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"Do Not Resuscitate" Tattoos: Adequate Evidence of a Patient's Intent to Die?

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INTRODUCTION

In late 2017, paramedics brought an unconscious, unidentified, and unaccompanied seventy-year-old man to the Jackson Memorial Hospital in Miami, Florida.[1] The man's blood alcohol content was elevated, and he had a history of diabetes mellitus, atrial fibrillation, and chronic obstructive pulmonary disease.[2] Upon the man's chest was a tattoo that read "DO NOT RESUSCITATE."[3] The tattoo also included his signature.[4]

This left his doctors with a legal and ethical dilemma: Is a "do not resuscitate" (DNR) tattoo a valid advance directive?[5] An advance directive is a legal document that explains a person's medical wishes if they become incompetent or noncommunicative.[6] The doctors reported, "We initially decided not to honor the tattoo, invoking the principle of not choosing an irreversible path when faced with uncertainty."[7] Despite their best efforts, doctors were unable to bring the man to consciousness and could not ask him about his goals of care.[8] His condition worsened to the point in which his pulmonary disease could become fatal.[9]

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1 Gregory E. Holt, Bianca Sarmento, Daniel Kett, & Kenneth W. Goodman, *An Unconscious Patient with a DNR Tattoo*, 377 NEW ENG. J. MED. 2192, 2192 (2017), http://www.nejm.org/doi/full/10.1056/NEJMc1713344?af=R&rss=currentIssue&.

2 *Id.*; *see also* Lindsey Beaver, *A Man Collapsed with "Do Not Resuscitate" Tattooed on His Chest. Doctors Didn't Know What to Do*, WASH. POST (Dec. 1, 2017), https://www.washingtonpost.com/news/to-your-health/wp/2017/12/01/a-man-collapsed-with-do-not-resuscitate-tattooed-on-his-chest-doctors-didnt-know-what-to-do/?utm_term=.c41b89c0565c.

3 *See* Holt et al., *supra* note 1 (image showing the word "not" was underlined in the man's tattoo).

4 Cydney Henderson, *Florida Man's "Do Not Resuscitate" Tattoo Creates Ethical Dilemma for Doctors*, USA TODAY (Dec. 2, 2017, 6:23 AM), https://www.usatoday.com/story/news/nation-now/2017/12/02/florida-mans-do-not-resuscitate-tattoo-creates-ethical-dilemma-doctors/915916001/ (updated Dec. 2, 2017, 8:33 AM).

5 Holt et al., *supra* note 1.

6 *Advance Directive*, BLACK'S LAW DICTIONARY (10th ed. 2014), available at Westlaw.

7 *Id.*

8 *Id.*

9 Henderson, *supra* note 4.

Because the patient's condition worsened and his intentions were uncertain, his doctors requested a recommendation from the hospital ethics committee.[10] While awaiting the results, doctors placed the man on antibiotics and gave him treatment to prevent his death.[11] The ethics committee reviewed the man's case and advised the doctors that they should honor the tattoo as a clear indicator of the man's intent not to be resuscitated.[12] The committee suggested that "it was most reasonable to infer that the tattoo expressed an authentic preference, that what might be seen as caution could also be seen as standing on ceremony, and that the law is sometimes not nimble enough to support patient-centered care and respect for patients' best interests."[13] Subsequently, the treating physician wrote a DNR order for the patient.[14] Shortly thereafter, the hospital's social work department obtained a copy of a DNR order that the man had previously executed on a Florida Department of Health form that was consistent with his tattoo.[15] That night, his condition continued to deteriorate.[16] Doctors honored the DNR order, and the man died without further lifesaving treatment.[17] Although this man's previously executed DNR advance directive confirmed the intentions behind obtaining his tattoo, the doctors noted the ambiguity, stating:

> This patient's tattooed DNR request produced more confusion than clarity, given concerns about its legality and likely unfounded beliefs that tattoos might represent permanent reminders of regretted decisions made while the person was intoxicated. We were relieved to find his written DNR request, especially because a review of the literature identified a case report of a person whose DNR tattoo did not reflect his current wishes. Despite the well-known difficulties that patients have in making their end-of-life wishes known, this case report neither supports nor opposes the use of tattoos to express end-of-life wishes when the person is incapacitated.[18]

This patient will be referred to throughout this Article as Patient Number One.

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10 *Id*.
11 Holt et al., *supra* note 1.
12 *Id.*
13 *Id.*
14 *Id.*
15 *Id.*
16 *Id.*
17 *Id.*
18 *Id.*

This was not the first time such an incident had occurred. There had been a previous patient—Patient Number Two. In the case report mentioned above, the doctors referenced another case in the medical literature in which a patient's DNR tattoo did *not* reflect his intentions.[19] In that case, a fifty-nine-year-old man had nonhealing wounds on his lower leg and was admitted to the hospital for its amputation.[20] The patient had "D.N.R." tattooed on his chest.[21] Consistent with his tattoo, the patient orally indicated in a preoperative interview that he would not want prolonged attempts at resuscitation.[22] If he entered cardiac or respiratory arrest, however, the patient indicated that he would like to be resuscitated.[23] The patient explained that he had lost a poker bet while he was inebriated and, as the loser, was required to tattoo "D.N.R." on his chest, even though it did not correctly indicate his advance directive intentions.[24] Accordingly, the patient's DNR intentions were accurately coded in his medical record so that medical personnel would be prepared to properly execute the patient's most up-to-date intentions.[25] It was suggested that because his tattoo did not reflect his wishes, he should consider getting the tattoo removed.[26] The man declined and instead opined that he did not think that anyone would take his tattoo seriously.[27]

As DNR tattoos gain popularity, medical providers are increasingly forced to determine their patients' most vital, life-determining intentions without clear guidance from their patients or from the law. When presented with a tattoo that signifies medical wishes, doctors and other medical staff must try to best determine whether the tattoo represents a patient's true desire to make an irreversible medical decision. People have tattoos for many reasons, as illustrated by the patient who had "D.N.R." tattooed across his chest because he lost a bet. It is literally a question of life or death: Can a tattoo adequately indicate a patient's current intent to die? This Article will discuss the history of medical tattoos, the emergence of end-of-life intention

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19 *Id.*

20 Lori Cooper & Paul Aronowitz, *DNR Tattoos: A Cautionary Tale*, 27 J. GEN. INTERNAL MED. 1383, 1383 (2012), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3445694/.

21 *Id.*

22 *Id.*

23 *Id.*

24 *Id.*

25 *Id.*

26 *Id.*

27 *Id.*

tattoos (including DNR tattoos), and the impact of DNR tattoos on medical providers and hospital ethics committees. Finally, this Article provides suggestions for the use of tattoos as a proxy for valid statutory DNR orders.

I
THE HISTORY OF MEDICAL TATTOOS

Tattoos are one of the most universal forms of art and one of the oldest ways in which humans express themselves.[28] The oldest known tattoos were found on a frozen body near the border of Italy and Austria.[29] The body, known as “Iceman,” is approximately 5200 years old, and it has fifty-seven tattoos.[30] The next known examples of tattoos were found on Egyptian mummies that date back 3000 years.[31] Historians believe that tattooing was used in rituals and for therapeutic purposes.[32] The Egyptians spread tattooing to other areas of the world.[33] Greek and Roman cultures originally used tattooing as a form of punishment.[34] Romans also marked their slaves with tattoos, and Roman soldiers tattooed themselves to identify their religion.[35]

As Christianity began to grow, tattooing became less prevalent in the West.[36] Tattooing was banned by the Emperor Constantine, who felt that they ruined the body and were an offense against God.[37] This sentiment was echoed in the Middle Ages by Pope Hadrian, who also banned tattoos.[38] Tattooing almost disappeared entirely in the West after the Normans, who held a deep disgust for tattoos, invaded Britain in 1066.[39]

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28 *See* Anderson v. City of Hermosa Beach, 621 F.3d 1051, 1066 (9th Cir. 2010) (citing Ward v. Rock Against Racism, 491 U.S. 781, 790 (1989)).

