Editorial

Flow Chart for the Interpretation of Do-Not-Resuscitate Order Statutes

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The study of do-not-resuscitate (DNR) orders is a confluence of medicine, law, and ethics. While the vast majority of physicians have issued DNR orders,[1,2] open discussion of such orders has been shrouded by lingering uncertainty about the legality of current practices. A climate of legal uncertainty can give rise to fears that a physician who issues a DNR order might face disciplinary action, malpractice liability, or criminal prosecution. Not surprisingly, some physicians have expressed a reluctance to issue medically appropriate DNR orders. Such indecisiveness often results in needless suffering and the misapplication of precious medical resources.

Fortunately, the actual likelihood of legal proceedings against a physician who issues a DNR order is exceedingly small. The few reported judicial opinions involving DNR orders uphold the prevailing practices of the medical profession. Perhaps the best known case is *Barber v Superior Court*,[3] in which murder charges were brought against two physicians who discontinued ventilation, issued a DNR order, and later removed the feeding tube from a patient in a persistent vegetative state. The physicians had consulted with the patient's family, who agreed with this course of action. In dismissing the charges, the California Court of Appeals ruled that withholding life-sustaining treatment under these circumstances was lawful and could not provide the basis for a criminal prosecution. Thus, the two physicians never had to stand trial. Courts in Massachusetts,[4] Delaware,[5] Washington,[6] and Arizona[7] have also upheld the legality of DNR orders in appropriate circumstances. While court decisions tend to support prevailing medical practices, many physicians desire more concrete guarantees of immunity from legal proceedings.

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Concern about legal liability is not the only factor drawing attention to DNR orders. Since January 1, 1988, the Joint Commission on Accreditation of Health Care Organizations (JCAHO) has mandated that all hospitals develop formal policies regarding the writing of DNR orders.[8] An amendment to federal Medicare laws may also prompt hospital review of current practices. The recently enacted Patient Self-Determination Act[9] directs hospitals and nursing homes to advise patients of their right to accept or refuse medical treatment and their right to formulate advance directives regarding their care should they become incompetent.[10] The law governing DNR orders is an important component of the patient's right to accept or refuse treatment. Although the Patient Self-Determination Act does not mandate a specific protocol for the implementation of DNR orders, it calls for acute care facilities to formulate a written policy on advance directives, present this information to the patient at admission, and record the patient's response in the medical record. These developments provide renewed incentives for hospitals to educate their staffs on the proper implementation of DNR orders.

It is against this background that states are beginning to consider legislation that directly addresses DNR orders. New York[11] became the first state to pass a "DNR law" in 1988, and Georgia[12] enacted a similar statute in 1991. Illinois[13] and Montana[14] have also enacted statutes directing the formulation of DNR protocols. Other states, either by statute or by administrative rule making, are expected to address the sensitive topic of DNR orders in the near future. DNR statutes, such as those enacted in New York and Georgia, are intended to remove the legal uncertainty surrounding DNR orders and provide a "safe harbor" for physicians who follow the statutory guidelines. More specifically, these statutes: (1) clarify the circumstances under which a DNR order is appropriate; (2) provide a listing of surrogate decision makers legally authorized to consent to the issuance of a DNR order on behalf of an incompetent patient; (3)

