Do-Not-Resuscitate (DNR) Orders

What’s the Risk?
Each competent patient has the right to direct his/her healthcare. This includes the right to make informed decisions for end-of-life care and whether or not to be resuscitated in the event of a medical emergency. While do-not-resuscitate (DNR) orders have been utilized for a number of years, problems persist in implementing these orders and patients may be denied the opportunity to make an informed decision about resuscitation. Sometimes, cardiopulmonary resuscitation (CPR) is performed on a patient who wanted it withheld. Yuen, Reid and Fetters list the following four ways DNR orders remain problematic:

- DNR discussions occur too infrequently and patients’ preferences regarding resuscitation are neglected.
- DNR discussions are delayed until it is too late for the patients to participate regarding resuscitation.
- Physicians do not provide adequate information to allow patients to make informed decisions.
- Physicians inappropriately extrapolate DNR orders to limit other treatment.

When Is This Risk an Issue?
This chapter addresses the history and regulatory requirements and offers an explanation of the issues that surround the topic of DNR orders.

The Patient Self-Determination Act
In 1990 the United States Congress enacted the Patient Self Determination Act (the Act) to grant rights to each adult patient.

Two landmark cases were most likely the catalyst for enactment of the Act: In re Quinlan and Cruzan v. Director, Missouri Department of Health. Both cases involved young adults who were determined to have permanent brain damage and be in a persistent vegetative state. The earlier case, Quinlan, dates back to 1976 and challenged the then prevailing notion that withdrawal of treatment would be considered a homicide. In the Cruzan case, the court initially followed the same logic applied by the court in Quinlan. However, after numerous appeals and testimony of the patient's family and friends, the court established a legal standard of requiring clear and convincing evidence of a patient’s wishes if there was no written advance directive. The courts that decided these cases considered the issues of quality of life, a patient’s preference for treatment, and surrogate decision-making—precisely the same issues addressed within the Act and which serve as the basis for DNR orders.

The Act requires all entities that receive federal funding to provide written information to patients regarding:
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- Their right to make healthcare decisions, including the right to accept or refuse health care.
- Their right to execute a legal document called an advance directive that allows them to maintain control over their care when they are unable to make or communicate those decisions.
- The facility’s policies related to the implementation of such patient rights (e.g., policies on withholding or withdrawing treatment that supports life).\(^\text{2}\)

A physician may also initiate this discussion with his/her patients in the office. These are the elements to be considered when writing DNR orders.

Whether the physician or hospital staff member starts this conversation, it should occur when a patient is able to understand the risks, benefits and alternatives of care and the consequences that may flow from his/her decisions. The discussion points should be reviewed with the patient for any needed clarification and the discussion should be thoroughly documented in the patient’s medical record. If an advance directive has been previously executed or DNR orders were written, both should be part of the permanent record and reviewed upon each hospitalization or prior to a planned procedure.

Policies can and may differ from one institution to another. In order to comply with a patient’s wishes, a physician must be aware of the end-of-life philosophies and protocols regarding withholding or withdrawing life-sustaining treatment at the facilities at which he/she hold privileges.

Incompetent Adults
The Act does not distinguish between competent, incompetent or incapacitated adults. These issues are germane to ensuring the patient’s wishes are accurately interpreted. If a patient is not able to communicate his/her wishes, has been declared legally incompetent or is incapacitated, a legal guardian, surrogate decision-maker or other person designated under state law should be consulted for healthcare decisions.

When a patient is temporarily incapacitated or has been deemed incompetent but has moments of lucidity, a professional should conduct a thorough evaluation to ensure that the patient understands the consequences of his/her decisions. This may prove especially challenging in the behavioral health and psychiatric venues. This is particularly true when a behavioral health patient also has a medical condition or will undergo a procedure that may require life-sustaining treatment and a discussion of a DNR order is warranted. State law may prescribe who may make decisions on behalf of these patients, indicate the level of professional required to assess the patient, and address the process through which the assessment must occur.

Family Members
Family members may be involved in end-of-life decisions when a patient has given verbal or written permission, is unable to communicate his/her wishes, has not designated a decision-maker and has no writing that outlines his/her wishes. It is best to engage the family members...
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early in the decision-making process to determine whether there are common understandings, needed clarifications or disagreements among them.

