PHYSICIAN’S GUIDELINES FOR WRITING
DO NOT RESUSCITATE ORDERS

“The purpose of CPR is the prevention of sudden unexpected death. CPR is not indicated in certain situations such as cases of terminal irreversible illness where death is not unexpected.”

The Illinois State Medical Society has created this document to assist physicians in determining when it is permissible to enter Do Not Resuscitate Orders. The Guidelines are the product of a review and analysis of court decisions, legal articles, policy statements and protocols from various state associations and institutions.

While there may be a variety of situations in which it is justifiable to withhold or withdraw life-sustaining treatment, the Guidelines presented here focus instead on a particular aspect of the dilemmas created by modern technology: The issue is whether or not to initiate CPR when a patient experiences an acute cardiac or respiratory arrest. What follows is a guide to the recommended components of a “DO NOT RESUSCITATE ORDER” (DNR).

As is the case with any physician order, a DNR order must be written and signed by a physician.

The Guidelines only illustrate the major points to be considered. This document does not constitute medical or legal advice, and it should not be treated as such.

These Guidelines are intended to serve as a useful starting point for discussions on DNR orders.

A. PATIENT PARTICIPATION IN THE DNR DECISION

For the protection of the patient, physician, hospital, nursing home or other entity, DNR orders should be written only in accordance with accepted standards of medical practice. The medical record should contain:

- documentation of the discussion regarding the DNR decision,

- the patient’s mental and medical condition,

- any authorization by the patient’s family or the consent of a court-appointed guardian who has express authority to grant such consent. If the competent, capable patient does not agree to the DNR order, then it cannot be written unless CPR is not indicated.
• Further, AMA policy recommends:\textsuperscript{2}

Efforts should be made to resuscitate patients who suffer cardiac or respiratory arrest except when circumstances indicate that cardiopulmonary resuscitation (CPR) would be inappropriate or not in accord with the desires or best interests of the patient.

Patients at risk of cardiac or respiratory failure should be encouraged to express in advance their preferences regarding the use of CPR, and this should be documented in the patient’s medical record. These discussions should include a description of the procedures encompassed by CPR and, when possible, should occur in an outpatient setting when general treatment preferences are discussed, or as early as possible during hospitalization. The physician has an ethical obligation to honor the resuscitation preferences expressed by the patient. Physicians should not permit their personal value judgments about quality of life to obstruct the implementation of a patient’s preferences regarding the use of CPR.

1. The Competent Patient

All patients are presumed competent until declared incompetent by a court or found to lack decisional capacity by the attending physician and one consulting physician. A competent patient must give his/her informed consent to a DNR order, except in cases where CPR is futile or not indicated. A competent patient is considered an adult (age 18 or over), or a court designated “emancipated minor,” who is conscious, alert, oriented and able to understand the nature and severity of his/her illness or condition. Such a patient is able to make informed and deliberate choices about the treatment or non-treatment of the illness or condition and is able to understand the probable consequences of refusing CPR.

No prior judicial approval is necessary for a competent patient to request the entry of a DNR order. Whenever such a request is made, the attending physician should immediately consult with the patient to ascertain that the patient understands his/her illness or condition and the probable consequences of refusing CPR.

2. Incompetent Patients

\textit{a. Adults Who Lack Decisional Capacity}

In a situation where a patient has been adjudged to be mentally disabled by a court, it is nevertheless advisable for the attending physician to first attempt discussion regarding DNR orders with the patient. If the patient lacks decisional capacity, the attending physician should determine whether or not the patient has executed a Power of Attorney
for Health Care. If so, then the agent designated to make decisions under the Power of Attorney for Health Care should be contacted to determine whether or not a DNR order should be written.

If there is no Power of Attorney for Health Care, and the patient lacks decisional capacity and suffers from a qualifying condition, then the designated surrogate under the Health Care Surrogate Act (HCSA) should be contacted to determine whether or not a DNR order should be written. If the patient does not suffer from a qualifying condition, then the physician is well advised to refrain from writing a DNR order and should request family members or hospital administration to seek judicial appointment of a legal guardian, who has express authority to consent to a DNR order.

b. The Competent Patient Who Becomes Incompetent During Treatment
If a competent patient becomes incompetent, his/her previously given consent to a DNR order should remain in effect so long as the clinical condition supporting the original decision remains in existence.

