

THE USE OF DO NOT RESUSCITATE (DNR) ORDERS IN SCHOOLS IN THE UNITED STATES OF AMERICA (US)

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Do not resuscitate orders (DNRs) raise issues about: the authority of parents and medical professionals to make decisions for children who often are not in a mental or physical state to comprehend the nature of the DNR, the rights of children to continued life despite their debilitating or terminal conditions, and the responsibilities of school personnel to implement a DNR that may result in greater impairment or death for a student. Litigation involving DNRs has almost invariably focused on minor children in medical settings although medical and nursing publications have provided considerable advice concerning emergency care in schools. However, most of these publications tend to address life-threatening medical emergencies to students in general in the context of limiting liability with limited focus on the continuing and persistent needs of disabled students. The purpose of this article will be to examine some of the policy issues connected to the appropriateness of DNRs in school settings as they impact students with disabilities.

I INTRODUCTION

Do not resuscitate (DNR) orders¹ generally are directives prepared by physicians at the request of parents to cease or deescalate life-supporting services based on a medical diagnosis that a child has reached a terminal condition where he or she can no longer make decisions for themselves and have no medical probability of recovering from their comatose or vegetative state. Such DNR orders, however, raise critical issues about the authority of parents and medical professionals to make decisions for children who often are not in a mental or physical state to comprehend the nature of the DNR order,² the rights of children to continued life despite their debilitating or terminal conditions,³ and the responsibilities of school personnel to implement a DNR order that may result in greater impairment or death for a student.⁴ Litigation involving DNR orders has almost invariably focused on minor children in medical settings⁵ although medical and nursing publications have provided considerable advice concerning emergency care in schools. However, most of these publications tend to address life-threatening medical emergencies to students in general in the context of limiting liability, with limited focus on the continuing and persistent needs of disabled students.⁶ The purpose of this article will be to examine some of the policy issues connected to the appropriateness of DNR orders in school settings, especially as they impact students with disabilities.

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II NURSING ISSUES CONCERNING CARE FOR STUDENTS

Students can have a variety of medical needs that could include chronic or other disabling conditions that qualify a student as disabled, as well as injuries not necessarily connected with disabilities but needing emergency medical care. For schools to have on-site emergency equipment and trained personnel to address any emergency situation is vital whether or not the student being serviced is a student with a disability. Thus, in the broadest application, assuring that student medical needs will be addressed applies as much to the football player⁷ with a concussion⁸ or a student with an injury from having tripped and fallen on the playground⁹ as it does to students with persistent, chronic, debilitating, or disabling conditions that demand regular attention.¹⁰ Among the chronic health conditions that can qualify a student as disabled can include, but are not limited to 'asthma, diabetes, allergies, genetic disorders, immunological disorders, cancer, orthopedic disorders, neuromotor disorders, and mental disorders'.¹¹ These kinds of conditions represent for school personnel the kind of 'increased risk for a chronic physical, developmental, behavioral, or emotional condition ... [that] requires health and related services of a type or amount beyond that required by children generally'.¹²

Providing for the physical and emotional well-being of students in general in school settings can involve the collaboration of a number of school personnel, but certain functions by virtue of US state law will be considered to be the prerogative of the school nurse. The role of the school nurse in the school setting is a complex one. Nurses are subject to the conditions of their state licensing laws, referred to as state nurse practice statutes, which explicate the qualifications needed for nursing practice,¹³ the tasks that may be provided by a licensed nurse,¹⁴ the tasks that can be delegated to unlicensed assistive personnel (UAP),¹⁵ and the conditions under which such delegation can occur.¹⁶ As a result of these licensing conditions, the school nurse's legal, professional and ethical duties will be different from those of other licensed professionals who manage the school (such as teachers, counselors, and administrators), and, where the creation of individualised health care plans (IHP)¹⁷ and emergency care plans (ECP)¹⁸ are necessary, the school nurse may be the only appropriate person under state law who can design them and manage their implementation.

For students with disabilities who have individualised education plans (IEPs)¹⁹ under the *Individuals with Disabilities Education Act* (IDEA)²⁰ or section 504 plans pursuant to the *Rehabilitation Act of 1973*,²¹ the IHP or the ECP can become part of those plans. The IHP or ECP can be incorporated into an IEP or added as an addendum with specific outcomes to academic goals. The integration of an IHP or ECP into a section 504 plan is less complex and, in the case of an IHP, can either be the foundation for a 504 plan or serve as the 504 plan itself.²²

III NURSING AND MEDICAL STATEMENTS ON DNR ORDERS

The need for direction by public schools in addressing the connection between the presence of severely disabled students and the desire by parents and medical personnel to design appropriate DNR orders has prompted policy states by medical organisations. The National Association of School Nurses Policy Statement on DNR has recommended the following:

It is the position of the National Association of School Nurses that DNR orders for a student must be evaluated on an individual basis at the local level, according to state and local laws. The local board of education should refer this matter to school district legal counsel for guidance. Each student involved should have an Individualised Health Care Plan (IHCP) and an Emergency Plan developed by the professional school nurse with

involvement from the parents, administrators, physicians, teachers, and, when appropriate, the student. The IHCP needs to include a written Do Not Resuscitate from the parent(s) as well as the physician's written Do Not Resuscitate order. In some states, the IHCP may need to include a court order to honor the DNR order. The plan should be reviewed at least annually. The IHCP also should state the procedure to be taken in case of respiratory or cardiac arrest.²³

The American Academy of Pediatrics Commission on School Health and Committee on Bioethics (*AAP Statement*), in its policy statement on 'Do Not Resuscitate Orders in Schools',²⁴ approaches the use of DNR orders with a 'best interest of the child' analysis. While the best interest of the child may, ostensibly, be the focus of a DNR Order, the interests of the child are often identical to or reflective of the interests of the parents. Thus, where resuscitative efforts 'would cause physical pain and emotional suffering' for the child, where 'the likelihood of resuscitation is small, ... [and where] [t]he experience for the child could be frightening and uncomfortable and provide no anticipated benefit, such as returning a child to a quality of life previously acceptable to the child and/or the family, ... these children and their families may not wish the experience of treatment in an intensive care unit that would not affect the underlying medical problems'.²⁵ On the other hand, schools have interests as well in addressing the needs of students whose unique requirements or fragile condition present difficult challenges. The *AAP Statement* notes that, from the schools' interests in the best interests of the child continuum, the interests of the schools may differ significantly from those of the parents, especially where school personnel are 'medically untrained' and may not 'feel bound to respond to an easily reversible condition, such as a mucous plug in a child with a tracheostomy tube'.²⁶ In addition, medically untrained personnel may have concerns about encountering 'circumstances not anticipated by a DNR order, such as when a child chokes on food or is injured'.²⁷ Driven very much by concerns about liability, the American Academy of Physicians (AAP) has proposed the following recommendations:

1. The AAP recommends that pediatricians and parents of children at increased risk of dying in school who desire a DNR order meet with school officials — including nursing personnel, teachers, administrators, and EMS personnel, and, when appropriate, the child. Individuals involved ideally will reach an agreement about the goals of in-school medical interventions and the best means to implement those goals. Concerted efforts to accommodate all points of view will help avoid confrontation and possible litigation.
2. Pediatricians need to assist parents and schools to review, as needed when warranted by a change in the child's condition, but at least every 6 months, plans for in-school care.
3. Pediatricians need to review the plan with the board of education and its legal counsel. Pediatricians and all other parties involved are encouraged to be realistic and flexible and to make room for negotiation and compromise.
4. Pediatricians and their chapter and district members should work with local and state Authorities responsible for EMS policies affecting out-of-hospital DNR orders to develop rational procedures and legal understanding about what can be done that respects the rights and interests of dying children.
5. Pediatricians should work with local school systems and parent-teacher organisations to develop age-appropriate educational programs about death and dying.²⁸

Both policies are vague and general and neither is prescriptive. Both suggest that DNR orders would apply to school settings but neither addresses the threshold issue as to whether a DNR order for a disabled student with an IEP would be compatible with the purposes of the IDEA. Both Statements reflect that designing a DNR order is a process that needs to include a wide range of persons, such parents, administrators, school nurses, physicians, school board attorneys, and teachers, and perhaps students as well, ‘when appropriate’.²⁹ Despite this variety of different, and perhaps differing, interests, courts tend to defer to the interests of parents in determining the necessity for, and appropriateness of, a DNR order.³⁰ While the evidence of physicians is necessary to determine whether the withholding of medical services is justified by a person’s medical condition, courts will generally defer to ‘the essential and traditional respect for family’ and will not intervene to contradict the decision of ‘a loving family, willing and able to assess what the patient would have decided as to his or her treatment’.³¹ However, even the combined consent of physicians and parent permission may not be sufficient to make a DNR order enforceable in a school setting for a disabled student with an IEP were the Order to be considered contrary to the purposes of the IDEA. Beyond these issues of best interest and the purpose of the IDEA, though, the *AAP Statement’s* recommendation for instructional lessons on death and dying is worrisome. Such lessons may have the potential to create, among the population of both disabled and non-disabled students in a classroom that it purports to help, the opposite result by generating anguish, confusion, and uncertainty. Thus, for example, how would the school design and develop a curriculum on death and dying appropriate to seven-year-olds where one or more sets of parents, in effect, by approving a DNR order in the school, has chosen to allow a child in their classroom to die? How would a seven-year-old child (or, more properly, almost any age child in a school) assimilate the legal notion of best interest of the child without distressing over how that concept might be applied to them by their own parents?

IV APPLYING A DNR TO A SCHOOL SETTING

Only one reported law case, has addressed the issue of a DNR order in a school. While the case involved only a state trial court decision and, thus, has limited precedential value, it does lay out in dramatic fashion relevant issues related to DNR orders. In *ABC School v Mr and Mrs M*,³² (*ABC School*), a public school that serviced disabled children, sought both injunctive and declaratory relief to support its refusal to honor a DNR order secured by a child’s parents. The child at issue in this case, a four-year-old girl with severe mental and physical disabilities, was transported to and from the ABC School five days a week where she stayed for approximately four hours each day, receiving physical, occupational, and speech therapies. During the preceding year, the child’s medical condition had deteriorated significantly, following an apneic spell when the child had ceased breathing and, during which, the school nurse had administered care while the child was transported to a hospital in an ambulance. After consultation with the parents, a physician prepared the following DNR that provided, 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.

The ABC School posited three reasons for refusing to honor this DNR order:

1. The school had in place ‘Preservation of Life Policy’ requiring ‘[t]eachers 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’.³³
2. Prior to the child’s enrollment in the school, the parents had been notified of the Policy and had stated that no DNR was in effect.
3. The school nurse at ABC School claimed that enforcing the DNR would violate the professional ethics of herself and other staff members and would place an undue burden on the nurse because she would not have the ability to confer with other medical personnel concerning Minor M.

In denying the school’s first two reasons, the trial court rejected the claim of detrimental reliance by the school, finding that ‘the possibility that a change in circumstance could give rise to DNR order was not so remote that ABC School was not apprised of the possibility’.³⁴ With regard to the third reason, the court noted that ‘[a]n order prohibiting CPR and medication [did] not require consultation with other medical personnel’,³⁵ and in any case, because of the child’s fragile condition, the denial of certain life saving measures (eg, CPR), was ‘in the best interests of Minor M’.³⁶ In addition, the court dispensed with the school’s ethical claim that had been based on the Supreme Judicial Court of Massachusetts’³⁷ decision in *Brophy v New England Sinai Hospital*³⁸ where the supreme court had upheld the ethical claim of physicians who could not be required to disconnect a person in a vegetative state from life-support systems. In parsing *Brophy*, the trial court in *ABC School* noted that *Brophy* dealt with requiring physicians ‘to take *active measures* which are contrary to their view of their ethical duty toward their patient’,³⁹ while, in *ABC School*, the staff was ‘being asked to refrain from giving unwanted and potentially harmful medical treatment to Minor M’.⁴⁰

The ABC School made one further abortive effort to minimise the impact of the court’s support for the DNR order by their actions by seeking a declaratory judgment that their actions be shielded under the state’s qualified immunity statute which provided in part that:

No collaborative school teacher ... or other ... collaborative employee who, in good faith, renders emergency first aid or transportation to a student who has become injured or incapacitated ... shall be liable in a suit for damages as a result of his acts or omissions either for such first aid or as a result of providing such emergency transportation to a place of safety ...⁴¹