29 Kelly-Ann Weimar, *A Picture Is Worth a Thousand Words: Tattoos and Tattooing Under the First Amendment*, 7 ARIZ. SUMMIT L. REV. 719, 721–22 (2014).

30 *Id.* at 722.

31 *Id.*; Traci Watson, *Sacred Tattoos Found on Egyptian Mummy*, 533 NATURE 155, 155 (2016), https://www.nature.com/news/intricate-animal-and-flower-tattoos-found-on-egyptian-mummy-1.19864.

32 Weimar, *supra* note 29, at 722.

33 *Id.*

34 *Id.*; *see also* R.C. Bell, *Some Curious Aspects of Tattooing*, 15 BRIT. J. PLASTIC SURGERY 255, 255 (1962) (providing a brief overview of ancient tattoo practices).

35 Weimar, *supra* note 29, at 722.

36 *Id.* at 722–23.

37 *Id.* at 723.

38 *Id.*

39 *Id.*

While tattooing became less prevalent in the West, its popularity grew in the Pacific region.[40] For example, in Japan, "facial tattoos began to carry negative connotations and [were] used for punitive purposes," signifying criminals or lower-class individuals.[41] In Tahiti, conversely, tattoos signified status and wealth.[42] Royal Polynesian families were elaborately decorated with tattoos.[43]

Tattooing was reintroduced to the West after James Cook landed in Tahiti in 1769.[44] Upon arrival, his sailors saw the elaborate Tahitian tattoos and started getting tattoos themselves.[45] Sailors then spread tattooing to lower- and working-class Europeans.[46] Although occasionally upper-class people had tattoos, at that time tattoos were generally viewed as a lower-class characteristic.[47] This sentiment was then spread to the United States, where tattooing was also primarily viewed as a lower-class trend.[48] In the 1890s, however, the electric tattoo machine was invented, and the art became popular among American soldiers.[49] At the time, tattoos were viewed as patriotic.[50] In 1936, *Life Magazine* estimated that 10% of the American population was tattooed.[51] After World War II, tattooing again lost popularity and became associated with bikers and criminals.[52]

Tattoos regained popularity and became more mainstream among Generation X and younger Americans.[53] By 2006, 36% of Americans aged 18 to 25 and 40% aged 26 to 40 had tattoos.[54] In 2012, an

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40 *Id.*; Snejina Vassileva & Evgeniya Hristakieva, *Medical Applications of Tattooing*, 25 CLINICS IN DERMATOLOGY 367, 368 (2007).

41 Weimar, *supra* note 29, at 723.

42 *Id.*

43 *Id.*

44 *Id.*

45 *Id.* at 723–24; Vassileva & Hristakieva, *supra* note 40.

46 Weimar, *supra* note 29, at 724.

47 *Id.*

48 *Id.*

49 *Id.*

50 *Id.*

51 *One out of Ten Americans is Tattooed*, LIFE, Dec. 21, 1936, at 30, 30.

52 Weimar, *supra* note 29, at 724.

53 Brian Elzweig & Donna K. Peeples, *Tattoos and Piercings: Issues of Body Modification at Work*, SAM ADVANCED MGMT. J., Winter 2011, at 13, 13.

54 PEW RESEARCH CENTER, HOW YOUNG PEOPLE VIEW THEIR LIVES, FUTURES AND POLITICS: A PORTRAIT OF "GENERATION NEXT" 21 (2007), https://people.ucsc.edu/~takagi/The%20PEW%20Report%20on%20Generation%20Next.pdf (For a summary of the report, visit http://www.people-press.org/2007/01/09/a-portrait-of-generation-next/.).

estimated 21% of all American adults had tattoos.[55] In recent years, the deviant and criminal stigma associated with tattoos has decreased, and tattoos are more mainstream than ever.[56]

People get tattoos for many reasons. Some people get tattoos to show self-identity, personal values, or cultural affiliation. Other people simply want to adorn their bodies with decorative artwork, permanent makeup, or scar camouflage. Many people want to test their pain threshold or resist authority.[57] And some people get tattoos for utilitarian medical purposes. For example, in rare cases, corneal tattooing has improved patients’ eyesight.[58] Doctors also tattoo patients to mark radiotherapy treatments and biopsy sites.[59]

Medical-purpose tattooing began with military personnel to identify their blood types. During World War II, each German Waffen-SS member received a mandatory “Nazi birthmark” on his arm or chest that signified his blood type.[60] After the war, these tattoos also became a way to identify German war criminals for prosecution.[61]

During the Cold War, blood-type tattoos were used to support quick and safe blood transfusions in America.[62] In a frightened response to the Korean Conflict in the early 1950s, some children in Northwest Indiana were given blood-type tattoos, to make crossmatching easier in the event of an atomic attack.[63] Because most of the donated blood in the United States was sent overseas for injured soldiers, blood-type tattoos were meant to quickly identify a proper donor, making people “walking blood banks.”[64] A similar program was proposed as a partial potential response to a nuclear attack in Chicago, but was never

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55 Samantha Braverman, *One in Five U.S. Adults Now Has a Tattoo*, HARRIS POLL (Feb. 23, 2012), https://theharrispoll.com/new-york-n-y-february-23-2012-there-is-a-lot-of-culture-and-lore-associated-with-tattoos-from-ancient-art-to-modern-expressionism-and-there-are-many-reasons-people-choose-to-get-or-not-get-p/.

56 *Id.*

57 Nicolas Kluger & Saleh Aldasouqi, *A New Purpose for Tattoos: Medical Alert Tattoos*, 42 LA PRESSE MÉDICALE 134, 135 (2017).

58 *Id.*

59 *Id.*

60 George J. Annas, *Mengele’s Birthmark: The Nuremberg Code in United States Courts*, 7 J. CONTEMP. HEALTH L. & POL’Y 17, 19 (1991).

61 *Id.*

62 Elizabeth K. Wolfe & Anne E. Laumann, *The Use of Blood-Type Tattoos During the Cold War*, 58 J. AM. ACAD. DERMATOLOGY 472, 472 (2008).

63 *Id.*

64 *Id.*

implemented.[65] In two counties in Utah, another similar program was used for a short period of time.[66]

American medical tattoo programs were, however, short-lived because doctors did not rely on the tattoos. The standard medical practice of the time required crossmatching blood types at the time of a transfusion, and the American Medical Association and the Federal Civil Defense Administration supported using plasma transfusions regardless of blood type.[67] Wearing military-style dog tags to show the blood type became preferable because of the cost, time, and risk of infection associated with tattooing.[68]

In the late 1950s, there was a large increase in the amount of inoculations of infants and children against a variety of diseases.[69] Accordingly, one British Medical Journal author suggested that patients who receive certain inoculations, including children, should be tattooed with codes reflecting their inoculated status.[70] The author suggested that this would help maintain a permanent vaccine record for recipients who may not remember their inoculation many years later.[71] Also, the author suggested that this would aid in treatment of patients who come to a hospital while unconscious or when the standard treatment is to reinoculate automatically for certain injuries.[72] Further, the author suggested internationally standardized tattoo codes and placement on the body.[73]

Tattooed inoculation records never became a codified requirement, nor did they become a societal norm in America. In recent years, however, medical tattoos have grown in popularity; many people have started to get tattoos to alert physicians, paramedics, and the public in general of various types of medical conditions.[74] Some people choose tattoos in lieu of more standard medical pendants or bracelets, which are easily broken or lost, to notify others of medical conditions such as allergies, diabetes, or treatment in the case of incapacity.[75] Of

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[65] *Id.* at 473–74.

