



# DO NOT ATTEMPT RESUSCITATION ORDERS IN OUR SCHOOLS: THE UNTHINKABLE ETHICAL DILEMMA FOR EDUCATORS

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For decades upon decades, we have used the short hand of the three “R”s, “Reading, wRiting, and Rithmetic”, for school. However, as noted by a journalist’s article title, “Reading, Writing, Do Not Resuscitate”,<sup>1</sup> with growing, and disconcerting frequency, a fourth “R” has been added, resuscitation— and with it is entailed the ethical dilemma of whether or not to resuscitate.

As described in that article, eight-year-old Katie, a second grader at Laremont School in Lake, County Illinois, “keenly enjoyed her trips to school.”<sup>2</sup> Before being rolled onto her school bus in the morning, Katie’s mother, Beth, checked to make sure that she had her bright yellow paper stating in bold letters “Do Not Resuscitate.”<sup>3</sup> Katie carried this notice with her everywhere she went, even to school. Katie was deprived of oxygen before birth. She couldn’t walk, talk or do things for herself. She was fed through a tube in her stomach and was susceptible to infections, violent choking, and coughing spasms.<sup>4</sup> Her health was taking a turn for the worse. While Do Not Attempt Resuscitation (DNAR) orders are common in hospitals and nursing homes, they are not common in schools. Katie’s mother obtained a legal DNAR and presented it to the school district. After two-years, school officials agreed to honor the DNAR directives.<sup>5</sup>

One day in November, Katie stopped breathing in class. The teacher picked her up, as allowed by the DNAR, and soon Katie started breathing on her own.<sup>6</sup> No attempt at resuscitation was made. The DNAR allowed Katie to be moved

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<sup>1</sup> See Jeff Long, *Reading, Writing, Do Not Resuscitate*, L.A. TIMES (Mar. 2, 2008), <http://articles.latimes.com/2008/mar/02/news/adna-dnr2>.

<sup>2</sup> *Id.*

<sup>3</sup> *Id.*

<sup>4</sup> *Id.*

<sup>5</sup> *Id.*

<sup>6</sup> *Id.*

to the nurse's office, the paramedics would be called, the school nurse could suction Katie's breathing tube, oxygen could be provided via a mask, and she could be positioned so as to make her breathing easier. But cardiopulmonary resuscitation could not be performed without her parents' permission.<sup>7</sup>

This story was written in 2008. Katie died at home on May 23, 2009 from complications from her illness.<sup>8</sup> However, we know that there are more students like Katie, and the numbers are growing, who come to school with chronic and terminal illnesses.<sup>9</sup> For some of these children, their parents have chosen to limit resuscitative efforts.<sup>10</sup> As a result, school officials will be confronted with DNAR orders similar to Katie's.

The National School Board Association recognizes the legal and practical considerations of this highly complex emotional area.<sup>11</sup> They raise the question, given that the law on DNARs in schools is unsettled, "how or if [schools] should honor a student's DNR order."<sup>12</sup>

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<sup>7</sup> See Long, *supra* n.1.

<sup>8</sup> Jessica Adelman, *The School-Based No-Not-Resuscitate-Order*, 13 DEPAUL J. HEALTH CARE L. 197, 197 (2010-11).

<sup>9</sup> American Academy of Pediatrics, Committee on School Health and Committee on Bioethics, *Do Not Resuscitate Orders in Schools*, 105 PEDIATRICS (April 2000) available at <http://pediatrics.aappublications.org/content/105/4/878>.

<sup>10</sup> *Id.*

<sup>11</sup> Jennifer M. Deutch, Lori G. Martin, & Jennifer A. Mueller, *Managing Students with Health Issues: 504 Plans, DNR Orders, and Contagious Diseases*, NAT'L SCH. BRD. ASSOC. 1, 16 (2015) available at [https://www.nsba.org/sites/default/files/file/16\\_FINAL\\_Deutch\\_Martin\\_Managing\\_Students\\_with\\_Health\\_Issues\\_Paper.pdf](https://www.nsba.org/sites/default/files/file/16_FINAL_Deutch_Martin_Managing_Students_with_Health_Issues_Paper.pdf).

<sup>12</sup> *Id.*

Educators cathect their relationship with their students.<sup>13</sup> Education is a helping profession. Nel Noddings asserts that education in its widest sense pursues an ethic of caring in society.<sup>14</sup> Educators take pride in their professional commitment to their students. Their codes of ethics<sup>15</sup> place a student's interests at the core of their professional service with educators acting *in loco parentis*.<sup>16</sup> Educators owe a duty to their students to take reasonable steps to protect them from foreseeable harm.<sup>17</sup> But what happens when educators receive a medical directive that requires that they do not attempt to resuscitate one of their students; do they allow the student to die? How do they reconcile this ethical dilemma of serving the best interests of one of their students who has a legal instrument

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<sup>13</sup> See DAN C. LORTIE, *SCHOOL TEACHER: A SOCIOLOGICAL STUDY* (2 ed., 2002).

<sup>14</sup> NEL NODDINGS, *THE CHALLENGE TO CARE IN SCHOOLS: AN ALTERNATIVE APPROACH TO EDUCATION* (1992).

<sup>15</sup> For examples of educator codes of ethics, see <http://www.nea.org/aboutnea/code.html>; <https://www.schoolcounselor.org/asca/media/asca/Resource%20Center/Legal%20and%20Ethical%20Issues/Sample%20Documents/EthicalStandards2010.pdf>; <http://www.aasa.org/content.aspx?id=1390>.

<sup>16</sup> The *in loco parentis* doctrine was articulated in 1769 by Sir William Blackstone. He asserted that a portion of the parental authority was delegated to the schoolmaster. Through compulsory education laws, state statutes, and court cases, *in loco parentis* requires that the educator act in the place of the parent when the child has been placed into the care and custody of the school. Todd A. DeMitchell, *The Duty to Protect: Blackstone's Doctrine of In Loco Parentis: A Lens for Viewing the Sexual Abuse of Students*, 202 BU EDUC. & L. J. 17, 18-19 (2002).