The court in *ABC School*, in denying the school’s request, reasoned that to grant the declaratory judgment ‘would vitiate the DNR order and essentially constitute an end-run around this court’s denial of the request for injunctive relief’.⁴²

While only of limited precedential value, *ABC School* is, nonetheless, a window into one court’s approach to parent actions allegedly taken in the best interest of their child and the court’s response to the school nurse’s concern about her professional ethics responsibilities. Worth noting is that the DNR order in *ABC School* was fairly complex and, in essence, had three separate categories for school personnel (primarily the school nurse) to understand and apply: those

measures prohibited at all times (CPR, intubation, defibrillation); those measures permitted at all times (oxygen, suctioning, stimulation); and, those measures permitted only with parent consent (arterial or venous puncture). While the ABC School was fortunate to have its own full-time nurse, delegation of responsibilities to UAPs with the attendant concerns about their training and supervision would still raise professional ethics issues for the school nurse. The *ABC School* trial court's refusal to permit the use of qualified immunity for school personnel in implementing a DNR order raises the unpleasant possibility that actions taken by school personnel contrary to the DNR order could state a prima facie case of negligence, and perhaps even gross negligence in states that require that standard for liability.⁴³ Since the ABC School had only students with disabilities, we are left to speculate how a classroom population of both typical and disabled students might have affected the various interests of the parties were one of the disabled students to appear with a DNR order. Would the school be expected to have assigned a one-on-one aide to the DNR order student so as to make certain that none of the prohibited services are provided, while the prescribed ones are attended to? If the aide has not been assigned, or, if assigned, is not available during an episodic event, what would be the school's expectations for the regular classroom teacher with regard to the other students? What preparation, if any, has been given to preparing the other students who may well be watching a friend suffer and die for failure to use special equipment, such as a defibrillator, which the students know is readily available?

V THE DNR AND THE IDEA

To the extent that students in a school need a DNR order, they may already have an individualised education program (IEP)⁴⁴ under the *Individuals with Disabilities Education Act* (IDEA),⁴⁵ or at the very least, a section 504 plan under the *Rehabilitation Act of 1973*.⁴⁶ However, while IEPs and section 504 plans are designed to enable a child to receive some educational benefit⁴⁷ or an accommodation to permit achievement of a major life function, a DNR order, one can argue, is at odds with this purpose. Although a DNR order may fit within what the NASNPS refers to an Individualised Health Care Plan (IHCP),⁴⁸ the notion that a child is to be denied a medical service or procedure will, to the extent that the student's health seriously deteriorates or the student dies, have the effect of denying all educational benefits to that child.

The US Supreme Court, in *Irving Independent School District v Tatro*⁴⁹ and *Cedar Rapids Community School District v Garrett F*,⁵⁰ held that the provision of nursing services to severely impaired students was not prohibited under the IDEA's 'medical services' exemption⁵¹ of 'related services'.⁵² In *Garrett F*, a student who at the age of four had his spinal cord severed in a motorcycle accident and 'who control[ed] his motorised wheelchair through use of a puff and suck straw, ... operate[d] a computer with a device that responds to head movements, [and] breathe[d] only with external aids, usually an electric ventilator',⁵³ needed assistance with

urinary bladder catheterisation once a day, the suctioning of his tracheotomy tube as needed, but at least once every six hours, with food and drink at lunchtime, in getting into a reclining position for five minutes of each hour, and ambu bagging occasionally as needed when the ventilator is checked for proper functioning. [In addition] [h]e also need[ed] assistance from someone familiar with his ventilator in the event there [was] a malfunction or electrical problem, and someone who [could] perform emergency procedures in the event he experience[d] autonomic hyperreflexia.⁵⁴

Once *Tatro* and *Garrett F* determined that even comprehensive and life-saving services could be required of school districts under the IDEA to assure students a free and appropriate

public education (FAPE), the discussion, arguably, escalated from state issues such as licensing standards to compliance with federal standards as reflected in the IDEA. The court decisions in *Tatro* and *Garrett F* skirted the first concern without addressing the second. In *Tatro*, the Attorney General of Texas had determined that the state's Nursing Practice Act permitted a nurse to provide a CIC without the supervision of a physician as long as the physician had issued a medical prescription,⁵⁵ thus bringing CIC within the IDEA's definition of related services that had to be provided by school districts.⁵⁶ Although the Iowa Board of Nursing in *Garrett F* had 'provided a declaratory ruling that the care required by Garret could not be delegated at school to a nonlicensed practitioner [and that] care [could] not be delegated from a registered nurse (RN) to a licensed practical nurse (LPN) unless an RN is in the same building at all times',⁵⁷ the effect was that a school district was required to provide the related services, even though the district would be required to hire a more expensive registered nurse. In effect, the nature of the person providing the services was viewed as a matter of finances⁵⁸ and the IDEA did not permit the diminution or avoidance of related services because of cost.⁵⁹

VI POLICY CONSIDERATIONS

Since the IDEA is a federal statute, determining what role, if any, the Supremacy Clause⁶⁰ would have on conflicts between the IDEA's mandate to provide related services in order for students to participate in education and decisions by school teachers, school nurses, school administrators to limit or prohibit services under a DNR order is difficult to assess.⁶¹ To the extent that a state imposes a higher standard of proof (clear and convincing) on a section 1983 claim that is commensurate with its burden of proof standard for state tort claims, a new trial is required using the lower section 1983 standard of preponderance of the evidence.⁶² In the absence of any reported law cases testing the constitutional or statutory viability of a DNR order with regard to public schools, one can only speculate as to the outcome.