[66] *Id.* at 474–75.

[67] *Id.* at 475.

[68] *Id.*

[69] Norman C. Lake, *Inoculation Recording by Tattooing*, 2 BRIT. MED. J. 141, 141 (1959).

[70] *Id.*

[71] *Id.* at 142.

[72] *Id.*

[73] *Id.*

[74] Kluger & Aldasouqi, *supra* note 57.

[75] *Id.*

particular importance to this Article, there has also been an increase in medical directive tattoos displaying DNR messages.[76]

II
TATTOOS EXPRESSING END-OF-LIFE DECISIONS

How should a hospital handle an unconscious patient with a DNR tattoo? Is a DNR tattoo sufficient basis for a medical team to write a DNR order? The traditional understanding is that a physician determines the time and manner of a patient's death.[77] As discussed in the introduction, some patients' true intentions conflict with their DNR tattoos, but this is not always the case. The uncertainty regarding a patient's true intentions has led to increased confusion among medical practitioners regarding whether a tattoo is a valid refusal of medical care. Some medical professionals believe that DNR medical tattoos cannot reliably communicate a patient's intent not to be resuscitated; other medical professionals, however, think that a DNR tattoo may clearly indicate a patient's intentions.

Some medical professionals are so certain that DNR tattoos clearly communicate a patient's intent that they themselves receive DNR tattoos. For example, Mary Wohlford, a retired nurse, had the words "DO NOT RESUSCITATE" tattooed to her chest at eighty years old.[78] During an interview, Wohlford noted that although some people may think she is crazy, she wanted to make clear her intention not to be resuscitated.[79] She opined that such a tattoo ensures that the responsibility of ending care does not fall on her family.[80] She believes that a DNR tattoo would show the clear intention of a person who was not conscious.[81] This would, in her opinion, avoid the protracted fights that occur in the decision of whether to let a hospital patient die.[82] It was also noted, however, that Wohlford did have, in addition to the

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[76] *Id.* at 136.

[77] Elizabeth Shaver, *Do Not Resuscitate: The Failure to Protect the Incompetent Patient's Right of Self-Determination*, 75 CORNELL L. REV. 218, 218 (1989).

[78] Diane E. Hoffmann & Jack Schwartz, *Who Decides Whether a Patient Lives or Dies?*, TRIAL, Oct. 2006, at 30, 30.

[79] *Great Grandma's Tattoo: Do Not Resuscitate*, WND (May 18, 2006, 1:00 AM), http://www.wnd.com/2006/05/36229/; *see also* Ken Fuson, *80-Year-Old's Tattoo Spells Out Last Wishes*, SEATTLE TIMES (May 17, 2006, 12:00 AM), http://old.seattletimes.com/html/nationworld/2002999156_tattoo17.html.

[80] Fuson, *supra* note 79.

[81] *Id.*

[82] *Great Grandma's Tattoo: Do Not Resuscitate*, *supra* note 79.

tattoo, a living will, which was hung on the side of her refrigerator for easy access.[83] As discussed below, a living will can be used as additional evidence of a patient's true intentions.

When determining a person's true intentions about resuscitation, proper decisions need the patient's informed consent.[84] Informed consent requires a physician to inform a patient of the proposed treatment plan and its associated risks.[85] Informed consent facilitates a person's self-determined control over his or her own body.[86] Once a doctor has informed the patient of the treatment and its risks, under the informed consent doctrine a patient can refuse to begin medical treatment or revoke consent if medical treatment has already begun.[87]

When deciding not to accept medical treatment, especially lifesaving medical treatment, informed consent requires more than accepting the risks of the treatment. A patient who refuses treatment would likely also take into consideration "moral, ethical, religious, and familial values"[88] when making their decision. The fact that the refusal may lead to death demonstrates the need for the informed consent process.[89] Seeking informed consent requires patient participation in the process so that the decision properly reflects the goal of self-determination.[90] When a patient is brought to a hospital and is incompetent or unconscious, problems often arise regarding the gathering of evidence that demonstrates a patient's self-determination. For these people, a surrogate (who is oftentimes a family member) is usually brought in to exercise the right of self-determination on behalf of the patient.[91] The surrogate's judgment is then substituted for the patient's judgment.[92] When no surrogate can be found to stand in the patient's stead, the problem of inferring the patient's wishes is exacerbated.[93] In those

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[83] *Id.*

[84] Shaver, *supra* note 77.

[85] *Id*. at 220.

[86] *Id.*

[87] *Id.*

[88] *Id.* at 218.

[89] Hoffmann & Schwartz, *supra* note 78.

[90] *See* Shaver, *supra* note 77, at 220 ("Under [the doctrine of informed consent], the physician must inform the patient as to the type of treatment and the risks involved, then the patient must consent to that particular treatment.").

[91] *Id.* at 219.

[92] *Id.*

[93] *Id.*; *see also* Hoffmann & Schwartz, *supra* note 78 ("Patients who lack the capacity to engage in the informed consent process, however, present special challenges.").

cases, the doctors or the hospital that is caring for the patient must exercise the right of self-determination on the patient's behalf.

Self-determination, achieved through informed consent, also allows a patient to refuse specific types of medical care while consenting to others. For example, a patient can specifically refuse to receive cardiopulmonary resuscitation (CPR).[94] A DNR order written by a physician based on this self-determination, by itself, only applies to the issuance of CPR and does not preclude certain other types of treatment such as blood transfusions, central line placement, or intensive care treatment.[95] To decide whether a patient has expressed self-determination, it follows that medical professionals must decide when and under what conditions a person would decide to deny the specific type of medical treatment. In Patient Number Two's case, the patient simply told the medical professionals that even though he had "D.N.R." tattooed on his chest, he wanted to be resuscitated.[96] Luckily for him, he came into the care of doctors while he was conscious and cognizant.[97] The doctors, upon review of his code status,[98] determined that he would want resuscitative efforts in cardiac arrest but not prolonged attempts at resuscitation.[99] Oral or written acknowledgment of a mentally competent person is likely the best way to indicate the patient's self-determination. It is specific, both to the treatment and to the type of illness that is being faced. It is also up-to-date, which is important, as people's decisions about whether they would want resuscitation and under what circumstances change over time.[100]

Oftentimes, however, doctors do not have the ability to interview a patient and, as a result, the question of self-determination as to resuscitation wishes becomes more difficult to answer. The right of self-determination can still be used in cases where a person who is

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94 Nicole Marie Saitta & Samuel D. Hodge, Jr., *Wrongful Prolongation of Life—A Cause of Action That Has Not Gained Traction Even Though a Physician Has Disregarded a "Do Not Resuscitate" Order*, 30 TEMP. J. SCI. TECH. & ENVTL. L. 221, 224 (2011).

95 *Id.*

96 Cooper & Aronowitz, *supra* note 20.

97 *Id.*

98 A "code" is called when a hospital patient goes into cardiac arrest. A code status refers to what level of intervention a patient would choose when the patient is in cardiac arrest. Some states therefore refer to a DNR order as a "no-code status." Dean M. Hashimoto, *A Structural Analysis of the Physician-Patient Relationship in No-Code Decisionmaking*, 93 YALE L.J. 362, 362 n.3 (1983).

99 Cooper & Aronowitz, *supra* note 20.

100 Kluger & Aldasouqi, *supra* note 57, at 137.

being treated is unconscious or incompetent if the patient has a valid statutory DNR order that was written in advance of care.[101]

A statutory DNR order is a type of advance directive that is written while a person is competent.[102] These advance directives are controlled by statutes which vary by state.[103] The DNR order allows a person to assert his or her intentions for resuscitation generally, the type of resuscitation techniques specifically, and under what circumstances resuscitation would be refused.[104] The DNR order may be a valid stand-alone document, or it may be part of another document, such as a health care power of attorney, a living will, or another type of advance directive.[105] These DNR orders, because they are made when a person is competent, allow for self-determination of the patient's healthcare wishes.