<sup>17</sup> See TODD A. DEMITCHELL, *NEGLIGENCE: WHAT PRINCIPALS NEED TO KNOW ABOUT AVOIDING LIABILITY* 25 (2006) (writing, "Since teachers stand *in loco parentis* (custodial and tutelary responsibilities), they must take affirmative actions in the face of foreseeable risks to protect students.").

initiated by their parents that requires that we refrain from taking action? Teresa Savage refers to this as a problem with “the moral agency of school personnel in enacting the DNAR order.”<sup>18</sup> This is compounded by the doctrine of *in loco parentis*. The educator and the school do not replace the parents; they act in the place of parents who are not at school. It can be argued that *in loco parentis* requires that the school and its teachers and nurses, acting in the place of the parent must follow the wishes of the parent in this non-curricular aspect of a child’s time at school.<sup>19</sup>

The implementation of a DNAR in a school, which is already complicated, is further compounded by the “general lack of medical committees to weigh in on the process of implementation, which are available in the medical setting.”<sup>20</sup> Essentially, schools, unlike hospitals, are not equipped or staffed to address this issue. Yet, they must respond to a lawful directive.

The stakes are unquestionably high and it is an unimaginably difficult decision for educators, who dedicate themselves to enriching the lives and expanding the future opportunities of their students: a terminally ill child could be saved by emergency care but left physically or mentally impaired — a greater burden for the family and child. And the results are, of course, irrevocable; once the decision is made to honor a DNAR order, you cannot undo the decision not to resuscitate. “The issues are certainly troubling, with no easy answers. This

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<sup>18</sup> Teresa Savage, *DNAR in Schools: Questions and Concerns*, 5 AMER. J. BIOETHICS 72, 72 (2005).

<sup>19</sup> This is not an assertion that parents through *in loco parentis* or under the asserted doctrine of substantive due process, can compel the school to meet their wishes on issues of curriculum offerings and instructional strategies. For a discussion of the tension between parents and the State over the curriculum that students/children receive in public schools, see Todd A. DeMitchell & Joseph J. Onosko, *A Parent’s Child and the state’s Future Citizen: Judicial and Legislative Responses to the Tension Over the Right to Direct an Education*, 22 S. CAL. INTERDIS. L. J. 591 (2013).

<sup>20</sup> See Deutch et al, *supra* note 11, at 17.

literal life and death decision is full of heartbreak for all involved.”<sup>21</sup>

This article explores the dilemma that educators face when confronted with a Do Not Attempt Resuscitation (DNAR) order. Part 1 explores what is a DNAR order and how prevalent it is in schools. The second part discusses medically fragile students who attend school and the relationship of special education to DNARs. Section three explores school responses to DNARs, including state guidelines. The duty that educators owe to their students is the focus of the fourth section. The fifth part follows up with a discussion of the legal responses to a DNAR. The next section addresses the ethical dilemma that confronts educators of students with these orders. The article concludes with a summation of ethical actions.

## I. WHAT IS DNAR?

Closed-chest cardiac massage was first used in 1960 as an effective means of resuscitating victims of cardiac arrest.<sup>22</sup> The practice soon became known as cardiopulmonary resuscitation (CPR). Twenty years later studies showed that the survival rate for patients [defined by the American Heart Association as living to discharge from the hospital,]<sup>23</sup> undergoing CPR was

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<sup>21</sup> Todd A. DeMitchell & Winston Thompson, *When a parent directs a child not be resuscitated, what should educators do?* THE CONVERSATION (May 2, 2016) available at <https://theconversation.com/when-a-parent-directs-a-child-not-be-resuscitated-what-should-educators-do-55556>.

<sup>22</sup> Jacqueline K. Yuen, M. Carrington, Reid, & Michael D. Fetters, *Hospital Do-Not-Resuscitate Orders: Why Have They Failed and How to Fix Them*, 26 J. GEN. INTERN. MED. 791 (2011) available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3138592/>.

<sup>23</sup> *Heart Disease and Stroke Statistics – 2013 Update online on December 12, 2012 Statistical Update*, CPR & FIRST AID: EMERGENCY AND CARDIO. CARE, [http://cpr.heart.org/AHA/ECC/CPRAndECC/General/UCM\\_477263\\_Cardiac-Arrest-Statistics.jsp](http://cpr.heart.org/AHA/ECC/CPRAndECC/General/UCM_477263_Cardiac-Arrest-Statistics.jsp).

only 10-15%.<sup>24</sup> Repeated resuscitations, while prolonging life, have inflicted agony on the terminally ill and offered little improvement to the prospect of recovery. “[P]atients who were successfully resuscitated often undergo aggressive treatment in the intensive care unit and suffer complications including rib fractures, permanent neurological deficits, and impaired functional status.”<sup>25</sup> The recognition that CPR “could cause more harm than benefit for some patients” led to the implementation of DNAR orders.<sup>26</sup>

As medical and technological advances prolong life<sup>27</sup> they also present challenges because “longer lives are not necessarily healthier lives.”<sup>28</sup> The American Heart Association defines survival rate by those individuals who live to discharge from the hospital. A physician writes,

One problem with medicine today, is that it is too good. People live longer than ever before, and many patients are able to recover from deadly illnesses the world knew nothing about when my grandparents were children. Doctors

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<sup>24</sup> Yuen, et al, *supra* note 22. This low survival statistic stands in sharp contrast to the perception of the outcome of CPR on television programs, *Chicago Hope*, *ER*, & *Rescue 911*, in which 67% of the individuals survive. Susan Diem et al., *Cardiopulmonary Resuscitation on Television — Miracles and Misinformation*, 334 N. ENGL. J. MED. 1578 (1996) available at <http://www.nejm.org/doi/full/10.1056/NEJM199606133342406#t=article>.

<sup>25</sup> *Id.*

<sup>26</sup> *Id.*

<sup>27</sup> News Release, WHO: *Number of People Over 60 Years Set to Trouble by 2050; Major Societal Changes Required* (Sept. 15, 2015) <http://www.who.int/mediacentre/news/releases/2015/older-persons-day/en/>.