Because schools deal with populations rather than just individuals, the design and implementation of DNR orders needs to be viewed differently than it would in hospitals or other medical facilities. The landmark case from Maine in 1994 involving the interaction between a school and a parent's DNR order for a 12-year-old multiply disabled child resulted in the public school refusing to follow the DNR order but the school did prepare an individual resuscitation plan (IRP) designed by the student's multidisciplinary team that put in place procedures to be followed in case of emergencies. In essence, the IRP became part of the child's IEP and was reviewable annually. The Office of Civil Rights (OCR) of the US Department of Education concluded that the school's replacement of the IRP for the parent's DNR order was not discriminatory.⁶³

In reported cases involving minor children in medical and other care facilities, courts have tended to defer to parents' decisions. Litigation has not always involved a formal DNR order but courts have addressed fact situations involving deteriorating health conditions that are the predicate to seeking a DNR order. In the seminal case, *In re Quinlan*,⁶⁴ the Supreme Court of New Jersey observed that the right to refuse medical treatment is part of a person's constitutional right to privacy.⁶⁵ In *In re LHR*,⁶⁶ the Supreme Court of Georgia, in a case that did not involve a DNR order, upheld the right of parents to remove life support equipment from their terminally ill minor child existing in chronic vegetative state with no hope of development of cognitive function. Eight years after *LHR*., the Supreme Court of Georgia, in *In re Doe*,⁶⁷ addressed a dispute between physicians wanting either a DNR order or permission to deescalate treatment to a minor child and the parents who opposed both deescalation and a DNR order, emphasising 'that the right to refuse treatment or indeed to terminate treatment may be exercised by the parents or legal guardian of

the infant after diagnosis that the infant is terminally ill with no hope of recovery and that the infant exists in a chronic vegetative state with no reasonable possibility of attaining cognitive function'.⁶⁸ While refusing to 'mandate a single, static formula for deciding when deescalation of medical treatment may be appropriate',⁶⁹ the state supreme court in *Doe* found that 'medical decision-making for incompetent patients is most often best left to the patient's family (or other designated proxy) and the medical community'.⁷⁰ However, the court noted that the corollary of its position concerning the rights of parents was that the hospital could not deescalate the child's treatment as long as both parents opposed deescalation. Likewise, the hospital could not have secured a DNR order if the parents opposed it. However, parents could consent to deescalation or a DNR order only if both agreed.⁷¹ More recently, the Supreme Court of Maine, in *In re Mathew W*,⁷² held, that, as to the effort of the Department of Health and Human Services (DHHS) to issue a DNR order for a child less than one year old, 'due process requires that parents be afforded the same procedural protections before approval of a DNR for their child as they are afforded prior to the termination of their parental rights'.⁷³ Attaching the due process rights of parents to oppose the DHHS's DNR order to the constitutionally protected rights of parents 'to direct the care and upbringing of their children',⁷⁴ the Supreme Court of Maine noted that the '[e]xercise of a DNR [by the DHHS] over the parents' objections not only infringe[d] upon the fundamental rights of parenthood, but could have the effect of conclusively preventing parents from raising their child or ever again exercising their fundamental rights'.⁷⁵

As a result of cases like *LHR* and *Doe*, state legislatures have intervened and established protocols for addressing DNR orders and issues attendant to the implementation of a DNR. Some of these state statutes are incredibly complex⁷⁶ and address not only such matters as the definitions of various debilitating conditions,⁷⁷ the authority of physicians,⁷⁸ and the criteria for creating and implementing a DNR order,⁷⁹ but also such matters as whether a DNR order is a suicide⁸⁰ and how DNR orders issued in other states are to be enforced.⁸¹ However, while the statutes identify those persons who can make decisions to withhold or withdraw life-saving treatment, nothing is said regarding a minor child who has an IEP.⁸²

In terms of school compliance with DNR orders, one author has suggested that 'many state and local educational systems do not comply with DNR orders directly, but summon Emergency Medical Services who are authorised to honor such orders'.⁸³ In effect, schools choose to pass the decision of whether to comply with a DNR order to someone else.

At the present time, the advice in policy statements concerning schools and DNR orders from medical organisations such as those mentioned earlier in this article from nursing and medical organisations appear undergirded by concerns about claims for tort liability. Arguably, the administering of emergency care, such as cardio-pulmonary resuscitation (CPR), in violation of an existing DNR order could arguably place school personnel at risk of state law assault and battery claims, as well as possible liability under a constitutional tort theory.⁸⁴ However, somewhat troublesome is the notion that enforcement of a DNR order in a classroom should be assessed solely by a tort standard. Thus, to follow through with this line of reasoning, if enforcing the a DNR order in a classroom does not rise to the level of a tort standard, such as outrageous conduct required for intentional infliction of emotional distress,⁸⁵ the DNR order should be enforced. While acceptable ethical conduct may, in fact, be defined as anything which does not violate a legal standard, at what point should we consider the population of students in the classroom in determining that definition? Assuming that a DNR order is enforceable as to a student with disabilities who is in a classroom with typical students, how does such lawfulness help us answer the seven-year-old student's questions, 'why did the school not try to help Billy?'

or ‘why did Mary’s parents want to let her die?’ Indeed, if one of more students in the class know how to administer CPR and is watching his or her friend experiencing loss of breathing, how will the teacher respond to the question, ‘why can’t I help Billy?’.

The very fact that, ‘on any given day, as much as 20% of the combined US adult and child populations can be found in schools’⁸⁶ is a powerful inducement to institute appropriate strategies for reducing the risk of injuries. What is missing from this strategic discussion and the policy statements is how, or whether, DNR orders have a place for fragile students with severe disabilities whose IEPs are designed under the IDEA to assure that they experience meaningful educational benefit in mainstreamed settings with students without disabilities. The very purpose of the IDEA and its IEPs is to assure that disabled students have goals and objectives under the IDEA that permit a meaningful performance comparable to students without disabilities but still commensurate with the nature of their disability. In effect, one could argue that treating students with disabilities the same as students without disabilities, in terms of compliance with a DNR order, would not qualify as discrimination under section 504 or the ADA.⁸⁷ In essence, just as a school is not likely to refuse to provide emergency, life-saving treatment to the football player with a concussion who is highly unlikely to have a DNR order, one can argue that so also should the school not be expected to refuse emergency care to the student with disabilities and an IEP simply because that student’s parents have secured a DNR order prohibiting such treatment.

