitals), and since CPR is an emergency service, CPR is not an appropriate service to offer to nursing home patients. Another is simply that, as skilled nursing facilities, there is no requirement to provide CPR services to their patients. Industry representatives also say that "past experience and review of the literature indicates that CPR in elderly patients is not associated with good functional outcome," so the nursing home will not perform CPR.

In a somewhat related matter, some people have suggested that nurses be allowed to officially pronounce death.

Legislation has been introduced to prohibit "do not resuscitate" orders in nursing homes and to allow nurses to make official determinations of death.

THE CONTENT OF THE BILLS:

House Bill 5013 would require that nursing home staff be trained in certain resuscitative procedures and would prohibit nursing homes both from having "do not resuscitate" policies and from requiring such orders from their patients.

More specifically, the bill would amend the Public Health Code (MCL 333.21713) to prohibit nursing home policies that withheld certain resuscitative procedures (mouth-to-mouth ventilation and precordial chest compressions) from nursing home residents unless the resident (or the resident's patient advocate or legal guardian) had requested in writing that no such procedures be taken on his or her behalf. Nursing homes could not require patients to make "do not resuscitate" orders, but could require that a patient consider making such a written statement before being admitted to the facility and at "reasonable" intervals afterwards.

In addition, the bill would require that nursing home staff be trained in mouth-to-mouth ventilation and precordial chest compressions (as defined by rule of the Department of Public Health).

A violation of the bill's provisions would be a misdemeanor, punishable by imprisonment for up to one year and a civil fine of $10,000 for each violation.

House Bill 5150 would create a "uniform determination of death act." The bill would define death and allow registered nurses as well as physicians to make official determinations of death. The bill would say that an individual was dead if there was irreversible cessation of either (1) circulatory and respiratory functions or (2) all brain functions (including the brain stem). The bill also would repeal Public Act 124 of 1979, the current law regarding the determination of death.

Tie-bar. Neither bill could take effect unless both were enacted.

BACKGROUND INFORMATION:

Currently, Michigan law (Public Act 124 of 1979) says that someone "will be considered dead if in the announced opinion of a physician, based on

ordinary standards of medical practice in the community, there is the irreversible cessation of spontaneous respiratory and circulatory functions. If artificial means of support preclude a determination that these functions have ceased, a person will be considered dead if in the announced opinion of a physician, based on ordinary standards of medical practice in the community, there is the irreversible cessation of spontaneous brain functions. Death will have occurred at the time when the relevant functions ceased." The common law standard for determining death has been the cessation of all vital functions, usually taken to be demonstrated by "an absence of spontaneous respiratory and cardiac functions." However, modern advances in life-saving technology have resulted in it being possible for someone to be artificially supported for respiration and circulation after all brain functions cease irreversibly, and at the same time to determine that brain function has ceased even though cardiorespiratory support continues. While the overwhelming majority of deaths will continue to be determined on the basis of the existing common law standard of total failure of the cardiorespiratory system, when artificial means of cardiorespiratory support are used, death still can be determined by alternative procedures.

Note: Public Act 90 of 1992 (enrolled Senate Bill 304) enacted the "determination of death act," under which physicians or registered nurses may pronounce someone dead if there is irreversible cessation of either (1) the person's circulatory and respiratory functions or (2) of all functions of the person's entire brain, including the brain stem. The act is virtually identical to House Bill 5150 as passed by the House, with two exceptions: the act's title is the "determination of death act" (rather than the bill's proposed "uniform determination of death act") and the act specifically retains the right of licensed health facilities and agencies to decide which of their staff may make official pronouncements of death in that facility or agency.

FISCAL IMPLICATIONS:

According to the House Fiscal Agency, House Bill 5150 would have no fiscal impact on the state. (11-6-91) According to the Senate Fiscal Agency, a similar "determination of death" bill (Senate Bill 304, Public Act 90 of 1992), has no fiscal implications for the state. (7-23-92)

ARGUMENTS:

For:

Shocking as it is, as a precondition to admission to some nursing homes, the homes reportedly are requiring that applicants sign so-called "do-not-resuscitate" orders, orders that exempt the nursing home from having to provide certain life-saving procedures (such as anti-choking techniques, mouth-to-mouth respiration, or chest compression for heart failure). Other nursing homes have written policies which indicate that they do not conduct CPR, nor do they summon emergency medical services unless ordered or requested by the patient.

Patients admitted to all nursing care facilities are entitled to receive adequate and appropriate care. Cardiopulmonary resuscitation surely meets the definition of adequate and appropriate care under appropriate circumstances. Withholding and not making available CPR surely can be construed to be inadequate and inappropriate care under certain circumstances. No nursing home should be able to force someone to give up his or her right to be medically revived, if that would be his or her choice, nor should the nursing home withhold a basic health care service which, when appropriately administered, can be life saving. Nursing homes should be required to at least promptly initiate CPR while other help is on the way.

Against:

House Bill 5013 leaves a number of nursing homes' questions and concerns unanswered. For example, do all nursing home staff need to be trained in resuscitation? If not, how many staff per shift? What staff training would be considered acceptable? In-house in-service training? A program leading to certification? (If so, which certification? American Heart Association or Red Cross?) Under what circumstances and at what level must resuscitation be provided? (For example, would the requirements include or exclude defibrillation or IV medications?)