<sup>28</sup> *Id.*

can keep people alive in ways once thought impossible.<sup>29</sup>

In response to the tension of extending lives and securing a quality of life, advance directives were developed. An advance directive informs a physician of the kind of care you would like to have if you become unable to make decisions regarding your medical treatment, as in the case of coma or severe brain damage. An example of an advance directive is a living will, which comes into effect when you are terminally ill. A durable power of attorney is an advance directive that states whom you have directed to make health care decisions for you. It is activated when you are unable to make such decisions.<sup>30</sup> The third type of advanced directive is a do not attempt resuscitate order. A DNAR order directs that cardiopulmonary resuscitation (CPR) not be performed if your heart stops or you stop breathing.<sup>31</sup> A DNAR order does not mean the abandonment of all medical treatment or a decrease in the

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<sup>29</sup> Jacquelyn Corley, *Why Doctors Choose to Die Differently* (Feb. 17, 2016), <http://www.cnn.com/2016/02/17/opinions/doctors-choose-quality-of-life-over-length-corley/index.html>.

<sup>30</sup> American Academy of Family Physicians, *Advance Directive and Do Not Resuscitate Order* (Jan. 2012), available at <http://familydoctor.org/familydoctor/en/healthcare-management/end-of-life-issues/advance-directives-and-do-not-resuscitate-orders.html>.

<sup>31</sup> A DNAR order has also been called a DNR, Do Not Resuscitate order. “The terminology eventually changed to “do not attempt resuscitation” (DNAR), acknowledging that resuscitation is not always successful.” American Academy of Pediatrics, *supra* note 8. “The American Heart Association in 2005 moved from the traditional do not resuscitate (DNR) terminology to do not attempt resuscitation (DNAR). DNAR reduces the implication that resuscitation is likely and creates a better emotional environmental to explain what the order means.” Joseph L. Breault, *DNR, DNAR, or AND? Is Language Important*, 11 OCHSNER. J. 302, 302 (2011). For purposes of clarity, we use the term DNAR throughout the paper.



quality or intensity of care<sup>32</sup>, i.e., it does not “of itself, rescind the obligations of the health care team to provide quality care, such as suction, oxygen, and pain medication.”<sup>33</sup>

They are implemented within the context of palliative care.<sup>34</sup> A DNAR resides in the junction of taking every effort to prolong a life and attempting to safeguard the quality of the life preserved. As indicated above, repeated resuscitations, while prolonging life, often inflicted agony on the terminally ill and offered little improvement to the prospect of recovery; as Daniel Goldberg notes, DNAR orders arose out of the need to address such suffering.”<sup>35</sup> The American Academy of Pediatrics (AAP) believes that it is ethically acceptable to forego CPR for children and adolescents when it is unlikely to be successful or when the risks outweigh the benefits.<sup>36</sup>

Since minor children typically do not have the judgment to make decisions regarding their medical procedures, parents use a “best interests” argument to sign a DNR order.<sup>37</sup> This is

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<sup>32</sup> American Academy of Family Physicians, *supra* note 30. *See, also* Clarence H. Braddock III & Joanna Derbenwick, *Do Not Resuscitate (DNAR) Orders*, ETHICS IN MED. (UNIV. OF WASH. SCH. OF MED.) (2014) available at <https://depts.washington.edu/bioethx/topics/dnr.html>. “In the 1960s, CPR was initially performed by anesthesiologists on adults and children who suffered from *witnessed* cardiac arrest following *reversible* illnesses and injuries.” *Id.*

<sup>33</sup> *Id.*

<sup>34</sup> Committee on School Health and Committee on Bioethics, *supra* note 9.

<sup>35</sup> Daniel S. Goldberg, *The Ethics of DNR Orders as to Neonatal & Pediatric Patients: The Ethical Dimension of Communication*, 27 HOUSTON J. OF HEALTH L. AND POL’Y 57,60 (2006).

<sup>36</sup> Committee on School Health and Committee on Bioethics, *supra* note 9.

<sup>37</sup> For a discussion of what standard should be applied to enter an order to terminate life support measures and enter a DNR order on the medical chart of a dependent child in Delaware Family Service’s

“grounded on traditional parental values and responsibilities. Every parent has a ‘fundamental right’ to rear his or her own child.”<sup>38</sup> The United States Supreme Court in *Wisconsin v. Yoder* noted the long history of Western Civilization reflecting a strong tradition of parental concern for the nurture and upbringing of their children. “This primary role of the parents in the upbringing of their children is now established beyond debate as an enduring American tradition.”<sup>39</sup> New York’s Public Health Law, like many state laws, gives parents the right, although not an absolute right, to give consent for selecting medical treatments.<sup>40</sup> Consequently, parents may sign a DNR order for their minor children.

DNAR orders are difficult enough for medical professionals who practice at hospitals where immediate medical care is available and ethics boards provide direct supervision. Practices such as “slow codes,” “light blue codes,” or “Hollywood codes,” in which CPR efforts do not involve aggressive attempts to bring the patient back to life, have also developed in these contexts.<sup>41</sup> “A ‘slow code’ is an act performed by the health care providers that resembles CPR yet is not the full effort of resuscitation while a ‘show code’ is a short and vigorous resuscitation performed to benefit the family while

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custody, *see*, *Division of Family Services v. Trueslo*, 846 A.2d 256 (2000).

<sup>38</sup> *In the Matter of AB*, 768 N.Y. S.2d 256, 269 (S. Ct. 2003) (internal citations omitted).

<sup>39</sup> *Wis. v. Yoder*, 406 U.S. 205, 232 (1972).

<sup>40</sup> PUBLIC HEALTH L. § 2504(2).

<sup>41</sup> Goldberg, *supra* note 35 at 62. *See also Speak Up and Stay Alive: The Voice for Patient Safety, Slow Codes, Show Codes, & Hollywood Codes* (Aug. 10, 2015) available at <http://patientsafetyradio.com/slow-codes-show-codes-hollywood-codes/>.

minimizing harm to the patient.”<sup>42</sup> As such, it is a form of symbolic resuscitation that is ethically fraught.<sup>43</sup>

However, school personnel are generally not prepared or equipped to make these incremental decisions or to develop processes that guide responses to crises of this kind. For educators, there are no “slow codes,” light blue codes,” or “Hollywood codes” in which CPR efforts do not involve aggressive attempts to bring the student back to life. There is only one shade of Code Blue in the schools. They either perform CPR or they do not. When CPR could be performed, even the act of waiting for medical personnel carries important consequences.