VII IMPLICATIONS AND CONCLUSION

The litigation involving DNR orders and minors has not addressed the issues relating to students who have IEPs. The authority that parents have in making decisions about DNR orders in hospital settings is blunted and defused in school settings where parents of children with disabilities are only one part of the decision-making process for their children. Where parents come to their child’s IEP meeting with a DNR order prepared by their physician, should the school district be entitled to reject the order, as they might do for new related services of different placements? The important difference is how can one equate a request for new related services or placements in order to enhance the child’s educational benefits with a DNR order request that may, effectively, be a request to allow a child to die? The legal viability a DNR order presents a cascade of other issues. If parents pursue a school’s rejection of the DNR order through the administrative due process and judicial reviews, would the result of this process result in a DNR order simply be superimposed on a student’s IEP? If an IEP team opposes a parent’s DNR order and refuses to include it in an IEP (assuming that such discretion is permissible), would the school be required to reimburse the parent for their cost in placing the child in a medical facility that will adhere to the DNR? In the absence of congressional amendment to the IDEA that expressly authorises the DNR order as part of the special education process, should the IDEA’s purpose in including children with special needs in the regular academic setting be viewed as the systemic antithesis of a DNR order designed to be implemented in a school?

Keywords: best interest of the child; disability; do not resuscitate order; individualized education plan; school nurse; special education.

ENDNOTES

- 1 DNR ‘is the usual acronym for a physician’s directive that cardiopulmonary resuscitation not be used in the event of a cardiac or respiratory event (Carol Costante, ‘DNR in the School Setting: Determining Policy and Procedures’, in Nadine Schwab and Mary Gelfman (eds), *Legal Issues in School Health*

- Services* (2001) 419. DNR orders are sometimes, perhaps more accurately, referred to as Do Not Attempt Resuscitation (DNAR) orders, but DNR will be used in this paper since it is more widely recognised. See Mary Fran Hazinski et al, 'AHA Scientific Statement, Response to Cardiac Arrest and Selected Life-Threatening Medical Emergencies' (2004) 109 *Circulation* 278, 280.
- 2 See *DK v Cabinet for Health and Family Services*, 221 SW 3d 382 (Kent Ct App, 2007) (holding that, while the Cabinet was authorised to act as a child's health decision maker where temporary custody had been granted to social services for the neglected and abused child, a DNR Order was not appropriate where the parents' rights had not been terminated).
 - 3 See *Belcher v Charleston Area Medical Center*, 422 SE 2d 827 (W Va, 1992) (holding that 17-year-old with muscular dystrophy who suffered breathing failure and for whom a physician had issued a DNR Order, at direction of parents, to not reintubate or resuscitate their son and who died following a cardiac failure where no resuscitation or intubation occurred, the parents were entitled to go to trial on wrongful death and medical malpractice claims as to whether their son was a 'mature minor' whose opinion should have been sought prior to issuance of the DNR Order).
 - 4 See Katherine Pohlman and Nadine Schwab, 'Managing Risks in Professional and Clinical Performance Dilemmas: Part I' (2000) 16 *Journal of School Nursing* 46 (commenting that a school district policy may 'dictate a nursing action (or omission of an action) that appears to conflict with legal or ethical standards of practice or, more specifically, may bring harm to a student').
 - 5 See *JN v Superior Ct*, 67 Cal Rptr 3d 384 (Cal Ct App, 2007) (court refused to issue a DNR order for 11-month-old child with severe head trauma even though supported by child's attorney and hospital bioethics consultation team where child had not been adjudged dependent; however, the court held that hospital doctors could remove intubation tube for breathing where a petition for dependency had been filed and the court in approving the order to remove the tube had balanced the interests of the child with those of the parents who opposed both removal of the intubation tube and the issuance of a DNR order).
 - 6 See, eg, Hazinski et al, above n 1, 284 where the recommendations for risk reduction focus on safe equipment, instruction, and supervision, factors that are important in assessing tort liability for students in general, with limited attention to the role of parent input as to the disabling conditions of students with allergies or asthma that qualify them as students with disabilities.
 - 7 See *Hammond v Board of Education of Carroll County*, 639 A 2d 223 [90 *Education Law Reporter* 256] (Md Ct App, 1994) (finding no negligence liability as a result of internal injuries to female student who had sued successfully to participate on football team where the combination of her knowledge of the sport and the safety instructions of the coach were sufficient to amount to assumption of risk).
 - 8 The risk of certain kinds of injuries, such as concussion, has resulted in state statutes specifying the terms under which students suspected of having a concussion can continue to participate. See *Revised Code of Washington* § 28A.600.485(3) and (4) where a student 'suspected of sustaining a concussion or head injury in a practice or game shall be removed from competition at that time' and cannot return until after having been 'evaluated by a licensed health care provider trained in the evaluation and management of concussion and receives written clearance to return to play from that health care provider'.
 - 9 See *Bellinger v Ballston Spa Central School District*, 871 NY S 2d 432 [240 *Education Law Reporter* 856] (NY App Div, 2008) (where plaintiff's daughter, a fifth grader at Wood Road Intermediate School in the Village of Ballston Spa, Saratoga County, was playing one-hand touch football at recess when she and a fellow teammate, both running toward the same opponent, collided on the field, resulting in the teammate's head hitting plaintiff's daughter in the mouth, knocking out three of her teeth and fracturing a fourth, the school had no liability for negligence where, even if playground supervision was inadequate at the time a fifth grade, female student was injured while playing one-hand touch football at recess, such negligent supervision was not a proximate cause of the student's injuries, there was no history of disciplinary problems or rough play among any of the children involved, and the collision at issue was spontaneous and accidental).
 - 10 See *Hilts v Board of Education of Gloversville Enlarged School District*, 857 NY S 2d 292 [232 *Education Law Reporter* 304] (NY App Div, 2008) (triable issue existed as to whether school nurse,

who had helped student injured on playground from nurse's office to school door, had released her hold on the girl too soon so she could walk from the school door to her mother's car, resulting in the girl falling and injuring her ankle; the issue for the court was properly phrased as to whether the nurse had assumed a duty to hold on to the girl until in the car).