Wohlford, the retired nurse discussed above, clearly communicated self-determination because her living will, with an advance directive, was valid and placed in an easily accessible place.[106] The advance directive allows Wohlford to communicate self-determination regardless of whether she is competent at the time of the decision to resuscitate because a valid advance directive would require competency at the time of its making. Answering the question of self-determination would be much more difficult to assess if Wohlford had a DNR tattoo but did not have a valid advance directive.

Unlike Wohlford, Patient Number One's intentions were less clear. Although it was later discovered that Patient Number One had a valid advance directive that included a DNR order, the treating physician, Gregory Holt, did not know about the patient's DNR order when initial life-saving measures were taken.[107] Because the patient was unconscious and could not communicate his intentions, the only evidence of Patient Number One's self-determination was his chest

[101] Shaver, *supra* note 77.

[102] Saitta & Hodge, *supra* note 94.

[103] Timothy P. O'Sullivan, *Drafting Health Care Advance Directives in a Rapidly Changing Legal and Sociological Environment*, 86 J. KAN. B. ASS'N 32, 33 (2017).

[104] Karen L. Schultz & Timothy D. Schultz, *Advance Directives: A Primer*, 63 TEX. B.J. 1034, 1038 (2000). These statutory DNR orders are often "out-of-hospital" DNR orders, which allow emergency medical providers to discontinue care immediately without stabilizing a patient to transport him or her to a hospital. *Id.* Without an out-of-hospital DNR order, emergency medical providers must make attempts to resuscitate and stabilize a patient. *Id.*

[105] O'Sullivan, *supra* note 103.

[106] *Great Grandma's Tattoo: Do Not Resuscitate*, *supra* note 79.

[107] Holt et al., *supra* note 1.

tattoo. After the fact, Holt stated, "We've always joked about this, but holy crap, this man actually did it. . . . You look at it, laugh a little, and then go: Oh no, I actually have to deal with this."[108]

There are legal and ethical dilemmas that must be addressed when faced with this situation. If a patient is incapacitated, is his or her tattoo a valid advance directive that would allow the treating physicians to write a DNR order? Patient Number One was brought to Jackson Memorial Hospital in Miami, Florida, while incapacitated.[109] Under Florida statutes,

> [r]esuscitation may be withheld or withdrawn from a patient by an emergency medical technician or paramedic if evidence of an order not to resuscitate by the patient's physician is presented to the emergency medical technician or paramedic. An order not to resuscitate, to be valid, must be on the form adopted by rule of the [Department of Health].[110]

The Florida Department of Health has strict requirements for its DNR form. The rule allows a patient to be denied CPR upon presentment of a copy of a Florida Do Not Resuscitate Order Form.[111] To be valid, the

> [f]orm shall be printed on yellow paper and have the words "DO NOT RESUSCITATE ORDER" printed in black and displayed across the top of the form. [The form] may be duplicated, provided that the content of the form is unaltered, the reproduction is of good quality, and it is duplicated on yellow paper. The shade of yellow does not have to be an exact duplicate . . . . The [Do Not Resuscitate Order] form . . . must be signed by the patient's physician. In addition, the patient, or, if the patient is incapable of providing informed consent, the patient's health care surrogate or proxy . . . or court appointed guardian or person acting pursuant to a durable power of attorney . . . must sign the form . . . in order for [it] to be valid.[112]

Patient Number One's tattoo did not meet the requirements of Florida's DNR statute for several reasons. Further, it is unlikely that it would satisfy any state's formal DNR requirements. First, in Florida, a valid out-of-hospital DNR order must be an official Florida Do Not

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108 Ed Yong, *What to Do When a Patient Has a "Do Not Resuscitate" Tattoo*, ATLANTIC (Dec. 1, 2017), https://www.theatlantic.com/health/archive/2017/12/what-to-do-when-a-patient-has-a-do-not-resuscitate-tattoo/547286/.

109 *Id.*

110 FLA. STAT. § 401.45(3)(a) (2018).

111 FLA. ADMIN. CODE ANN. r. 64J-2.018(1) (2018).

112 FLA. ADMIN. CODE ANN. r. 64J-2.018(2)(a)–(3) (2018).

Resuscitate Form.[113] The form is readily available on the Florida Department of Health's website.[114] Second, the form must be printed on yellow paper.[115] Third, the form must be signed by not only the person (or surrogate of the person) who is refusing CPR but also that person's physician.[116]

These requirements, at first glance, seem to impede on the notion of a person's self-determination. The adding of statutory and regulatory requirements such as these can be seen as adding extra, perhaps unnecessary, steps for a person making their wishes known. Part of self-determination, however, is that healthcare decisions are made with informed consent. Informed consent also "implies a logical corollary that the patient generally possesses the right not to consent, that is, to refuse treatment."[117] As such, the DNR formalities required under the Florida statute provide evidence of the executor's informed consent.

The requirement that the order be completed on a specific form shows that a DNR order in Florida was not made without the executor's effort to be involved in the process and consider the consequences of the decision. In cases where a surrogate executes the form for another person, it can be inferred that the surrogate has had discussions with or is acting in the best interest of the person.

The requirement that the form be printed on yellow paper likely has two purposes. One purpose is similar to the requirement for using the form itself: to induce the executor to make effort. Many people would need to purchase yellow paper, as it is not necessarily common at home, which would show a level of diligence in the process itself. The second purpose is to make locating a DNR order easy. Standardized requirements for yellow paper make a DNR order stand out among a patient's numerous medical records.

The final step—requiring signatures on the DNR order by both the patient and the patient's physician—implies that a discussion was had over the ramifications of the DNR order with the physician. The decision of whether to resuscitate and under what conditions would take place after the person is given medical advice. The decision is

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[113] 64J-2.018(1).

[114] Florida's "Do Not Resuscitate Order" can be accessed at the Florida Department of Health's website at http://www.floridahealth.gov/licensing-and-regulation/ems-system/_documents/dnro-updated-form-bw.pdf.

[115] 64J-2.018(2)(a).

[116] 64J-2.018(3).

[117] Hoffmann & Schwartz, *supra* note 78 (internal quotation omitted).

therefore made with informed consent, either by the person or by a surrogate.

When Patient Number One was brought to the hospital, it was not known if he had a valid Florida Do Not Resuscitate Order.[118] When he arrived at the hospital, unconscious and unable to be consulted on his DNR wishes, the only indicator that the hospital had about his self-determination was his tattoo that read "DO NOT RESUSCITATE."[119] When faced with this type of situation, doctors would have to decide if there is consent to withhold treatment and if this consent is informed. When a person such as Patient Number One is brought into a hospital unconscious and without a surrogate, the medical team must plan a course of treatment.

III
Choosing Treatment Using the Path of Least Permanence When Facing Uncertainty

The phrase "first, do no harm" is often cited (although incorrectly) as part of the Hippocratic Oath.[120] Although many medical schools do not require students to take the Hippocratic Oath, or any other similar oath, the phrase "first, do no harm" has become part of the folklore of medical practice.[121] When Patient Number One arrived at the hospital, his physician honored this principle by "not choosing an irreversible path when faced with uncertainty."[122] The doctors initially provided him with empirical antibiotics, intravenous fluid, resuscitation, and vasopressors, and then he was treated with bilevel positive airway pressure.[123] However, the decision to give lifesaving measures left the doctors conflicted "owing to the patient's extraordinary effort to make his presumed advance directive known."[124] It appears that the doctors believed that Patient Number One had made a self-determined decision about refusing medical treatment, but had no way of knowing if the

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118 Holt et al., *supra* note 1.