c. Minor Patients
If the patient is a minor (under 18 years of age), a DNR order should be discussed with the minor’s parents, or with a court-appointed legal guardian who has express authority to make such a decision. If the minor’s parents disagree as to an appropriate course of action, and there is no court-appointed guardian, then the physician should request the family or the hospital’s administration to seek the appointment of a legal guardian who has express authority to make such a decision. In the event the minor’s parents are divorced, the physician should attempt to discuss the decision with, and get the consent of, both parents, unless the non-custodial parent is unavailable to give permission. In this regard, it should be emphasized that Illinois law recognizes that a divorced parent does not lose the right to participate in health care decisions regarding children who are under the custody of the other parent.

d. Resolution of Disputes
If family members or ancillary medical personnel disagree with a DNR order authorized by an agent under a Power of Attorney for Health Care, a surrogate under the HCSA, or a court-appointed guardian, then it may be advisable to request the assistance of the hospital committee assigned to deal with ethical issues or to obtain guidance from hospital legal counsel in order to carry out the intent of the patient or guardian.

B. PROCEDURES FOR PATIENT CARE
The various parties caring for the patient should understand their roles under a DNR order.
1. Continuity of Care

The fact that a DNR order has been written does not relieve the attending physician, nursing staff and other parties from the responsibility of continuing to monitor the condition of the patient or from providing basic care services. A DNR order should not influence any other therapeutic interventions that may be appropriate for the patient. In fact, hospital medical staff bylaws may suspend or revoke DNR orders for patients receiving other therapeutic interventions – most commonly in the case of surgical interventions.

2. Change in Patient’s Condition

If a patient should unexpectedly improve or recover from the underlying condition for which a DNR order was entered, then the attending physician should withdraw the order and inform the patient or guardian.

3. Written Orders

All DNR orders must be written or signed by the attending physician in the patient’s medical record. A separate written DNR order document also may be used and, if so, must be included in the patient’s medical record. Such a document is considered an advance directive. For emergency medical service systems, a valid written DNR must include the following information:

1) Name of the patient;
2) Name and signature of attending physician;
3) Effective date;
4) The words “Do Not Resuscitate”;
5) Evidence of consent – either:
   A) signature of patient; or
   B) signature of authorized legal guardian; or
   C) signature of agent under power of attorney for health care; or
   D) signature of surrogate decision-maker.

Appropriate documentation supporting the DNR order should be included in the progress notes.

SEE ATTACHED UNIFORM DNR FORM CREATED BY THE STATE OF ILLINOIS FOR ALL HEALTH CARE SETTINGS.

4. Progress Notes

The DNR order, as with any order, should be reviewed as often as medically appropriate and in accordance with established policy.
5. Revocation of DNR Order

A patient must be permitted to revoke the DNR order at any time orally or in writing. In the event of a revocation: a) The attending physician should be notified immediately, and a “Cancel DNR order” elicited from the physician; and b) The revocation of the order should be documented in the nurse’s notes, in the physician’s progress notes and in other appropriate documentation and procedures to ensure notification of health care providers (such as home health care services).

C. DEFINITIONS

The following definitions may be referred to in determining when to enter a DNR order and to ensure its application and implementation is understood by all personnel:

“Attending Physician” -- Means the physician who has primary responsibility for the patient’s care and treatment. The term does not include resident physicians.

“Cardiopulmonary Resuscitation” (CPR) – Any extraordinary means employed to resuscitate a patient following cardiac or respiratory arrest, including precordial chest thumps and direct current shock (cardioversion or defibrillation).

“Death” – Means when, according to accepted medical standards, there is (i) an irreversible cessation of circulatory and respiratory functions or (ii) an irreversible cessation of all functions of the entire brain, including the brain stem.6

“Decisional capacity” – Means the ability to understand and appreciate the nature and consequences of a decision regarding forgoing life-sustaining treatment and the ability to reach and communicate an informed decision in the matter as determined by the attending physician.7

“Family” – The spouse, adult children, parents, and adult brothers and sisters.