- 11 National Association of School Nurses (NASN, 2009), *School Nursing Services Role in Health Care*, (September 29, 2009), 1.
- 12 National Association of School Nurses (NASN, 2006), *School Nursing Management of Students with Chronic Health Conditions* 1, quoting from PW Newacheck et al, 'An Epidemiological Profile of Children with Special Health Care Needs' (1998) 102 PEDIATRICS 117, 117.
- 13 See *Ohio Revised Code* § 4723.01 (defining the 'practice of nursing as a registered nurse and the nursing regimen').
- 14 See *Ohio Revised Code* § 4723.151 (practices prohibited for licensed nurses); § 4723.17(permitted practices and prohibitions for licensed practical nurses).
- 15 See *Ohio Administrative Code* §§ 4723-13-02 and 4723-13-039 (setting limits on delegation of nursing functions). See also, *Moye v Special School District No 6, South St Paul*, 23 IDELE 229 (D Minn, 1995) (where parents did not want their child removed from the classroom so the school nurse could suction their child's tracheostomy tube and wanted a UAP to perform the function in the classroom so their child would not miss the class, a federal district court held that under the state's nurse practice act the nurse delegate [UAP] could not be required to perform the function).
- 16 Nadine Schwab and Mary Gelfman (eds), *Legal Issues in School Health Services: A Resource for School Administrators, School Attorneys, School Nurses* (2001), 55-79.
- 17 National Association of School Nurses, *Position Statement: Individualized Healthcare Plans (IHP)* (2008) (*NASN Position Statement 2008*) 'The IHP is a written document that outlines the provision of student healthcare services intended to achieve specific student outcomes. ... The need for an IHP is based on required nursing care, not educational entitlement such as special education or Section 504 of the *Rehabilitation Act of 1973*'.
- 18 *NASN*, above n 12, 3. The ECP is the outcome of the IHP and is a step-by-step set of procedures directed to non-nursing personnel who may have to respond to emergency situations in schools or at school activities.
- 19 IEPs are discussed later in this article but, basically they are 'a written statement for each child with a disability that is developed, reviewed, and revised in accordance with section 1414(d) of [IDEA]': 20 USC § 1401(a)(14).
- 20 IDEA is the federal statute, first enacted in 1975 as the *Education for All Children Handicapped Act* (EHA) and identifying the public school district's responsibilities to find, evaluate, and provide appropriate services and placements for children with disabilities. See 20 USC § 1400 et seq.
- 21 A nondiscrimination act, s 504 requires accommodations for students who are prevented from achieving a major life activity because of their disability, even if the child does not qualify for special education under the IDEA. See 29 USC § 794.
- 22 National Association School Nurses (NASN), *Issue Brief: School Health Services Role in Health Care—Section 504 of the Rehabilitation Act of 1973* (2005).
- 23 National Association of School Nurses Position Statement (*NASCPS*), *Do Not Resuscitate* (Nov 2004).
- 24 American Academy of Pediatrics, Committee on School Health and Committee on Bioethics, 'Do Not Resuscitate Orders' (2000) 105 *Pediatrics* 878 (hereafter referred to as *AAP*).
- 25 *Ibid* 878.
- 26 *Ibid*.
- 27 *Ibid*. See *Mitchell v Special Joint Agreement School District No. 208*, 897 N E 2d 352 [238 *Education Law Reporter* [836] (Ill App Ct, 2008) (finding no liability as to a mentally impaired special education student who, even though the classroom teacher and classroom aide knew that the student had, in the past, stuffed food into his mouth and swallowed it without chewing, grabbed a nearby cupcake, while the aide was watching him and backing up to a nearby sink, and choked on it suffering serious brain damage; despite the history of past occurrences, the court found in this case that 'school staff [had] maintained close supervision over [the student], evincing concern for his safety').

- 28 Ibid 879
- 29 Ibid; NASCPS, above n 23 (no pagination).
- 30 See *Parham v JR*, 442 US 584 (1979) (in a challenge by children sent to mental health facilities with parent permission, the Supreme Court observed that ‘parents retain a substantial, if not the dominant, role in the decision ... [t]he traditional assumption that parents act in the best interest of their children should apply’). For a broad based, international discussion of the best interests of children and their parents, See Ralph Mawdsley and Hans Visser, ‘The Best Interest of the Child and the Right of Parents to Make Decisions for Their Children: Comparing the United States and South Africa’, (2007) 15 *International Journal of Education Reform* 344; J. Joy Cumming, Ralph Mawdsley, and Elda De Waal, ‘The “Best Interests of the Child”, Parents’ Rights and Educational Decision-making for Children: A Comparative Analysis of Interpretation in the United States of America, South Africa and Australia’ (2006) 11 *Australia & New Zealand Journal of Law and Education* 43.
- 31 *In re Fiori*, 673 A 2d 905, 913 (Pa, 1996) (upholding removing life support treatment for an adult patient in a vegetative state).
- 32 1997 WL 34594167 (Mass Superior Ct, Barnstable County, 1997).
- 33 Ibid *1.
- 34 Ibid *3.
- 35 Ibid.
- 36 Ibid *2.
- 37 This is the title of the highest court in the State of Massachusetts, usually referred to as a Supreme Court in other states.
- 38 497 N E 2d 626 (Mass, 1986) (holding that court could not compel physicians to act contrary to their ethical views and remove or clamp the G-tube of a patient in a vegetative state, but patient’s wife could remove patient to another hospital where the physicians were willing to perform that function).
- 39 Ibid 639 (emphasis in original).
- 40 *ABC School*, 1997 WL 34594167 (Mass Superior Ct, Barnstable County, 1997), *3.
- 41 Mass Gen Laws Annotation § 55A. This statute grants exemption from civil liability for school personnel’s contact with ‘sick, injured or incapacitated pupils’ in areas of ‘emergency first aid or transportation’ as long as the personnel have acted in ‘good faith’.
- 42 *ABC School*, 1997 WL 34594167 (Mass Superior Ct, Barnstable County, 1997), *3.
- 43 See *Mitchell v Special Joint Agreement School District No. 208*, 897 N E 2d 352 [238 *Education Law Reporter* [836] (Ill App Ct, 2008), 354-55 (while failure of school to have a behavioral intervention plan [BIP] constituted a violation of the IDEA by not providing FAPE, it did not constitute negligence where the school personnel’s monitoring the student satisfied the tort liability standard for supervision).
- 44 An IEP ‘means a written statement for each child with a disability that is developed, reviewed, and revised in accordance with section 1414(d) of [IDEA]’: 20 USC § 1401(a)(14). An IEP is a comprehensive document prepared by specified school personnel plus a parent or guardian that contains the following: ‘a statement of the child’s present levels of academic achievement and functional performance’; ‘a statement of measurable annual goals, including academic and functional goals’; ‘a description of how the child’s progress toward meeting the annual goals ... will be measured and when periodic reports on the progress the child is making toward meeting the annual goals (such as through the use of quarterly or other periodic reports, concurrent with the issuance of report cards) will be provided’; ‘a statement of the special education and related services and supplementary aids and services, based on peer-reviewed research to the extent practicable, to be provided to the child, or on behalf of the child, and a statement of the program modifications or supports for school personnel that will be provided’; ‘an explanation of the extent, if any, to which the child will not participate with nondisabled children in the regular class and in [described] activities’; ‘a statement of any individual appropriate accommodations that are necessary to measure the academic achievement and functional performance of the child on State and district wide assessments’; and, ‘beginning not later than the first IEP to be in effect when the child is 16, and updated annually thereafter, ... appropriate measurable postsecondary goals [and] ... transition services (including courses of study) needed to assist the child in reaching those goals’: 20 USC §§ 1414(d)(1)(A)(i)(I),(II),(III),(IV),(V),(VI),(VII),VIII).