119 *Id.*

120 The phrase is generally attributed to Hippocrates, but, in actuality, it is derived from another of his works, *Of the Epidemics*. Robert H. Shmerling, *First, Do No Harm*, HARV. HEALTH PUB. (Oct. 13, 2015, 8:31 AM), https://www.health.harvard.edu/blog/first-do-no-harm-201510138421 (updated Oct. 14, 2015, 11:27 AM). The Hippocratic Oath instead contains the phrase to "abstain from whatever is deleterious and mischievous." *Id.*

121 *Id.*

122 Holt et al., *supra* note 1.

123 *Id.*

124 *Id.*

decision was made with informed consent. In recognizing the conflict, the doctors referred the case to the hospital ethics committee to aid in determining a course of action.[125]

When a patient is brought to the hospital, the patient is usually best suited to determine whether he would like to be resuscitated.[126] However, this may not always be the case. When a person is unconscious, or the person has decisional incapacity for another reason, another person must make the decision on the patient's behalf.[127] Alternatively, if there is an available, valid out-of-hospital DNR order, the decision to resuscitate is based upon the DNR order. The order would show that the patient employed self-determination in making the decision, thus also using informed consent. If there is no DNR order, the decision would have to be made by proxies of the patient. The proxies to the decision are parties who are interested in the outcome of the decision whether to perform resuscitative techniques or other lifesaving measures.[128] These parties include the physician, the patient's family, the state, and to the extent that he can or has previously made his decisions known, the patient himself.[129] The primary goal is to elicit as much information about the patient's wishes as possible so that resuscitation efforts best mirror the patient's self-determination.[130] The physician has an interest in gathering such information because she is the one who is in the best position to determine the likelihood of recovery and viability of a patient.[131] The physician also may have a unique understanding of the economic and moral concerns involved in the decision.[132] The patient's family is useful in determining what a patient's wishes were prior to being incapacitated.[133] The patient's family also serves another purpose. The family is in "a better position than the patient to seek legal sanctions" when a DNR order is written in a manner that they perceive is unfair.[134] Finally, "[t]he state has an

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125 *Id.*

126 Hashimoto, *supra* note 98, at 371–72.

127 Hoffmann & Schwartz, *supra* note 78, at 30.

128 Hashimoto, *supra* note 98, at 371.

129 *Id.*

130 *See* Hoffmann & Schwartz, *supra* note 78 (explaining that patients and their families may even seek an injunction requiring health care providers to comply with the patient's wishes).

131 Hashimoto, *supra* note 98, at 372.

132 *Id.*

133 *Id.* at 373.

134 *Id.*

important interest in promoting the preservation of life."[135] However, sometimes this interest may conflict with the principle of self-determination.[136]

IV
THE ROLE OF HOSPITAL ETHICS COMMITTEES

Hospitals have established ethics committees to help make decisions in the patient's best interest that are made while considering the notion of self-determination.[137] Healthcare ethics committees began in the 1960s to mediate ethical disputes in patient care settings.[138] Hospital ethics committees serve that same purpose within a hospital setting. The movement for hospital ethics committees grew out of legal controversies about the refusal of life-sustaining treatments.[139]

The movement began with a hospital ethics committee that was established in 1976 by the New Jersey Supreme Court in the case of Karen Quinlan.[140] *In re Quinlan* involved a father who wanted the court to allow him to become his twenty-two-year-old daughter's guardian so that he could refuse further medical treatment for her.[141] His daughter, Karen Quinlan, became comatose but she did not meet the New Jersey definition of brain death.[142] Although she had no sapient brain response, she still had vegetative brain function.[143] New Jersey, at the time, required the death of both the sapient and the vegetative functions for there to be brain death.[144] All the doctors who examined her prior to the court hearing the case felt that she had no reasonable hope to recover to a cognitive and sapient state and that she would not survive if taken off the respirator.[145] The doctors did not want to disconnect the respirator, at least in part because the County

135 *Id.*

136 *Id.* at 374.

137 *Id.* at 376.

138 *See, e.g.*, *id.*; Cynthia M.A. Geppert & Wayne Shelton, *Health Care Ethics Committees as Mediators of Social Values and the Culture of Medicine*, 18 AMA J. ETHICS 534, 534 (2016).

139 George Annas & Michael Grodin, *Hospital Ethics Committees, Consultants, and Courts*, 18 AMA J. ETHICS 554, 554 (2016).

140 *Id.*

141 *In re* Quinlan, 355 A.2d 647, 651 (N.J. 1976).

142 *Id.*

143 *Id.* at 654.

144 *Id.*

145 *Id.* at 655.

Prosecutor and the Attorney General opined that there would be criminal liability for doing so.[146] The court, writing in terms of self-determination, noted,

> Our affirmation of Karen's independent right of choice, however, would ordinarily be based upon her competency to assert it. The sad truth, however, is that she is grossly incompetent and we cannot discern her supposed choice based on the testimony of her previous conversations with friends, where such testimony is without sufficient probative weight. Nevertheless, we have concluded that Karen's right of privacy may be asserted on her behalf by her guardian under the peculiar circumstances here present.
>
> If a putative decision by Karen to permit this non-cognitive, vegetative existence to terminate by natural forces is regarded as a valuable incident of her right of privacy, as we believe it to be, then it should not be discarded solely on the basis that her condition prevents her conscious exercise of the choice. The only practical way to prevent destruction of the right is to permit the guardian and family of Karen to render their best judgment, subject to the qualifications hereinafter stated, as to whether she would exercise it in these circumstances. If their conclusion is in the affirmative this decision should be accepted by a society the overwhelming majority of whose members would, we think, in similar circumstances, exercise such a choice in the same way for themselves or for those closest to them.[147]

In doing such, the court directed Karen Quinlan's father to be a proxy for his daughter's self-determination.[148] The court noted, however, that time had passed since her medical condition had last been described to the court.[149] In so noting, the court ordered that Karen Quinlan's case be referred to the hospital's ethics committee for an updated assessment of her condition.[150] The court determined that if there was no reasonable possibility for recovery from being comatose, then life support could be terminated without any civil or criminal liability on any party.[151]

After *In re Quinlan*, many hospitals formed ethics committees to limit their exposure to liability.[152] Committee members—typically physicians, social workers, attorneys, and theologists[153]—review the

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[146] *Id.* at 669.

[147] *Id.* at 664 (citations omitted).

[148] *Id.* at 671.

[149] *Id.*

[150] *Id*.

[151] *Id.*

[152] Annas & Grodin, *supra* note 139, at 554–55.

[153] *See In re Quinlan*, 355 A.2d at 668 ("Many hospitals have established an Ethics Committee composed of physicians, social workers, attorneys, and theologians . . . ."); *But*

individual circumstances of each case to resolve ethical dilemmas. Because the review is conducted by a group of qualified individuals, courts find this practice especially persuasive to limit the hospital's exposure to liability.[154] A hospital ethics committee reviews cases in only an advisory capacity, which does not provide a guarantee of immunity from tort liability. However, because of its review, "the likelihood of a successful lawsuit [against a medical provider who takes the advice of an ethics committee] approaches zero."[155]

V
TATTOOS AS PROXIES FOR MEDICAL CARE ORDERS

In Patient Number One's case, although the patient was incapacitated, the hospital ethics committee saw his tattoo as a reasonably clear indicator of his self-determination.[156] Perhaps the decision of the ethics committee was based on the design of the tattoo itself. Patient Number One had the words "DO NOT RESUSCITATE" written in large, bold, capital letters.[157] It was placed on a prominent area, along his collarbones, so as not to be missed upon examination.[158] The word NOT was underlined for emphasis.[159] The man also had his signature tattooed under the word "RESUSCITATE."[160] The hospital ethics committee determined that these facts sufficiently communicated the patient's intent not to be resuscitated. In other words, Patient Number One's tattoo was a valid proxy.