Minors
The Act is only applicable to adult patients and does not define who is considered an adult. State law may also impose requirements. However, healthcare facilities may have specific instructions on authoring DNR orders for minor patients, particularly if this is the principal population they serve. Therefore, practitioners should familiarize themselves with the applicable laws, consult the policy at the facility where they hold privileges regarding end-of-life decisions for minors, and also develop policies to govern their own practices. It is important for the practitioner to know whether and how state law and facilities define the term minor. Guidance from medical societies is also available on managing DNR orders for minor patients. For more information on minors, see the chapter titled Informed Consent: Minors.

Assistance in Developing DNR Orders
The Act, which is federal legislation, is focused on a hospital’s requirements to advise patients of their right to formulate decisions for future care. It provides a definition of the type of writing that may serve as an advance directive and thus the basis for a DNR order. State law may allow reliance upon an advance directive such as a living will, durable power of attorney for healthcare, Three Wishes, or other document to guide the development of DNR orders. It may also allow testimony of an individual for this purpose.

Finally, healthcare facilities may have policies that detail development of DNR orders that consider federal and state law, accreditation requirements, and the organization’s religious or philosophical tenets and define what may serve as the basis to support DNR orders. Providers who perform procedures within these facilities are advised to familiarize themselves with all the laws and policies that govern this topic, as they are critical in developing DNR orders that mirror the patient’s wishes and comply with applicable regulations.

Healthcare Professional Authorized to Write DNR Orders
State law may define the level of professional authorized to write a DNR order. A healthcare facility’s policies may also provide direction as to the level of practitioner permitted to write DNR orders, as well as other requirements, such as co-signing, dating and timing the orders and associated documents.

Obstacles to Executing and Implementing DNR Orders and Advance Directives
It is important to know that there are impediments to developing and implementing DNR orders and advance directives, even when providers have the very best intentions.

A patient may not understand the concepts involved and therefore not be amenable to discussing advance directives and DNR orders. Limited English proficiency, diminished senses, or the mere stress of the situation can impact the discussion. Cultural, ethnic or religious bias may also make the patient reluctant or even unwilling to discuss this topic.
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Barriers to implementation may exist even when the patient has executed a legally recognized advance directive and a physician has properly authored a DNR order after a discussion with the patient or an individual legally responsible for the patient. There are a number of reasons why this may happen that are discussed below.

A healthcare facility may have policies that prohibit withdrawal of life-sustaining treatment that are based upon religious or philosophical reasons. Facilities may cite these as a basis to refuse the patient’s wishes. However, they are required to advise the patient of the policy upon admission or shortly thereafter. They must also have a policy in place to transfer patients to a facility that provides the requested treatment or acknowledges the patient’s right to refuse treatment.

Some facilities may only allow the DNR orders and directives to be executed under certain circumstances. For example, despite guidance from medical societies and medical ethics boards, the practice of suspending DNR orders or a patient’s written advance directive during surgery or while the patient is under anesthesia still occurs.10

One or more of the patient’s healthcare providers may have religious or philosophical objections to the patient’s DNR order and advance directive. If this occurs and time permits, the objecting healthcare provider should withdraw from care after a suitable substitute provider is found and agrees to care for the patient.

Confusion or conflicts among the patient’s healthcare providers or family members with regard to their understanding of the patient’s advance directive or DNR order may impede implementation. Family disputes may also occur over care to be provided or withheld when the patient is unable to communicate his/her wishes and has not designated a decision-maker, executed an advance directive, or had a discussion with their healthcare provider on this topic. It is important to obtain needed direction and resolve conflicts in order to abide by the patient’s wishes, minimize family frustrations, and avoid liability for failing to follow a patient’s wishes. For all these reasons, careful consideration and thorough communication and documentation are warranted.

A facility’s policy may govern preliminary steps to gain consensus among family members and/or healthcare providers. When agreement among the family members cannot be reached, state law may offer additional guidance regarding which family member or other individual has authority to make decisions regarding end-of-life care. When family member or healthcare provider consensus is frustrated, it may also be necessary to convene the facility’s ethics committee, seek legal advice or some combination thereof.

Emergency medical services (EMS) personnel may institute life-sustaining measures if they are called to the scene of a patient arresting, as they may be required to do so under state law. Home health personnel may do the same if they witness an arrest while providing care. This presents additional issues for the healthcare provider who receives the patient in a facility after life-sustaining treatment has begun.
How Can I Reduce Risk?