- 45 The IDEA is a comprehensive federal statute identifying the rights and remedies for students determined to be in need of special education: 20 USC § 1400 et seq.
- 46 29 USC § 794.
- 47 *Board of Education v Rowley*, 458 US 176, 200 [5 *Education Law Reporter* 34] (1982) (sets floor for compliance with the IDEA that a child is to receive ‘some educational benefit’). See *Timothy W v Rochester School District N 5*, 875 F 2d 954 [54 *Education Law Reporter* 74] (1st Cir, 1989) (holding that a severely disabled child did not have to demonstrate that he could benefit educationally from special education in order to be eligible for that education).
- 48 National Association of School Nurses Position Statement, *Do Not Resuscitate*, Nov. 2004 (no pagination).
- 49 468 US 883 [18 *Education Law Reporter* 138] (1984) (holding that requiring school to provide eight-year-old child born with spina bifida with clean intermittent catheterisation [CIC] so that she could attend special education classes did not violate the state’s *Nurse Practices Act* since the CIC could be done by a trained lay person).
- 50 526 US 66 [132 *Education Law Reporter* 40] (1999) (holding that school providing one-on-one nursing services for severely disabled student constituted related services and did not fall within IDEA’s medical exemption).
- 51 The IDEA exempts from the definition of ‘related services’ those ‘medical services’ that are other than for ‘diagnostic and evaluation purposes’ and ‘a medical device that is surgically implanted, or the replacement of such device’: 20 USC § 1401(26) (A), (B).
- 52 20 USC 1401(26)(A):
The term ‘related services’ means transportation, and such developmental, corrective, and other supportive services (including speech-language pathology and audiology services, interpreting services, psychological services, physical and occupational therapy, recreation, including therapeutic recreation, social work services, school nurse services designed to enable a child with a disability to receive a free appropriate public education as described in the individualized education program of the child, counseling services, including rehabilitation counseling, orientation and mobility services, and medical services, except that such medical services shall be for diagnostic and evaluation purposes only) as may be required to assist a child with a disability to benefit from special education, and includes the early identification and assessment of disabling conditions in children.
- 53 526 US 66 [132 *Education Law Reporter* 40] (1999), 68, n 2.
- 54 *Ibid* n 3.
Autonomic hyperreflexia is an uncontrolled visceral reaction to anxiety or a full bladder. Blood pressure increases, heart rate increases, and flushing and sweating may occur. Garret [had] not experienced autonomic hyperreflexia frequently [during the litigation], and [when it had occurred it had] usually been alleviated by catheterization. He [had] not ever experienced autonomic hyperreflexia at school. Garret is capable of communicating his needs orally or in another fashion so long as he has not been rendered unable to do so by an extended lack of oxygen: *Ibid*.
- 55 See Texas Attorney General Op. H-1295 (Dec. 19, 1978) (‘Professional nurses may also administer medications and treatments on a physician’s prescription ... without any statutory requirement of direct supervision by the physician’).
- 56 *Tatro v State of Texas*, 516 F Supp 968, 976 (D C Tex, 1981) (observing that ‘with only minimal additional training a professional nurse should be more than capable of performing CIC’).
- 57 *Garrett F* 526 US 66 [132 *Education Law Reporter* 40] (1999), United States Supreme Court Petitioner’s Brief, Appellate Brief, *7.
- 58 In *Garrett F*, the school district had been expending \$9 500 of its own funds annually to pay for an educational assistant to aid the student with his computer and academic courses, but the hiring of a nurse to address the medical needs would require an additional expenditure of \$20,000 to \$30,000 per year: *Ibid*.
- 59 See *ibid* 71 (while not addressing the issue of cost on its merits, the Supreme Court, nonetheless, appeared to cite with approval the Administrative Law Judge’s (ALJ) determination on the merits that ‘[he had]found no legal authority for establishing a cost-based test for determining what related

services are required by the statute’).