## II. CHILDREN WITH SPECIAL HEALTHCARE NEEDS IN THE SCHOOLS

This challenge constitutes an emerging issue in our schools. Some children, who might otherwise have died at an earlier age, not only survive but also attend schools. There has been an increase in numbers of children with special health care needs (CSHCN) attending school.<sup>44</sup> In 2008, it was estimated by the U.S. Department of Health and Human Services that 60% of the 10.2 million under age 18 had their daily activities affected by their health conditions, impacting their education for those school aged children.<sup>45</sup> “Consequently, some children with chronic and terminal conditions are at risk of dying while attending school.”<sup>46</sup>

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<sup>42</sup> Braddock III & Derbenwick, *supra* note 32.

<sup>43</sup> *Id.*

<sup>44</sup> Lori S. Anderson, *Mothers of Children with Special Health Care Needs: Documenting the Experience of Their Children's Care in the School Setting*, 25 J. SCH. NURS. 342, 342 (Oct. 2009) available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2764271/>.

<sup>45</sup> *Id.*

<sup>46</sup> American Academy of Pediatrics, *supra* note 9, at 878.

A medically fragile child has been defined as a child who is at “increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require[s] health and related services of a type or amount beyond that required by children generally.”<sup>47</sup> These medically fragile students, also referred to as children with medical complexity (CMC)<sup>48</sup>, with a terminal diagnosis often wish to live a “normal” and/or minimally encumbered life for as long as they can; this may include attending school with their friends. These students most often experience several functional difficulties such as breathing, swallowing, and repeated or chronic pain. Almost 36% of schools have at least one medically fragile student,<sup>49</sup> receiving such services as catheterization, IV medications, stoma, tracheostomy and ventilator care.<sup>50</sup>

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<sup>47</sup> Katherine H. Burns, Patrick H. Casey, Robert E. Lyle, T.M. Lyle, T. Mac Bird, Jill J. Fussell, & James M. Robbins, *Increasing Prevalence of Medically Complex Children in US Hospitals*, 126 PEDIATRICS 638, 639 (Oct. 2010) available at <http://pediatrics.aappublications.org/content/126/4/638#ref-1>.

<sup>48</sup> Eyal Cohen, Dennis Z. Kuo, Rishi Agrawal, Jay G. Berry, Santi K.M. Bhagat, Tamar D. Simon, & Rajendu Srivastava, *Children With Medical Complexity: An Emerging Population for Clinical and Research Initiatives*, 127 PEDIATRICS 529 (Mar. 2011) available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3387912/> (writing, children with special health care needs includes “children who are the most medically fragile and have the most intensive health care needs.”). *Id.*

<sup>49</sup> Board of Education, Independent School District, 271, Bloomington, Minn., Policy 518 § I *Do Not Resuscitate (DNR) Orders*, Adopted Nov. 26, 2001, available at [https://www.bloomington.k12.mn.us/sites/default/files/content\\_file\\_attachments/Pol%20518%20.pdf](https://www.bloomington.k12.mn.us/sites/default/files/content_file_attachments/Pol%20518%20.pdf).

<sup>50</sup> School Health Policies and Practices Study, *Results from the School Health Policies and Practices Study 2014*. U.S. DEP’T. OF HEALTH AND HUMAN SERV. & CENTERS FOR DISEASE CONTROL AND PREVENTION 89 (2015) available at

Some children come to school with severe medical conditions that require a heightened duty of care. For example, in *Cedar Rapids Community School District v. Garret F.*<sup>51</sup> the United States Supreme Court held that the Cedar Rapids Community School District must provide Garret with assistance with urinary bladder catheterization once a day, suctioning of his tracheostomy tube as needed, but at least once every six hours, and ambu bagging. He also needs someone who is familiar with his ventilator in the event there is a malfunction or electrical problem and someone who can perform emergency procedures in the event that he experiences autonomic hyperreflexia. A delay of ten minutes in suctioning the tracheostomy could result in death or further brain damage. The Court provided a clear statement, endorsing the rights of students with complex health needs to attend school. Justice Stevens wrote:

This case is about whether meaningful access to the public schools will be assured [i]t is undisputed that the services at issue must be provided if Garret is to remain in school. Under the statute, our precedent, and the purposes of the IDEA [Individuals with Disabilities Education Act], the District must fund such 'related services' in order to help guarantee that students like Garret are integrated into the public schools.<sup>52</sup>

Sewall and Balkman note that the confluence of special education rights of inclusion for identified students and medical technological advancements have placed students in schools

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[http://www.cdc.gov/healthyyouth/data/shpps/pdf/shpps-508-final\\_101315.pdf](http://www.cdc.gov/healthyyouth/data/shpps/pdf/shpps-508-final_101315.pdf).

<sup>51</sup> 526 U.S. 66 (1999).

<sup>52</sup> *Id.* at 79.

where DNR orders are brought to schools for implementation.<sup>53</sup> For example, some children with medically fragile conditions such as Duchenne muscular dystrophy, are at risk for heart failure and sudden death. However, the incidents of successful CPR outcomes is limited, exposing the patient to the risk of brain damage.<sup>54</sup>

### III. THE DNAR AND SCHOOL POLICIES

The American Association of Pediatrics (AAP) estimates that on any given day, 2,500 adolescents and 1,400 preadolescent children in the US are within six months of dying.<sup>55</sup> Furthermore, the AAP cited a Centers for Disease Control Prevention study that DNAR orders in schools increased from 29.7% in 2000, to 46.2% in 2006.<sup>56</sup> Increasingly, these children and adolescents with life-limiting conditions are attending schools in the communities where they live. This has raised issues of accommodating students' and families' health care preferences.<sup>57</sup>

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<sup>53</sup> Angela Maynard Sewall & Kathy Balkman, *DNR Orders and School Responsibility: New Legal Concerns and Questions*, 23 REMEDIAL AND SPECIAL EDU. 7 (2002).