Nursing homes also are concerned that the bill would create a new standard of malpractice and would punish oversight and mistakes, as well as prohibit situations in which non-resuscitation would be more merciful than resuscitation. For example, what if a frail elderly patient without a legal guardian or patient advocate "arrests" (that is, experiences cardiac or respiratory failure) and the family agrees with the physician that resuscitation is not what the patient would want and that such

attempts would not be helpful? Must resuscitation then be administered? Who would pay for the services? What would the home's liability be if resuscitation failed to revive the patient, or, if the patient survived but with significant injury or reduced quality of life? What about statistics that reportedly indicate a high failure rate (for example, a poor outcome) of resuscitation given to the elderly with chronic conditions? What if resuscitation were initiated against the patient's expressed but unwritten wishes? What about the difference between witnessed and unwitnessed "events?" Shouldn't people who have "died in their sleep" be exempted from resuscitative efforts? What about patients who experience heart or respiratory failure for whom enough time has passed that a "successful" resuscitative effort would result in a brain dead patient? How often would the resident's decision on resuscitation, even if written, have to be reviewed?

Response:

Some of these questions already are answered in the bill, while the others can be worked out once the nursing home residents' right to choose resuscitation is clearly mandated. For example, the Department of Public Health would promulgate rules defining the resuscitative procedures (mouth-to-mouth ventilation, and precordial chest compressions) required by the bill. The bill also would clearly say that if a nursing home patient decided not to have resuscitative efforts made on his or her behalf, this decision would have to be stated in writing, and would allow nursing homes to ask patients to consider making such a written statement before entering the home. Also, with regard to so-called "unwitnessed events," House Bill 5150, by giving nurses the legal power to declare death, would allow them to decide whether resuscitative measures were called for.

Against:

House Bill 5013 doesn't go far enough. Current state law, surprisingly, does not require CPR training of physicians, nurses, or nurses' aids. Rather than just require that nursing home staffs be trained in resuscitative measures, it would make more sense to require, as a condition of licensing or certification, that all health care professionals be trained and certified in cardiopulmonary resuscitation.

For:

House Bill 5150 would authorize registered nurses to pronounce death, thus giving them the authority to decide the appropriateness of resuscitative measures. The current law regarding the determination of death allows only physicians to pronounce the death of an individual. When someone dies in a hospital, there usually is no problem in having a physician present to pronounce death. However, a number of factors have changed the nature of the location and the type of health care professionals present when death occurs: in long term care settings and in hospice services in the home, the registered nurse frequently has been the health professional caring for the person who has just died. Rather than requiring ambulance transportation of the body to the hospital to confirm death before taking the body to the funeral home, or to call emergency medical services personnel (or the county medical examiner), it would make more sense to allow registered nurses, in addition to doctors, to pronounce death. By doing this, House Bill 5150 would reduce not only the financial but emotional costs to the family and community and add dignity to the death of people dying in their homes or in long term care facilities.

For:

House Bill 5150 is needed to update a now-outdated law governing the official determination of death. The current determination of death law (Public Act 124 of 1979) needs to be revised in light of evolving thinking on the subject. The Michigan law was based on a model act proposed in 1972, and at the time was a clear advance, but a ten-year evolution in statutory language has shown some problems with the existing law. In 1980, the National Conference of Commissioners on Uniform State Laws (NCCUSL) promulgated the Uniform Determination of Death Act (UDDA), which was approved by the American Medical Association and adopted by 22 states and the District of Columbia.

Current Michigan law differs from the UDDA in a number of respects: The Michigan statute refers to a person being "considered dead," whereas the UDDA simply states when a person "is dead." The law should say when someone is dead, and not suggest (by the use of language such as "is considered") that the determination of death is somehow not necessarily related to the physiological facts. Secondly, the Michigan law refers to "spontaneous" respiratory and circulatory functions and brain functions, but the word "spontaneous" has turned out to be medically ambiguous and unsatisfactory as a standard for making a

determination of death. The UDDA eliminates the reference to "spontaneous." The Michigan law also does not clearly say that all brain functions must have ceased. The brain has a number of functions, and physiologically all need not fail at the same time. Under the UDDA, the entire brain must cease to function, irreversibly. The "entire brain" includes the brain stem, as well as the neocortex. By specifying the entire brain, the bill would distinguish death from "neocortical death" or "persistent vegetative state" (which are not considered valid medical or legal bases for determining death). The Michigan statute refers to a determination of death "based on ordinary standards of medical practice in the community," a localized standard which can impose unnecessary proof problems by requiring proof that a particular means of determining cardiorespiratory or brain death is not only consistent with accepted medical practice but also is the practice used in the particular community. There should be no local or regional variation in determining death. Before death determinations were subject to statute and before brain death became an issue, there was virtual uniformity among the states under the common law. By adopting the bill, which is based on the UDDA, uniformity of the statute would be maintained.

The UDDA sets the general legal standard for determining death, but not the medical criteria for doing so. The medical profession would remain free to formulate acceptable medical practices and to utilize new biomedical knowledge, diagnostic tests, and equipment. House Bill 5150, by adopting the UDDA, would codify the common law cardiorespiratory standard for determining death and establish an appropriate statutory standard for making brain death determinations. It would do this by recognizing cardiorespiratory and brain death in accordance with the criteria the medical profession has universally accepted. It would not authorize euthanasia or "death with dignity," and would not enact any sort of living will.

POSITIONS:

Citizens for Better Care supports House Bill 5013. (1-28-92)

The American Association for Retired Persons supports House Bill 5013. (8-31-92)

The Health Care Association of Michigan supports House Bill 5013. (9-1-92)

The Michigan Non-Profit Homes Association opposes House Bill 5013. (1-28-92)

The Michigan Nurses Association supports House Bill 5150. (12-18-91)

The Michigan Association for Local Public Health supports House Bill 5150. (11-6-91)