Healthcare providers have significant interests in a patient’s end-of-life care. They want to support their patient’s wishes to obtain or refuse life-sustaining treatment, draft DNR orders that reflect those wishes, comply with laws that govern these matters and avoid liability. The tables below provide recommendations that address these issues.

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<tr>
<th>Recognize Requirements of Advance Directives and DNR Orders</th>
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<tr>
<td>Know the federal requirements</td>
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<td>• Recognize that The Patient Self-Determination Act</td>
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<td>requires health facilities to advise adult patients of</td>
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<td>their right to:</td>
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<tr>
<td>1. Make healthcare decisions, refuse treatment and</td>
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<td>decide disposition of organs;</td>
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<td>2. Execute an advance directive to guide healthcare</td>
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<td>when the patient cannot make or communicate decisions;</td>
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<td>3. Receive an explanation of the facility’s policy</td>
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<td>regarding withholding or withdrawing life-</td>
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<td>sustaining treatment.</td>
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<td>Know the state requirements</td>
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<tr>
<td>• Understand your state’s requirements regarding</td>
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<td>advance directives and DNR orders.</td>
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<td>Know the facility requirements</td>
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<tr>
<td>• Understand the policies pertaining to advance</td>
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<td>directives and DNR orders at the facilities where you</td>
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<td>practice.</td>
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<td>• Consider whether the facility’s policies may impact</td>
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<td>your patients’ care decisions.</td>
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<th>Assess Patient Readiness &amp; Plan Discussion</th>
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<td>Determine patient capability and competency</td>
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<tr>
<td>• Determine if the patient is incompetent or temporarily</td>
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<td>incapacitated and follow the facility’s protocols or</td>
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<td>state law to identify someone legally responsible to</td>
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<td>speak on behalf of the patient.</td>
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<td>• Determine if the patient has limited English proficiency,</td>
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<td>hearing and/or visual deficiencies. Obtain an</td>
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<td>interpreter and/or hearing or visual aids as needed</td>
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<td>to communicate with the patient.</td>
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<tr>
<td>• Determine whether any cultural, religious or philosophical issues may impact the discussion and seek guidance on whether and how to address the topic.</td>
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<tr>
<td>• Determine if the patient is a minor and obtain wishes of patient (if old enough to understand) and</td>
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Discuss advance directives and DNR orders
- Clarify existing advance directives or DNR orders.
- Discuss advance directives and options for DNR orders with your patient.
- Advise the patient of any facility requirements that may impact his/her decisions, such as removing feeding tubes or suspending DNR orders during surgery.
- Document the discussion and the names of those individuals involved in or witnessing the decision-making process.

Obtain Assistance in DNR Order Development

Determine methods to verify patient’s wishes
- Determine whether a legally recognized document addresses the patient’s wishes.
- Consult family members and friends when the patient cannot communicate his/her wishes.
- Consult facility policy and state law on selecting an advocate who may speak on behalf of the patient, as needed.

Recognize Barriers to Executing and Implementing Advance Directives and DNR Orders

Determine the patient’s limitations
- Recognize the patient’s stress level, diminishing senses, and cultural, ethnic, religious, philosophical and/or language barriers.

Know facility policies
- Determine whether the facility’s policies may impede your patient’s wishes for life-sustaining treatment.
- Understand and follow the facility’s policies for re-instatement of DNR orders that were suspended.

Identify potential conflicts
- Determine whether any conflicts exist among the patient’s healthcare providers with regard to their understanding of the patient’s advance directive and DNR orders.
- Determine the patient’s healthcare provider’s philosophical, ethical or religious objections to the patient’s advance directive and DNR orders.
- Determine conflicts among the patient’s family members regarding life-sustaining treatment when a patient has not designated an advocate, authored an
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Recognize Barriers to Executing and Implementing Advance Directives and DNR Orders

- advance directive or had a discussion with a healthcare provider.
- Resolve conflicts through ethics committees and remedies available through the legal system.
- Document the decisions in the medical record.

Anticipate and Address Outpatient Obstacles to DNR Orders

**Understand outpatient DNR issues**

- Recognize that EMS, home health staff members and other individuals may institute life-sustaining treatment that contradicts a patient’s written advance directive or DNR orders.
- Determine whether your state maintains a DNR order verification program that enables EMS personnel and others to verify and honor the patient’s advance directive or DNR orders.

References:

2. Ibid.
3. Ibid.
7. Ibid.
9. Ibid.