<sup>54</sup> Garey Noritz & David J. Birnkrant, *Incidence and Outcomes of Cardiopulmonary Resuscitation in Patients with End-Stage Duchenne Muscular Dystrophy* (Oct. 2007) available at <http://journal.publications.chestnet.org/article.aspx?articleid=1093919>.

<sup>55</sup> AMERICAN ACADEMY OF PEDIATRICS, COUNCIL ON SCHOOL HEALTH AND COMMITTEE ON BIOETHICS, *Honoring Do-Not-Attempt-Resuscitation Request in Schools*, 125 PEDIATRICS (May 2010) available at <http://pediatrics.aappublications.org/content/125/5/1073>.

<sup>56</sup> *Id.*

<sup>57</sup> *Id.*

The Individuals with Disabilities Education Act of 1997 (IDEA) requires a “zero reject” of students<sup>58</sup> with a disability, including students within the category of Other Health Impairment.<sup>59</sup> Similarly, IDEA<sup>60</sup> and section 504 of the Rehabilitation Act of 1973<sup>61</sup> requires that schools educate students with a disability alongside their peers who do not have a recognized disability. While, schools under IDEA are not required to provide medical services<sup>62</sup> to special education students, they must provide supplementary and school health services and school nurse services.<sup>63</sup> Consequently, children

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<sup>58</sup> The Act assures in pertinent part, “that all children with disabilities have available to them ... a free appropriate public education which emphasizes special education and related services designed to meet their unique needs.” 20 U.S.C. § 1400(c). *See Timothy W. v. Rochester School District*, 875 F.2d 954 (1st Cir. 1989) for the articulation of the concept of “zero reject” of students with a disability from receiving an appropriate education.

<sup>59</sup> Center for Parent Information and Resources, Other Health Impaired (July 2015). Available at <http://www.parentcenterhub.org/repository/ohi/#idea>. *See also, Detsel v. Sullivan*, 895 F.2d 58 (2nd Cir. 1990).

<sup>60</sup> “To the maximum extent appropriate, children with disabilities, . . . are educated with children who are not disabled . . . 20 U.S.C. § 1412(a)(5)(A).

<sup>61</sup> For the regulations stipulating the least restrictive environment requirements for academic setting, non-academic setting, and comparable facilities, *see* 34 C.F.R. § 104.34.

<sup>62</sup> Medical services can only be provided for diagnostic and evaluative purposes. 34 CFR § 300.34(c)(5).

<sup>63</sup> 34 CFR § 300.34(c)(13). For a discussion of the difference between medical services and school health services, *see Cedar Rapids Comm. Sch. Dist. v. Garret F.*, 526 U.S. 66 (1999); Leslie S. Margolis, Leslie S. Margolis, *Provision of School Health Services to Students with Disabilities: e Intersection of Health Care Policy, Education and the Law in the Post-Garret F. Era*, 5 J. HEALTH CARE L. & POL’Y 99 (2002).

with complex chronic conditions attend school and their needs must be adequately addressed. This is typically done through IEPs (Individualized Education Program) under IDEA or under a section 504 accommodation plan. The IEP or 504 plans are often augmented by an individualized health care plan.

While it is rare for students with a DNAR to die at school, it does not alleviate the need to plan for the possibility.<sup>64</sup> Children who are terminally ill typically do not attend school during the last several days of their life. It is the “anticipated decline or death occurring at an unanticipated time, in a school setting before the arrival of trained medical personnel”<sup>65</sup> that necessitates the need for planning. For example, the Board of Education in Bloomington, Minnesota regulations implementing Board Policy 518, requires an Individual Health Plan (IHP)<sup>66</sup> to be developed in response to a DNR order. The regulations state a duty to follow the medical orders for the DNR.<sup>67</sup> The Individual Health Plan includes:

- Specific medical interventions that are allowed and disallowed by the DNR order.
- Procedures to be followed for emergencies.

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<sup>64</sup> Kathryn L. Weise, *Do-Not-Attempt-Resuscitation Orders in Public Schools*, 12 AMA J. OF ETHICS, 569, 571 (July 2010), available at <http://journalofethics.ama-assn.org/2010/07/pdf/pfor1-1007.pdf>.

<sup>65</sup> *Id.*

<sup>66</sup> For a discussion of individual health plans, see Bernadett Moran McDowell, et al., *Individualized Healthcare Plans: The Role of the School Nurse* (2015), available at <https://www.nasn.org/PolicyAdvocacy/PositionPapersandReports/NA-SNPositionStatementsFullView/tabid/462/ArticleId/32/Individualized-Healthcare-Plans-IHP-Revised-2008>; Perry A. Zirkel, *Section 504 Eligibility and Students on Individual Health Plans*, 276 ED. L. R. 577 (2012).

<sup>67</sup> Board of Education, Independent School District, 271, Bloomington, M.N., Policy 518 § II (4) *Do Not Resuscitate (DNR) Orders* (adopted, Nov. 26, 2001) available at [https://www.bloomington.k12.mn.us/sites/default/files/content\\_file\\_attachments/Pol%20518%20.pdf](https://www.bloomington.k12.mn.us/sites/default/files/content_file_attachments/Pol%20518%20.pdf).



- Plans for interaction with local emergency personnel.
- Plans for ongoing assessment of the student's health status.
- Guidelines for removal of the student from class activities.
- Guidelines for dealing with other students in the classroom.
- Palliative care (comfort measures to be administered).
  - Protocol for handling an emergency on the school bus or during school related activities.
  - Training and support for school staff.
  - Plan for ongoing communication with the family.
  - Plan for response to an emergency situation in the event that the School's Health Associate is not available.<sup>68</sup>

A school policy adopted (2012) by the Massachusetts' Franklin School Committee acknowledged that "some students with health impairments, parents/guardians may request school personnel withhold emergency care of their child in the event of a life-threatening situation" requires that all students with a DN[A]R and a Do Not Intubate (DNI) must wear a bracelet identifying the DN[A]R or DNI order.<sup>69</sup> The individual health care plan (IHP) must be reviewed annually.