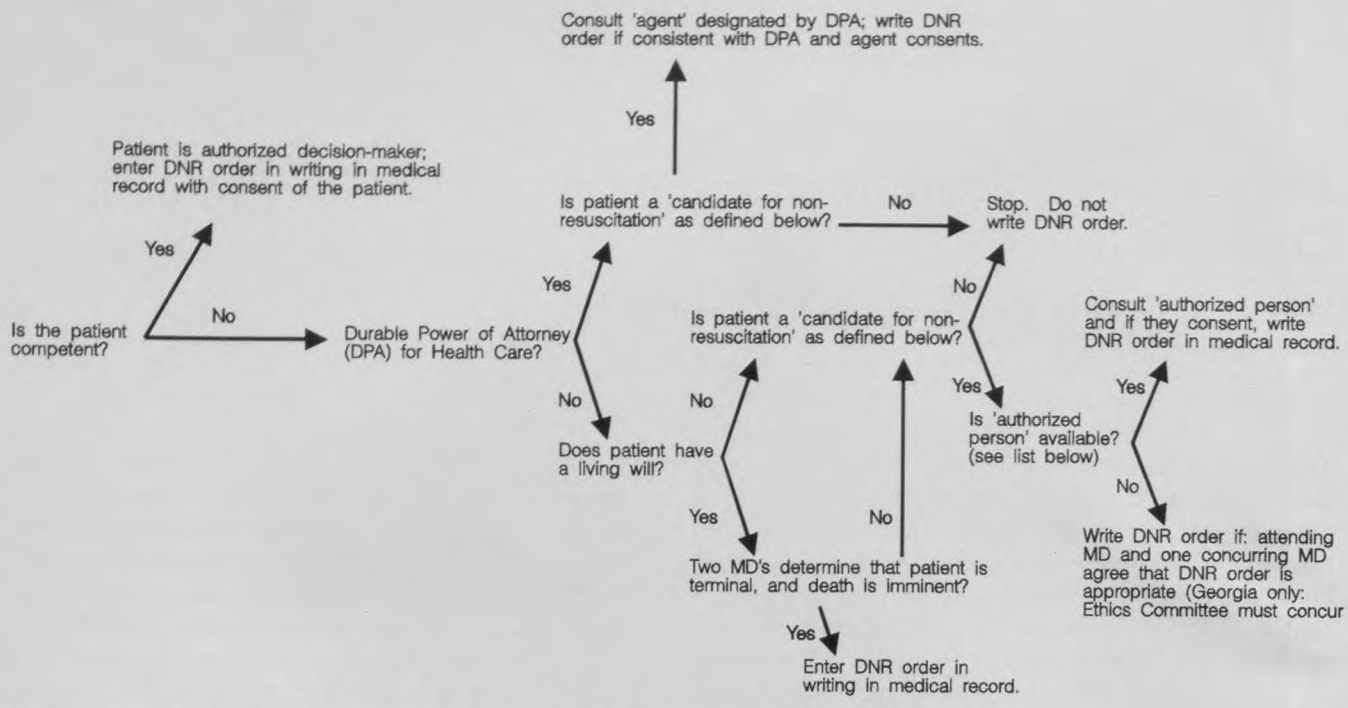

Figure 1. Flow chart to assist in the interpretation of DNR statutes in the states of New York and Georgia.

offer a procedure for issuing a DNR order when the patient has not given prior consent and none of the authorized surrogate decision makers are available; and (4) grant immunity from civil liability, criminal prosecution, or professional disciplinary action to health care facilities and physicians who, in good faith, carry out a decision regarding a DNR order. While the New York statute has been criticized as unnecessarily cumbersome and complex,[15,16] it and the more recent Georgia statute take an important first step toward clarifying legal responsibilities in a sensitive and confusing area.

Proposed DNR Statute Flow Chart

Even the most carefully crafted statute is of little value unless its provisions are effectively communicated to the members of the medical staff. All too often hospitals simply distribute a cover letter with a verbatim copy of the law. Even if physicians take the time to read the full text of the statute, misinterpretation is possible owing to their lack of legal training. DNR laws can be easily understood, however, when presented as a series of decision points. Such a decision tree can be presented graphically in the form of a flow chart, a device that can expedite learning and enhance understanding of DNR laws.

To facilitate the effective communication of legal guidelines for DNR orders, a DNR decision-making flow chart has been developed (Figure 1) that outlines the important tenets of the New York and Georgia DNR statutes. While the proposed flow chart is legally valid only in New York and Georgia, it can easily be adapted for use in other states as similar legislation is enacted. It is recommended that a DNR flow chart, adapted to the laws of the applicable state, be reproduced and posted at nursing stations for easy reference by health care providers.

Use of the Flow Chart

As an example of flow chart use, consider the case of a comatose homeless patient with no known family members. Beginning at the left side of the diagram, the first question is whether the patient is competent. This is a medical judgment, and in the case of a comatose patient, the answer would be no. The attending physician may wish to use a standard test of cognitive function such as the Mini-Mental State[17] or obtain a neurologic or psychiatric consultation to assist in the assessment of competence. If the patient is not competent and has provided no durable power of attorney or living will, one proceeds to the question "Is the patient a 'candidate for nonresuscitation' as defined below?" This decision must be made by the attending physician and one concurring physician, according to the criteria set forth in the applicable state law summarized below the flow chart.

If the patient is a possible candidate for nonresuscitation, an "authorized person," as defined in the flow chart, should be sought. If no family members are available, New York State law allows a close friend to serve as the authorized decision maker, and an appropriate search should be conducted to locate such a person. If the attending physician is unable to locate an authorized person, and the attending and one concurring physician believe that a DNR order is appropriate, such an order should be issued. In Georgia, concurrence of the facility's ethics committee is required.

In a second example, an outpatient with end-stage lung cancer is hospitalized and intubated following respiratory collapse. Because of anoxic brain damage suffered during the arrest, she is incompetent. Unfortunately, she has not prepared an advance directive. Her husband asks, after consultation with their family, that the patient be removed from the ventilator and allowed to die. The attending physician, proceeding from left to right through the flow chart, answers the first four questions in the negative. The attending and a concurring physician must then decide whether the patient is a candidate for nonresuscitation. The patient meets criteria A and C shown at the base of the flow chart; therefore, the attending physician should seek an authorized person to act as the patient's surrogate decision maker. The highest available person on the list is her husband, and he consents to the DNR order.

Conclusions

Flow charts cannot fully convert the nuances and complexities of DNR laws. Each institution should consult its attorneys for further guidance and a more detailed explanation of the procedural aspects of such laws. Flow charts can, however, provide a useful reference for the day-to-day implementation of the law.

Decision making regarding DNR orders is a complex process that must be based on good communication between patients and health care providers. It requires a clear understanding of the prognosis on the part of the patient and family and an appreciation of the patient's value system by the physicians.

It is hoped that a better understanding of the relevant legal principles will increase physicians' willingness to discuss DNR orders with their patients. An enhanced physician-patient relationship could emerge from such discussion, a relationship marked by a clearer understanding of the patient's values and desires as the end of life draws near.

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