- 60 *US Constitution*, art VI, Clause 2 (‘This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding’).
- 61 The Supremacy Clause has been interpreted as declaring that ‘[a] state statute is void to the extent that it actually conflicts with a valid federal statute: *Edgar v Mite Corporation*, 457 US 624, 631 (1982). In effect, this means that a state law will be found to violate the supremacy clause when either of two conditions exists: (1) compliance with both federal and state law is impossible, or (2) ‘... state law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress’: *Dow Chemical Co v Exxon Corporation*, 139 F 3d 1470, 1473 (Fed Cir. 1998).
- 62 See *Shaw v Leatherberry*, 706 NW 2d 299 (Wis, 2005). For a discussion of the Supremacy Clause as it applies to education, see, Jeffrey Fung, ‘Pushing the Envelope on Higher Education: How States Have Coped with Federal Legislation Limiting Postsecondary Education Benefits to Undocumented Students’ (2007) 6 *Whittier Journal of Child & Family Advocacy* 415 (lamenting that while states are required under the Equal Protection Clause to provide elementary and secondary education to most illegal aliens, post-secondary institutions are preempted under the Supremacy Clause from providing such education because of federal prohibitions); Louis Nappen, ‘The Privacy Advantages of Homeschooling’ (2005) 9 *Chapman Law Review* 73 (discussing how the *US Patriot Act* [Pub. L. No. 107-56, 115 Stat 272 (2001)] preempts library privacy by allowing government access to library circulation records listing books checked out by patrons, or records of internet use and prohibits the library from disclosing the existence of a warrant or the fact that records were produced, not even to the patron).
- 63 Lewiston (Me), ‘Public Schools’ (1994) 21 *Individuals with Disabilities Education Law Reporter* 83 (OCR 1994).
- 64 355 A 2d 647, 663 (N J, 1976), cert denied, *Garger v NJ*, 429 US 922 (1976) (finding that the right to refuse medical treatment is a constitutional right based on a person’s right to privacy and a person who is incompetent does not lose this right to privacy, and, moreover; ‘the individual’s right to privacy grows as the degree of bodily invasion increases and the prognosis dims’).
- 65 The *US Constitution* contains no express right to privacy, but exists ‘in the penumbra of specific guarantees of the Bill of Rights “formed by emanations from those guarantees that help give them life and substance”’: *Griswold v Conn*, 381 US 479, 484 (1965). However, state constitutions frequently have provisions that are broad enough to include privacy. See, eg, *NJ Constitution*, Art I, par 1(‘All persons are by nature free and independent, and have certain natural and unalienable rights, among which are those of enjoying and defending life and liberty, of acquiring, possessing, and protecting property, and of pursuing and obtaining safety and happiness’).
- 66 321 S E 2d 716 (Ga, 1984).
- 67 418 S E 2d 3 (Ga, 1992)
- 68 *Ibid* 5.
- 69 *Ibid* 6.
- 70 *Ibid*.
- 71 *Ibid* 6-7.
- 72 903 A 2d 333 (Me, 2006).
- 73 *Ibid* 337.
- 74 *Ibid*, citing to *Troxel v Granville*, 530 US 57, 66 (2000) where the US Supreme Court invalidated a state statute granting visitation rights to grandchildren even where the visitation occurred over the objections of parents who had lawful custody, reasoning that ‘the Due Process Clause of the Fourteenth Amendment protects the fundamental right of parents to make decisions concerning the care, custody, and control of their children’. The US Supreme Court has had a long tradition of protecting, under the liberty clause of the Fourteenth Amendment, the right of parents to make decisions for their children. See *Meyer v Nebraska*, 262 US 390, 399 (1923) (invalidating criminal conviction of religious school teacher instructing in other than the English language, finding that the state statute requiring instruction

only in English violated ‘the right of parents to “establish a home and bring up children” and “to control the education of their own”’); *Pierce v Society of Sisters*, 268 US 510 , 534-35(1925) (invalidating state statute requiring all children to be taught in public schools, holding that the ‘liberty of parents and guardians’ includes the right ‘to direct the upbringing and education of children under their control’); and, *Wisconsin v Yoder*, 406 US 205, 232 (1972) (in reversing truancy convictions of two Amish parents for refusing to send their children to school until age 16, the Supreme Court observed that ‘[t]he history and culture of Western civilization reflect a strong tradition of parental concern for the nurture and upbringing of their children [and] [t]his primary role of the parents in the upbringing of their children is now established beyond debate as an enduring American tradition’.).

75 *In re Matthew*, 903 A 2d 333 (Me, 2006), 337.

76 See Ohio Rev Code, §§2133.02-2135.12.

77 Ohio Rev Code § 2133.01 (defining hydration, incompetent, life-sustaining treatment, permanently unconscious state, terminal condition).

78 Ohio Rev Code § 2133.03.

79 Ohio Rev Code, §§ 2133.21 (DNR identification, DNR order, DNR protocol, CPR); 2133.08 (descending order of priority for withholding or withdrawing life sustaining treatment).

80 Ohio Rev Code § 2133.12 (DNR is not a suicide).

81 Ohio Rev Code § 2133.14.

82 See Ohio Rev Code § 2133.08.

83 Costante, above n 1, 422.

84 See, eg, in a non-DNR case, *Davis v Carter*, 555 F 3d 979 [241 *Education Law Reporter* 539] (11th Cir, 2009) where, while coaches had acted with deliberate indifference by not permitting football players sufficient water during a summer practice, the conduct was not so conscience shocking so as to generate liability under intentional infliction of emotional distress or the constitutional tort of violating a student’s bodily integrity. But see, *Neal v Fulton County Board of Education*, 229 F 3d 1069 [148 *Education Law Reporter* 86] (11th Cir, 2000) (where a coach hitting a player with a weight lock that caused the student’s eye to pop out of its socket met the conscience shocking standard) and *Patrick v Great Valley School District*, 296 Fed Appx 258 (3d Cir, 2008) (coach’s permitting two wrestlers practice where weight difference exceeded 90 pounds might constitute conscience shocking conduct as to the coach but not as to the school board that had no custom or practice of allowing such conduct).

85 Costante, above n1, 429. The author suggests that a student might suffer ‘extreme emotional harm’ resulting from witnessing a student receiving emergency treatment against that student’s wishes, but such an approach assumes that a DNR Order can be treated simply as a zero-sum game that views emergency treatment as equal to no emergency treatment, without having to consider student responses. One can argue, though, that, because schools deal with populations of students, the decisions to treat or not treat are not equal and the attempt to consider them as such affects significantly our perspective of the value of human life.

86 Hazinski et al, above n 1, 288.

87 Emergency cases where a DNR Order might be in place for a student without an IEP, or section 504 plan, are difficult to construct, but see *Knapp v Northwestern University*, 101 F 3d 473 [114 *Education Law Reporter* 460] (7th Cir, 1996) where the Seventh Circuit rejected the disability discrimination claim of a university student whom Northwestern refused to permit to practise or play with the team, although the student continued to receive an athletic scholarship, because the student had experienced sudden cardiac death while playing high school basketball. Even assuming that the student could have secured injunctive relief requiring that the university permit him to practise with the team and a DNR Order prohibiting the university from using life-saving treatment were he to experience sudden cardiac stoppage during a game or practice, one is hard pressed to think that the university personnel would have not have attempted some form of emergency treatment. Worth noting is that the university’s decision was not altered even though doctors, while plaintiff was still in high school, had inserted an internal cardioverter-defibrillator in his abdomen, a device that detects heart arrhythmia and delivers a shock to convert the abnormal heart rhythm back to normal.