Several states offer guidance for schools which have been presented with a DNAR order. For example, in New Hampshire, the state Department of Education notes that a DNAR "can be a

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<sup>68</sup> *Id.*

<sup>69</sup> Franklin Massachusetts School Committee, Do Not Resuscitate Order (DNR)/Do Not Intubate, (Sept. 27, 2012), available at [http://franklinschool.vt-s.net/Pages/FranklinCom\\_Emanual/j/Jdocs/JLCE](http://franklinschool.vt-s.net/Pages/FranklinCom_Emanual/j/Jdocs/JLCE). Intubation is defined as, "The insertion of a tube into the mouth or nose to help with breathing." Brigham and Women's Faulkner Hospital, Understanding Do Not Resuscitate (DNR) Orders (n.d.) available at [http://www.brighamandwomensfaulkner.org/about-us/patient-visitor-information/advance-care-directives/dnr-orders.aspx#.V\\_GIzDJ-Jo4](http://www.brighamandwomensfaulkner.org/about-us/patient-visitor-information/advance-care-directives/dnr-orders.aspx#.V_GIzDJ-Jo4).

contentious issue and are always a challenge.”<sup>70</sup> Furthermore, it states the importance of developing an IHP for the student who has a DNAR. It also states that schools should develop a policy to address DNARs. The policy should balance the interests of the parents and their child with the interests of the school personnel.<sup>71</sup> The guidance recommends the following components should be part of the policy.

- Verifying the DNR order with the physician
- Ensuring the student's IHP addresses mortuary arrangements and transport
- Ensuring the student's IHP specifically outlines what actions may and may not be performed
- Ensuring the student's IHP addresses protocol for notifying family of the death
- Notification of EMS and Medical Examiner that student has a DNR order when they enroll (requires written consent from parents)
- Plan of support for staff and students after the death
- Plans for where the body will be kept
- Pronouncing the death

For more related information see the Massachusetts Department of Elementary & Secondary Education guidelines Students with Comfort Care/Do Not Resuscitate Orders.<sup>72</sup> Their guidelines reflect the importance of a broad based consulting approach to this health/educational issue. The Massachusetts Department of Public Health (MDPH) Office of Emergency Medicine and the MDPH Legal Office collaborated with education department.<sup>73</sup>

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<sup>70</sup> N.H. DEPT. OF EDU., *Do Not Resuscitate (DNR) Reference Sheet*, available at [http://www.education.nh.gov/instruction/school\\_health/faq\\_dnr.htm](http://www.education.nh.gov/instruction/school_health/faq_dnr.htm).

<sup>71</sup> *Id.* “The policy should be drafted to limit the trauma to staff and other students as well as to respect the wishes of the families impacted.” *Id.*

<sup>72</sup> Anne H. Sheetz, *Students with Comfort Care/Do Not Resuscitate Orders*, MASS. DEP’T OF ELEM. & SECONDARY EDU. (Nov. 30, 2004), available at <http://www.doe.mass.edu/news/news.aspx?id=2154>.

<sup>73</sup> *Id.*

#### IV. THE DUTY OWED AND A DNAR

DNAR orders at school raise a host of challenges. One question associated with this challenge is, what duty is owed to those students with foreseeable risk of injury? For example, in *Cedar Rapids Community School District v. Garret F.*<sup>74</sup> the United States Supreme Court held that the Cedar Rapids Community School District must provide Garret with assistance with urinary bladder catheterization once a day, suctioning of his tracheostomy tube as needed, but at least once every six hours, ambu. bagging.<sup>75</sup> He also needs someone who is familiar with his ventilator in the event there is a malfunction or electrical problem and someone who can perform emergency procedures in the event that he experiences autonomic hyperreflexia. “Tracheostomy complications may have catastrophic consequences.”<sup>76</sup> While this case was the subject of a lawsuit as to whether the required intensive nursing services were part of a medical exclusion under IDEA’s related services,<sup>77</sup> it does underscore that the duty owed for foreseeable harm, once defined, must be discharged in an appropriate manner. It also strengthened the position that students may need more services, including continuous care.<sup>78</sup>

As this case indicates, the issues facing educators are not simple. To appropriately address the complex ethical terrain of

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<sup>74</sup> *Cedar Rapids Community Sch. Dist. v. Garrett F.*, 526 U.S. 66 (1999).

<sup>75</sup> *Id.* at 83.

<sup>76</sup> CENTER FOR INFANTS AND CHILDREN WITH SPECIAL NEEDS, CARE OF THE CHILD WITH A TRACHEOSTOMY 25 (Nov. 2009).

<sup>77</sup> See 20 U.S.C. § 1400 *et seq.*

<sup>78</sup> Julie F. Mead & Mark A. Paige, *Parents as Advocates: Examining the History and Evolution of Parents’ Rights to Advocate for Children with Disabilities under IDEA*, 34 J. OF LEGIS. 123, 139 (2008).

DNAR orders in schools, it may be wise to consider the very essence of educator's ethical conduct in their professional roles and the degree to which they are equipped to make ad hoc judgments about how best to discharge their ethical obligations.

Generally, in line with the ethical duties of their profession (see below), educators know how to protect students from the worst forms of harm, but with terminally ill students who have a do not attempt resuscitate order (DNAR), do they know whether and how to let them die in school? A school does not and cannot ensure the absolute safety of its pupils.<sup>79</sup> However, in the case of a DNAR order in a school, one could argue that the school promises almost the opposite outcome of safety while under the school's supervision.

Educators have an ethical duty to exercise their professional judgment in the best interests of their students. The National Education Association Code of Ethics, reads in pertinent part, teachers must make reasonable efforts to protect students "from conditions harmful to learning or to health and safety."<sup>80</sup> Educators also have a legal duty to act in their students' interests by taking reasonable steps to reduce the likelihood of foreseeable harm.<sup>81</sup>

Confounding the ethical dilemma is an argument against accepting a DNAR orders that is often advanced regarding the harm on the bystanders, students and adults who witness the withholding of CPR. A cardiac arrest, especially on the part of a child, "is a startling event to witness and potentially traumatic

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<sup>79</sup> See *Diaz v. Brentwood Union Free Sch. Dist.*, 36 N.Y.S. 3d 161, 162 (A.D. 2 Dept. 2016) ("A school is not an insurer of the safety of its students . . .") (internal citations omitted). For a discussion of the limits of the duty owed, see DeMitchell, *supra* note 16, at 27.