Conversely, if Patient Number Two were incapacitated, it is unlikely that his "D.N.R." tattoo, without further evidence, would sufficiently indicate his informed consent not to be resuscitated. Patient Number Two's tattoo was administered in a prominent place, the center of his

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see Geppert & Shelton, *supra* note 138, at 536 (criticizing the lack of diversity on hospital ethics committees, noting that, currently, "34 percent of ethics consultants were physicians and another 31 percent nurses").

154 *See In re Quinlan*, 355 A.2d at 669 ("I believe that an [ethics committee] could lend itself well to an assumption of a legal status which would allow courses of action not now undertaken because of the concern for liability.") (quoting *The Physician's Dilemma—A Doctor's View: What the Law Should Be*, 27 BAYLOR L. REV. 6, 8–9 (1975)).

155 Annas & Grodin, *supra* note 139, at 555.

156 Holt et al., *supra* note 1.

157 *See* Yong, *supra* note 108 (showing photograph of patient's tattoo).

158 *Id.*

159 *See id.*

160 *Id.*

chest, but it only read "D.N.R."[161] A tattoo that reads "D.N.R.,"s by itself, could be a request to refuse resuscitation, but it could represent other things as well. It could be a person's initials, the name of a rock and roll band, or many other things.[162]

For a medical tattoo to be an effective reflection of a person's intent, the tattoo must be able to be seen quickly by medical personnel.[163] The tattoo should be placed in a location that is likely to be focused on in an emergency, such as the inside of the wrist or on the chest.[164] Also, medical tattoos should not be used by people who have many other tattoos lest the medical tattoo be overlooked.[165] Because tattoos fade and blur over time, the tattoo should be large enough that it does not become difficult to read even many years after its completion.[166]

A. Proxies Currently Used for Medical Orders

Although a hospital ethics committee may look at a tattoo as evidence of a person's DNR wishes, an Emergency Medical Technician (EMT) likely would not suspend resuscitation based on a tattoo prior to bringing a patient to the hospital. An EMT would not have the benefit of an ethics committee to aid in these types of decisions and would therefore choose to resuscitate as the path of least harm. In an emergency, EMTs will look for a valid out-of-hospital DNR order.[167] If none is found, then the person will be treated with resuscitative care.[168] Some states have allowed for a more portable proxy to be used to show that there is a valid out-of-hospital DNR order. For example, Wisconsin allows a limited population of people to have a bracelet to allow for quick decision-making on resuscitation

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161 Cooper & Aronowitz, *supra* note 20.

162 There are at least three bands with the name "DNR." *See* DNR THE BAND, http://www.dnrtheband.com (last visited Oct. 13, 2018); DNR: FAIRFIELD COUNTY'S (ALMOST) ALL-PHYSICIAN ROCK BAND, http://www.dnrrocks.com (last visited Oct. 13, 2018); WE R DNR, http://www.werdnr.com (last visited Oct. 13, 2018).

163 Kluger & Aldasouqi, *supra* note 57.

164 *Id.*

165 *Id.*

166 *Id.* at 136–37.

167 Jason A. Frank, *Long Term Care in the 21st Century*, 38 MD. B.J. 18, 22 (2005).

168 *See id.* at 22 ("Advance medical directives that appoint agent(s) and give instructions are the simplest, most direct way to insure that medical treatment a patient actually receives is in fact the treatment he or she wants.").

in an out-of-hospital situation.[169] The bracelets can be used only by people over eighteen years old who meet the following criteria:

> (a) The person has a terminal condition.
>
> (b) The person has a medical condition such that, were the person to suffer cardiac or pulmonary failure, resuscitation would be unsuccessful in restoring cardiac or respiratory function or the person would experience repeated cardiac or pulmonary failure within a short period before death occurs.
>
> (c) The person has a medical condition such that, were the person to suffer cardiac or pulmonary failure, resuscitation of that person would cause significant physical pain or harm that would outweigh the possibility that resuscitation would successfully restore cardiac or respiratory function for an indefinite period of time.[170]

Florida requires medical personnel to honor a miniature version of a valid DNR order called a Patient Identification Device (PID).[171] A PID can be laminated and hole punched so that it can be attached to a chain and be visibly displayed on the person.[172] If the PID is signed by the patient's physician,[173] and an EMT can identify that the patient is the one to whom the PID is ascribed,[174] then an "emergency medical technician or paramedic shall withhold or withdraw cardiopulmonary resuscitation."[175] These devices allow for more patient autonomy, while still protecting the concept of self-determination. Because Patient Number One lived in Florida, if he had a PID instead of a tattoo, he probably would not have been resuscitated prior to arriving at the hospital.

Oregon has created a database that allows a person to voluntarily execute and file a physician order for life-sustaining treatment (POLST) form.[176] The POLST form must be printed on pink card stock, and it must be signed by a doctor, a physician's assistant, or a

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169 Jane Barclay Mandel, *Wisconsin's Do Not Resuscitate Bracelet Law Raises Legal and Medical Issues*, WIS. LAW., Dec. 1997, at 14, 15.

170 WIS. STAT. § 154.17(4) (2018).

171 FLA. ADMIN. CODE ANN. r. 64J-2.018(2)(b) (2018).

172 *Id.*

173 64J-2.018(3).

174 64J-2.018(4).

175 64J-2.018(1).

176 OR. REV. STAT. § 127.666 (2017). Similar programs are available in other states as well. *See National POLST Paradigm Program Designations*, NAT'L POLST PARADIGM, http://polst.org/programs-in-your-state/ (last visited Oct. 13, 2018).

nurse practitioner.[177] Presumably, this is so "the health care professional and patient work together to make decisions about what medical treatments the patient would like to receive or avoid based on the person's values, beliefs, and goals for care."[178] Unless the patient opts out, the registry will then keep a copy of each POLST, as well as any revisions or revocations to them.[179] POLST forms are not designed to replace an advance directive. Instead, a POLST is a medical order, which can include DNR orders, for emergency situations.[180] The orders must be followed by EMTs,[181] physicians, and physician's assistants.[182] When the POLST is registered, the patient is assigned a unique identifying number.[183] He or she is also given a magnet and stickers with the identifying number on them.[184] In an emergency, an EMT will search for the form, magnet, or stickers on the person's refrigerator and in their medicine cabinets.[185] Emergency personnel can then call the registry and use the number to determine the patient's care orders in the POLST.[186] The registry allows for a quick process for determining the patient's wishes in an emergency.

B. Should States Allow the Use of Tattoos as a Proxy for DNR Orders?

With states allowing proxies for a valid DNR order such as a bracelet or a PID, and with the growing prevalence of tattoos (especially DNR tattoos), it is necessary to examine whether to treat a DNR tattoo as a valid DNR order. Patient Number One's doctors opined that "[d]espite the well-known difficulties that patients have in making their end of life wishes known," they "neither support[ed] nor oppose[d] the use of tattoos to express end-of-life wishes when the person is

177 *See* The Oregon POLST Coalition, *POLST Brochure*, OR. POLST, https://static1.squarespace.com/static/52dc687be4b032209172e33e/t/594850bf6b8f5b0e58711e24/1497911491279/2017.04.14+POLST+Community+Brochure.pdf (last updated Apr. 14, 2017) [hereinafter *POLST Brochure*]. See Oregon POLST's website at https://oregonpolst.org/ for the latest version of the Oregon POLST form.