“Forgo life-sustaining treatment” – Means to withhold, withdraw, or terminate all or any portion of life-sustaining treatment with knowledge that the patient’s death is likely to result.8

“Imminent” (as in “death is imminent”) – Means a determination made by the attending physician according to accepted medical standards that death will occur in a relatively short period of time, even if life-sustaining treatment is initiated or continued.9

“Life-sustaining treatment” – Means any medical treatment, procedure, or intervention that, in the judgment of the attending physician, when applied to a patient with a qualifying condition, would not be effective to remove the qualifying condition or would serve only to prolong the dying process. Those procedures can include assisted ventilation, renal dialysis, surgical procedures, blood transfusions, and the administration of drugs, antibiotics, and artificial nutrition and hydration.10
“Qualifying condition” – Means the existence of one or more of the following conditions in a patient certified in writing in the patient’s medical record by the attending physician and by at least one other qualified physician:

(1) “Terminal condition” means an illness or injury for which there is no reasonable prospect of cure or recovery, death is imminent, and the application of life-sustaining treatment would only prolong the dying process.

(2) “Permanent unconsciousness” means a condition that, to a high degree of medical certainty, (i) will last permanently, without improvement, (ii) in which thought, sensation, purposeful action, social interaction, and awareness of self and environment are absent, and (iii) for which initiating or continuing life-sustaining treatment, in light of the patient’s medical condition, provides only minimal medical benefit.

(3) “Incurable or irreversible condition” means an illness or injury (i) for which there is no reasonable prospect of cure or recovery, (ii) that ultimately will cause the patient’s death even if life-sustaining treatment is initiated or continued, (iii) that imposes severe pain or otherwise imposes an inhumane burden on the patient, and (iv) for which initiating or continuing life-sustaining treatment, in light of the patient’s medical condition, provides only minimal medical benefit.

The determination that a patient has a qualifying condition creates no presumption regarding the application or non-application of life-sustaining treatment. It is only after a determination by the attending physician [and another physician] that the patient has a qualifying condition that the surrogate decision maker may consider whether or not to forgo life-sustaining treatment. In making this decision, the surrogate shall weigh the burdens on the patient of initiating or continuing life-sustaining treatment against the benefits of that treatment.

“Terminal Condition” – an incurable and irreversible condition, where death is “imminent” and the application of life-sustaining procedures serves only to prolong the dying process or an incurable condition that is deemed fatal.
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FINAL COMMENT

The above guidelines are offered to provide necessary information to assist you to understand the legal standards for the creation and use of DNR orders. Comments and suggestions on the guidelines are welcome. The Illinois Department of Public Health has adopted Guidelines for Healthcare Professionals and Providers and Patients to create an advance directive using the IDPH “Uniform Do-Not-Resuscitate (DNR) Order Form.”

(Derived from ISMS Revised Guidelines for Writing Do Not Resuscitate Orders.)

ENDNOTES

1. “Standards for CPR and ECC,” JAMA, Aug. 1, 1980 (Vol. 244, No. 5.).


3. 755 ILCS 40/10.


5. 77 Ill. Adm. Code 515.380(e)(1)-(5).


7. 755 ILCS 40/10.

8. 755 ILCS 40/10.


10. 755 ILCS 40/10.

11. 755 ILCS 40/10.


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Illinois Department of Public Health

UNIFORM DO-NOT-RESUSCITATE (DNR) ADVANCE DIRECTIVE

Patient’s name ___________________________

Summarize medical condition:

When This Form Should Be Reviewed

This DNR order, in effect until revoked, should be reviewed periodically, particularly if –

- The patient/resident is transferred from one care setting or care level to another, or
- There is a substantial change in patient/resident health status, or
- The patient/resident treatment preferences change.

How to Complete the Form Review

1. Review the other side of this form.
2. Complete the following section.
   If this form is to be voided, write “VOID” in large letters on the other side of the form.
   After voiding the form, a new form may be completed.

Date    Reviewer    Location of review

Outcome of Review
☐ No change
☐ FORM VOIDED; new form completed
☐ FORM VOIDED; no new form completed

Date    Reviewer    Location of review

Outcome of Review
☐ No change
☐ FORM VOIDED; new form completed
☐ FORM VOIDED; no new form completed

Date    Reviewer    Location of review

Outcome of Review
☐ No change
☐ FORM VOIDED; new form completed
☐ FORM VOIDED; no new form completed

Advance Directives

I also have the following advance directives:  
☐ Health Care Power of Attorney
☐ Living Will
☐ Mental Health Treatment Preference Declaration

Contact person (name and phone number) ____________________________

◆ Send this form or a copy of both sides with the individual upon transfer or discharge.

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