<sup>80</sup> National Education Association, *Code of Ethics of the Education Profession* (n.d.) available at <http://www.nea.org/aboutnea/code.html>.

<sup>81</sup> W. PAGE KEETON, PROSSER AND KEETON OF TORTS 164 (5 ed. 1984) ("A duty or obligation recognized by the law requiring the person to conform to certain standard of conduct, for the protection of others against unreasonable risks.").

for bystanders.”<sup>82</sup> However, witnessing an unsuccessful CPR attempt may be equally traumatizing.<sup>83</sup>

These duties present difficulties for educators who wish to act ethically in their professional role relative to their students and DNAR orders. A responsible analysis of these issues may require educators to pursue clarity on the limits of their professional judgments, carefulness in defining students’ interests, and appropriate attention to what is or is not characterized as harm.

## V. LEGAL RESPONSES TO A DNAR IN THE SCHOOLS

As stated above, DNARs in schools legal as well ethical challenges. While there is dearth of cases on these advanced directives in schools, one case does add to the discussion — *ABC School v. Mr. Mrs. M.*<sup>84</sup> In this case, a Massachusetts Superior Court of Barnstable addressed the issue of whether a public school could refuse to honor a DNR.<sup>85</sup> The school sought declaratory and injunctive relief on the basis that honoring the DNR is contrary to their professional ethics. The defendant parents also requested (Minor M) constitutional right to refuse medical treatment.

Minor M was a four-year old girl who was severely disabled both mentally and physically. At the time of the trial she weighed only twenty pounds.<sup>86</sup> In the year before the proceeding her medical condition deteriorated. In March of 1997 Minor M stopped breathing while at school. The school nurse administered care to her until she was transported to the

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<sup>82</sup> American Academy of Pediatrics, *supra* note 8, at 1075.

<sup>83</sup> *Id.*

<sup>84</sup> *ABC Sch. v. Mr. Mrs. M.*, 97518 (Mass. CMMW., July 30, 1997), available at <https://casetext.com/case/abc-school-v-mr-mrs-m>.

<sup>85</sup> *Id.* at para. 1.

<sup>86</sup> *Id.* at para. 4.

hospital. After consultation with Minor M's physician, a DNR Order was developed. The Order states in relevant part:

Should Minor M have a cardiorespiratory arrest, she may receive oxygen, suction and stimulation. She should receive rectal valium if she appears to be having a prolonged seizure. Minor M should not receive cardiopulmonary resuscitation, intubation, defibrillation, or cardiac medications. Invasive procedures such as arterial or venous puncture should only be done after approval of her parents.

Should Minor M have an apneic spell at school, she should receive oxygen, suction and stimulation. If she responds to this, her parents should be contacted and she can be transported home. If she does not respond, she should be transported by ambulance to the local hospital.<sup>87</sup>

The DNR order was submitted to the School. The ABC School refused to honor it arguing that it was at odds with their "Preservation of Life Policy" requiring: "Teachers of the ABC School classes [to] provide whatever means are available to them to preserve and protect a child's life in the event of a crisis."<sup>88</sup> Several of the faculty members stated that honoring the DNR Order "is contrary to their professional ethics."<sup>89</sup> The school brought suit seeking relief from having to implement the DNR order.

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<sup>87</sup> *Id.* at para 5.

<sup>88</sup> *Id.* at para. 6.

<sup>89</sup> *Id.* at para 7.

The court noted that the issue was one of first impression in Massachusetts. The court found that the parents had a right to establish the directive in the best interests of their daughter and the court would not provide the declaratory or injunctive relief the school district requested.<sup>90</sup>

The court also declined to grant immunity to any of the educators who did not follow the DNAR as acting in good faith. The court held that to issue a declaratory judgment in which the educators at ABC School could act under the protection of “good faith immunity” “would vitiate the DNR Order and essentially constitute an end-run around the court’s denial of the request for injunctive relief.”<sup>91</sup> Consequently, the court ordered that, “[The] ABC School and its personnel shall honor the terms of the DNR Order for Minor M.”<sup>92</sup> Deciding whether to allow a loved one to die does not reside within the professional expertise or obligations of educators; it belongs to the parents the court affirmed.

Another legal consideration raises the potential issue of harm if the educator with knowledge of the DNAR rejects its requirements and attempts CPR with disastrous results, that educator may have supplied harm and could possibly be legally liable. For example, if the educator was told not to administer the chest compressions and the mouth to mouth breathing, he/she could be liable for battery, as an intentional, unauthorized harmful or offensive touching of another. It is not a negligent act; an intentional act is a purposeful act.

While the action of the educator is not intended to cause harm to the student, in fact the intent is just the opposite, it is

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<sup>90</sup> *Id.* at para. 8.

<sup>91</sup> *Id.* at para. 13

<sup>92</sup> *Id.* at para. 14. However, *see* Lewiston, Maine Pub. Sch., 21 IDELR 83 (OCR) 1994 in which the Office for Civil Rights held that a student with a disability was not discriminated against by a general school policy that prohibited school personnel from complying with a DNAR order. This order only addressed whether the special education was discriminated against on the basis of disability in the general policy that applied equally to all students and did not address whether the DNAR order was binding on the school district.

not central to the battery. The issue is consent; did the student consent to the chest compression touching? For example, a Mississippi court in a case of a medical procedure opined, “Concisely stated in one sentence, no physician may perform any procedure on a patient no matter how slight or well intentioned without that patient’s informed consent, and violation of this rule constitutes a battery.”<sup>93</sup> Most likely the good intentions of the educator in administering CPR in violation of a DNAR Order would constitute a battery. An Arizona surgeon was not saved by his good intentions for exceeding the consent that was given by a patient.<sup>94</sup>

What happens if the CPR causes suffering or worsens the medical condition of the medically fragile child? What damages can be assessed against that educator for pain and suffering? An act of good faith in defiance of a legal order will not likely serve as a safe harbor, even if the educator was motivated by assessment of harmful circumstances.