178 *Health Care Professionals Understanding the POLST Process*, OR. POLST, https://oregonpolst.org/health-care-process (last visited Oct. 23, 2018).

179 OR. REV. STAT. § 127.666(2)(a)(A)–(C) (2017).

180 *POLST Brochure*, *supra* note 177 (comparing advance directives to POLST orders).

181 OR. ADMIN. R. 847-035-0030(6) (2018).

182 OR. ADMIN. R. 847-010-0110(1) (2018).

183 *Patient and Family Tips for Understanding the POLST Process*, OR. POLST, https://oregonpolst.org/polst-process (last visited Oct. 14, 2018).

184 *Id.*

185 *Id.*

186 *Id.*

incapacitated."[187] Perhaps this neutrality arises from there being both positive and negative aspects of allowing for DNR tattoos.

One of the biggest negatives of recognizing tattoos as a valid DNR order is the permanence of a tattoo compared to a paper document. People over time change their decisions about when and under what conditions they might wish to be resuscitated.[188] For example, the British Medical Journal reports of a case in which a depressed seventy-five-year-old widower who had a heart condition had "DO NOT RESUSCITATE" tattooed on his chest in large letters.[189] However, after successful heart treatment and finding a new partner, the man changed his mind and decided that he would like to be resuscitated in an emergency.[190] The problems associated with a tattoo communicating a message that was not an informed, self-determined decision was germane enough that Patient Number Two's treating physicians recommended that he have his tattoo removed "to circumvent future confusion about his code status."[191] He declined because "he did not think anyone would take his tattoo seriously."[192]

The permanence of a tattoo could, however, also be an advantage for using them as DNR orders. Once a person is tattooed, the advance directive would be with that person at all times.[193] Written advance directives are often not available when a person is brought into the emergency room, and great effort may be needed to locate a paper document.[194] This is why some states allow for proxies for the formal paperwork that is more portable, such as a bracelet or PID. Although the tattoo would be harder to alter or change, it would not be as easily broken, lost, or otherwise separated from the person wishing to use it as an advance directive.

Another perceived problem with a DNR tattoo is the ambiguity of instructions to medical teams. Generally, "unless [a person is] willing to tattoo a lot of skin," a paper DNR order will better allow a person to

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187 Holt et al., *supra* note 1, at 2193.

188 Kluger & Aldasouqi, *supra* note 57, at 137.

189 M.W.H. Behan, R. Veasey, M. Higson, & A.N. Sulke, *Second Thoughts*, 331 BRIT. MED. J. 1552, 1552 (2005).

190 *Id.*

191 Cooper & Aronowitz, *supra* note 20.

192 *Id.*

193 Tom Tomlinson, *Three Cheers for the DNR Tattoo*, MSU BIOETHICS: BIOETHICS IN THE NEWS (Jan. 9, 2018), https://msubioethics.com/2018/01/09/three-cheers-for-the-dnr-tattoo/.

194 *Id.*

elaborate on his or her preferences than a tattoo.[195] A paper DNR order allows for a patient to state their resuscitation expectations and which outcomes and interventions they would like to avoid.[196] However, even with the extra space, a paper form may still not contain more detail than a tattoo. Many people do not elaborate on their wishes just because they have the space to do so. This leaves many paper forms ambiguous. Neither a tattoo nor a paper form sheds light on the motivations behind the decisions.[197] Questions may arise regarding whether a person gave informed consent for the actual situation leading to the DNR decision. Other information, such as whether the person got the tattoo while in a period of declining health or what the eventual prognosis is when the resuscitation is needed, is informative of the patient's wishes. This may be why the hospital ethics committee reviewing Patient Number One's case allowed the use of a tattoo to recommend the doctors sign a DNR order.

Perhaps the biggest concern for using a tattoo as a proxy for a DNR order is that the formal requirements associated with a valid paper DNR order, as discussed in Part II, seem to correlate with showing that the decision was made using self-determination. The formality in obtaining a statutory DNR order also shows that a person willing to take those steps fully believes, following informed consent, in the instructions that it contains. However, getting a tattoo also requires a level of effort and physical pain that could show the seriousness of the decision. One commentator noted, "Unless you imagine I was somehow unconscious or blind drunk when I got my tattoo, the wishes expressed thereupon are undoubtedly mine."[198] It was further noted that the formal elements required by some states, such as getting witnesses to sign the DNR order, can be incorporated into a tattoo.[199]

C. DNR Tattoos Can Clarify the Uncertainty of Medical Providers

By not being accepted as a statutory DNR order, tattoo DNR orders also present problems for doctors and EMTs. The statutory DNR order allows for a sort of safe harbor in the decision of whether to apply resuscitative techniques to a patient. If there is a statutory DNR order, then there is no liability for not giving resuscitative techniques, as

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195 *Id.*
196 *Id.*
197 *Id.*
198 *Id.*
199 *Id.*

statutes generally eliminate liability for doctors who do not treat or discontinue treatments based on a valid DNR order. For example, Florida law states that

> [a]ny licensee, physician, medical director, or emergency medical technician or paramedic who acts under the direction of a medical director is not subject to criminal prosecution or civil liability, and has not engaged in negligent or unprofessional conduct, as a result of the withholding or withdrawal of resuscitation from a patient pursuant to [denial of emergency treatment laws] and rules adopted by the department.[200]

In addition, following the advice of a hospital ethics committee may also shield medical personnel from liability. As discussed above,[201] following the advice of a group of experts seems to limit liability.[202] It would also seem, however, that the advice given by an ethics committee could be skewed toward keeping a patient alive, not only to limit liability but also for ethical reasons. This is in line with the concept that the state has an interest in preserving the life of the people within that state.[203] Further, when a person is resuscitated against what would have been his or her wishes, generally there is no tort liability. Although there have been several commenters who have suggested that there should be tort liability for wrongful prolongation or elongation of life, no court has recognized this cause of action.[204] Other attempts have been made to bring civil lawsuits alleging battery, negligence, and intentional or negligent infliction of emotional distress where one was resuscitated against their wishes.[205] Traditionally these claims have also been unsuccessful, although recently some have been successful.[206] Cases where there was success, however, seem to require that the treating physician knew there was a valid statutory DNR order and did not abide by it.[207] Medical battery is an established tort;

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200 FLA. STAT. § 401.45(3)(b) (2018).

201 *See supra* text accompanying notes 152–55.

202 Annas & Grodin, *supra* note 139, at 554–55.

203 Hashimoto, *supra* note 98, at 373.

204 *See generally*, Saitta & Hodge, *supra* note 94. Shaver, *supra* note 77.

205 Thaddeus Mason Pope, *Clinicians May Not Administer Life-Sustaining Treatment Without Consent: Civil, Criminal, and Disciplinary Sanctions*, 9 J. HEALTH & BIOMEDICAL L. 213, 260 (2013).

206 *See id.* at 260–73 (reviewing cases).

207 *See* Terry v. Red River Ctr. Corp., 862 So. 2d 1061, 1064–65 (La. Ct. App. 2003) (finding that a nursing home may have acted negligently when it did not abide by an existing DNR order, but because the plaintiff did not allege any intentional tort occurred, the nursing home was not liable).

however, for medical battery to occur, there must be a "harmful or offensive contact" with the patient by a clinician.[208] This would mean that resuscitative techniques would have to be seen as harmful or offensive contact. Consent to the contact, however, would prevent the contact from being a battery.[209] During an emergency, when a patient cannot consent for themselves, there is implied consent for a physician to treat a patient.[210] This is known as the emergency exception to the informed consent requirement in patient treatment.[211] Because informed consent is implied, medical battery would be limited to cases where the treating physician knew about a DNR order and disregarded it.[212]

Similarly, proving a case for negligently failing to comply with a refusal of treatment order also requires the physician to know about the order. To state the claim, the following elements must be proven: (1) that the clinician had a duty to care for the patient in accord with his or her expressed preferences; (2) that the clinician breached that duty, deviating from the relevant standard of care; (3) that the patient suffered damages; and (4) that those damages were caused by the breach of duty.[213]

Even if the wishes of an incapacitated person are not known, a claim that meets the four elements described above absolves a treating physician of liability.[214] Without knowledge of a documented refusal of treatment, a physician will likely be held negligent only in cases where she did not consult or adequately maintain the patient's records.[215] Additionally, a cause of action for negligent infliction of emotional distress is unlikely to succeed because it would require that the doctor realize she created an unreasonable risk of causing emotional distress.[216] Thus, lacking knowledge of a documented refusal of treatment also limits a cause of action for intentional infliction of

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208 Pope, *supra* note 205, at 261.

209 *Id.* at 262.

210 Miller *ex rel.* Miller v. HCA, Inc., 118 S.W.3d 758, 767 (Tex. 2003) (quoting Gravis v. Physicians & Surgeons Hosp. of Alice, 427 S.W.2d 310, 311 (Tex. 1968)).

211 Hashimoto, *supra* note 98, at 365.

212 *See* Pope, *supra* note 205, at 268 ("If the clinician is unaware of the patient's advance directive or other refusal, then the plaintiff probably cannot establish the requisite intent for battery. But the patient might still be able to establish negligence.").

213 WILLIAM LLOYD PROSSER, HANDBOOK OF THE LAW OF TORTS § 30 (4th ed. 1971).

214 Pope, *supra* note 205, at 269.

215 *Id.*

216 *Id.* at 272.

emotional distress.[217] Further, lacking knowledge is not extreme and outrageous conduct in treating a person, which is a required element of the tort.[218]

Commenters maintain that allowing these types of causes of action will protect a person's right to self-determination.[219] However, if the patient's self-determined wishes were not made clear to the treating physician, then the treating physician may not be liable.[220] In cases lacking a clear indication of informed consent not to be treated, the state's interest in protecting life seems to outweigh the infringement on self-determination. Due to the state's interest, in an emergency an EMT or treating physician would ignore a tattoo that does not meet the statutory requirements of a DNR order to limit their liability. After a patient is in the hospital, however, a hospital ethics committee could use the tattoo as evidence of self-determination and informed consent if the tattoo clearly represents the patient's true intentions. But, if there is doubt, again, it would be wise for the ethics committee or treating physician to err on the side of taking the path of least permanence and resuscitate the patient.

VI
SUGGESTIONS FOR THE USE OF TATTOOS AS A PROXY

A solution that may balance the interest of the state in preserving life and the principle of self-determination through informed consent would be for states to authorize tattoos as a proxy for a statutory DNR order. This authorization would allow states to permit a standardized tattoo that people can voluntarily obtain. It would also allow doctors and EMTs to know the tattoo will protect them from liability in cases where they do not resuscitate a patient. Because both tattooing and medical practice are state regulated, a process could be put in place where a DNR tattoo can only be administered when permitted by the state to guarantee informed consent. To guard the state's interest in protection of life, states could, if they wanted, limit these tattoos only to patients who have a valid statutory DNR order. States could also standardize the location of the tattoo to make sure it is noticed in an

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217 *Id.* at 270–71.

218 *Id.*

219 *See generally* Saitta & Hodge, *supra* note 94. Shaver, *supra* note 77.

220 Saitta & Hodge, *supra* note 94, at 231–32.

emergency. State authorization and standardization would make a tattoo an excellent proxy for an out-of-hospital DNR order.

Medical tattooing has been around for many years. People have attempted to use DNR tattoos to show their voluntary consent to self-determination or their wish to refuse certain medical treatments. Because of the ambiguity associated with the message a tattoo may convey, even in the most obvious instances, a proxy may not have the desired impact. For example, a Finnish anesthesiologist had an image identical to his organ donor card tattooed on his chest.[221] This is an obvious attempt to show his intent to donate his organs should he become brain dead. Because he is an anesthesiologist who deals with brain death regularly, the decision to donate his organs is likely made with informed consent. However, in the United States, his tattoo may not be honored if a statutory compliant organ donor card is not found. A hospital ethics committee examining a situation like this would not necessarily agree that organ donation is still the current wish of the man should he become brain dead. Allowing for a standardized tattoo would alleviate uncertainty and ambiguity in determining the wishes of the patient.

One of the main criticisms of tattooing as a proxy for a valid DNR order is the difficulty of changing a person's tattoo if they change their mind about resuscitation.[222] At least one suggestion was previously made for a standardized tattoo to aid in decisions to resuscitate.[223] The suggestion called for a standardized tattoo that could be copyrighted by the American Academy of Hospice and Palliative Medicine.[224] The suggestion was that the tattoo's message state, "Consider do not resuscitate."[225] This would allow the "guided and educated decision of [the patient's] medical team for medical futility in [his or her] present clinical scenario."[226] The wording of the tattoo allows a patient to let medical responders decide on the spot if the person's conditions were futile and, if not, to give life support.[227] Yet this solution is problematic in terms of self-determination. It cedes the ultimate decision to the medical team responding to the patient instead of having people decide

221 Kluger & Aldasouqi, *supra* note 57, at 136.

222 *Id.* at 137; *see* discussion *supra* Section V.B.

223 *See* Deepak Gupta, *Tattoo Flash: Consider "Do Not Resuscitate*,*"* 13 J. PALLIATIVE MED. 1155, 1155 (2010).

224 *Id.*

225 *Id.*

226 *Id.*

227 *Id.*

on the treatment in advance themselves. This may be attractive to some people because there is a facet of self-determination in ceding the decision to medical experts. However, someone other than the patient is determining whether care is administered.

Perhaps a better solution is allowing a standard tattoo with an identification number or other device incorporated in it. The serial number could be linked to an easily accessible database for EMTs and doctors. Then, the database can show more specifically what types of treatments the patient has consented to and under what circumstances the patient would like treatment withheld. This would ameliorate two of the concerns mentioned above: permanency and lack of space. This would allow the decision to be made by the patient in consultation with a physician, rather than by medical providers alone. Identification numbers linked to a database allow for a greater amount of self-determined decision-making on the part of the patient and make tattoos a viable alternative as a proxy for DNR orders.

CONCLUSION

With the increased popularity of tattoos, DNR tattoos are also becoming more common. Like Patient Number One, many people assume that their DNR tattoo shows valid informed consent not to be resuscitated. Unfortunately, for most DNR tattoo recipients including Patient Number One, it is unlikely that medical professionals will honor a DNR tattoo without further evidence of consent. Without additional evidence of a patient's intentions, a tattoo does not show informed consent. As exhibited in Patient Number One's case, when faced with ambiguity regarding resuscitation decisions, doctors and EMTs will likely follow the path of least permanence and choose to resuscitate the patient. They make this decision because they fear liability.

To remedy this vitally important issue, states could require medical professionals to honor standardized DNR tattoos. Standardizing the tattoo and the conditions upon which it could be administered would limit ambiguity. These standardized tattoos could provide evidence of the informed consent needed for self-determination of the person in their end-of-life decision-making. Medical personnel would be shielded from liability if DNR tattoos were standardized and recognized as a patient's true intentions.

Ultimately, free will is what separates the living from the dead. A person's final execution of free will can be the most significant decision he or she will ever make. If implemented properly, a standardized DNR

tattoo will honor a patient's informed, consensual, and final execution of free will in an easily accessible manner. The burden that medical professionals carry in making split-second, irrevocable decisions is too great to allow for inaccessible or unreliable guidance. DNR tattoos, if codified, standardized, and properly executed, could ameliorate this burden by allowing a person's self-determined wishes to be met.