## VI. PROFESSIONAL ETHICS AND A DNAR ORDER

Parents’ submission to a school of their advance directive requiring that CPR not be attempted on their child “creates ethically sensitive repercussions” for school personnel.<sup>95</sup> First, do the ethics of the profession serve as a bar for following a DNAR or do they require an affirmative action to implement the legal wishes of the parents? While educators can surely exercise professional judgment in explicitly educational matters of curriculum (sometimes doing so even when that judgment is at odds with parents’ stated preferences<sup>96</sup>), to what degree should

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<sup>93</sup> *Fox v. Smith*, 594 So. 2d 596, 604 (Miss. 1992).

<sup>94</sup> *Cathemer v. Hunter*, 558 P.2d 975, 979 (Ariz. Ct. App. 1976).

<sup>95</sup> See Weise, *supra* note 67 at 1.

<sup>96</sup> See, e.g., Kathie Forster, *Parents Rights and Educational Policy*, 21 *EDU. PHIL. AND THEORY* 47 (1989); Nava Maslovaty, *Teachers’ Choice of Teaching Strategies for Dealing with Socio-Moral Dilemmas in the Elementary School*, 29 *J. OF MORAL EDU.* 429 (2000); RICHARDS, SHEILA, WHAT CAN TEACHERS DO ABOUT BADLY BEHAVED PARENTS? 36 (2001).



educators be guided by the duties of their profession in making what amounts to medical judgments? If medical professionals are guided by their professional ethics to follow DNARs, could the educator's professional obligations result in legitimate resistance in that medical domain?

Secondly, without making reference to professional ethics (or under circumstances in which the above claim regarding the limits of those ethical obligations is challenged), could an educator's understanding of student interests guide action against the content of DNARs? This is a complicated issue for instances of medically fragile children. One view of student interest might prioritize the students' interest as a right to life, arguing that the promotion of that right requires educators to act in attempts to extend student life. Another view might prioritize the students' interest as a right to bodily integrity, arguing that the promotion of that right requires educators to respect the explicit statements (likely articulated by the guardians on behalf of the child) of what is and is not appropriate for a student's body.<sup>97</sup> No matter which view an educator personally holds, that educator may do well to consider the student's view (likely articulated by the guardians on behalf of the child) of which right ought to be prioritized in defining the student's interest. Failure to be careful in this activity may result in educators extending their personal vision and values in potentially offensive, oppressive, and/or unethical ways. Educators have no reason to support the claim that their own sense of a student's interest ought to guide action against the explicit views expressed via the content of a DNAR.

Furthermore, without reference to professional ethics or an overbearing account of student interests (or under circumstances in which the above conclusions regarding these issues is contested), might the educator resist DNARs on the

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<sup>97</sup> Both sets of views are well captured in the philosophical literature. See J.O. Famakinwa, *Interpreting the Right to Life* 22 (Sept. 1, 2011); Caroline Harnacke, *The Ashley Treatment: Improving Quality of Life or Infringing Dignity and Rights?* 30 *BIOETHICS* 141 (2016); Lisa Campo-Engelstein, Jane Jankowski, and Marcy Mullen, *Should Health Care Providers Uphold the DNR of a Terminally Ill Patient Who Attempts Suicide?* 28 (2016).

grounds that a student is experiencing harm? While this issue is surely related to the previous plea for carefulness in defining goals, this consideration sees educators attending to the student's present circumstances (instead of pursuing a more general aim). Attention to harm might compel an educator to resist a DNAR in instances when the educator recognizes that a student's DNAR represents parental mistreatment, neglect, or some other illegal or unethical practice or circumstance.<sup>98</sup> Such circumstances might be rare and would surely require attentive appraisal, but the ethical refusal of a DNAR might be justified.

Of course, this third consideration raises another potential issue of harm. If the educator with knowledge of the DNAR rejects its requirements and attempts CPR with disastrous results, that educator may have enacted harm and could possibly be legally liable and ethically blameworthy. For example, if the educator was told not to administer the chest compressions and the mouth to mouth breathing, he/she could be liable for battery, as an unauthorized harmful or offensive touching of another. What happens if the CPR causes suffering or worsens the medical condition of the medically fragile child? What damages can be assessed against that educator for pain and suffering? An act of good faith in defiance of a legal order will not likely serve as a safe harbor, even if the educator was motivated by assessment of harmful circumstances. It would seem that educators have little reason to risk the potential harm that might be caused by disregarding the dictates of a DNAR.

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<sup>98</sup> Unfortunately, instances in which parents or legal guardians have medical desires for children that constitute egregious harm are far too common. *See, e.g.,* <http://www.foxnews.com/health/2017/02/01/pennsylvania-parents-charged-in-connection-with-toddlers-pneumonia-death.html>. While it is unlikely that such standards might find purchase through a DNAR, that situation is not impossible.

## VII. ETHICAL ACTION EVEN WHEN INACTION IS AN ACTION

Writing a DNAR for a child is difficult and gut wrenching for parents as well as for physicians. Carrying out the directive raises the emotional toll. When that order is followed at school it can be a horrendous and deeply emotional event. Education is a helping profession; how do its educators help when served with a lawful advance directive not to attempt CPR? Do they disregard the order and substitute their judgment for that of the parents, thus acting not *in the place of* the parent but *instead of* the parent? Do they reject the order thus rejecting the admission of the child who likely has a legal right to a free appropriate public education though IDEA?<sup>99</sup> Or does the educator plan and provide the care at the end of life that was provided during life, for as peaceful a setting as possibly should the unthinkable happen at school? The way we respond to and help to shape the end of life of one of our students and may help us and our students to understand and affirm the dignity of life, even at its end; “Care is never futile.”<sup>100</sup>

The choices are not easy. But one thing that we know is that as professionals we are dedicated to serving the best interests of our students even when the path is hard and we prefer not to trod upon it. Our ethical choices define not only us, but our profession as well.

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<sup>99</sup> See *Timothy W. v. Rochester*, 875 F.2d 954 (1<sup>st</sup> Cir. 1989), holding there was “zero reject” of students eligible under special education law.

<sup>100</sup> ANONYMOUS AUTHOR, ETHICAL ISSUES: DO NOT ATTEMPT RESUSCITATION 1, 2 (April 2007), available at <http://ethics.missouri.edu/docs/DNAR%204-07.pdf>

