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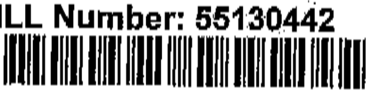

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DNR Procedures: Purple Dots Revisited

GRAND JURY OF THE SUPREME COURT
OF THE STATE OF NEW YORK, QUEENS COUNTY

Introduction

WE. THE SPECIAL JANUARY THIRD ADDITIONAL 1983 GRAND JURY, in and for the County of Queens, pursuant to section 190.85, subdivision 1(c) of the Criminal Procedure Law, hereby submit this report of stated findings, and based thereon, propose recommendations for legislative, administrative and executive action in the public interest.

Our recommendations call for the State of New York to recognize and regulate the process by which physicians, usually in a hospital setting, determine and direct that certain terminally ill patients should not be artificially resuscitated in the event of cardiac arrest. Such a direction is generally expressed in the form of a "do not resuscitate" (DNR) or "no-code" order.

The need to decide whether to resuscitate a patient is a recent phenomenon. Twenty-five years ago, a patient whose heart stopped beating inevitably lost breathing, and then brain. functions and died. But modern medical research has demonstrated that circulation can, in what is still a relatively small number of cases, be successfully maintained by external cardiac massage while the beating of the heart is restored through pharmacological, electrical, or manual means. The resuscitation procedure itself is fairly straightforward and is in widespread use. Unfortunately, the technology available to forestall death has developed faster than the ability to treat its causes.

Because cardiac arrest occurs at some point in the dying process of every person, whatever the underlying cause, the decision to attempt resuscitation is potentially relevant for all patients. For example, a child who has been pulled from a lake after nearly drowning may be revived through prompt cardiopulmonary resuscitation and, if the blood supply to his brain was not interrupted for more than a few minutes, he can go on to live a long and healthy life with no adverse affects whatever. Any physician who did not attempt cardiopulmonary resuscitation in that situation would be regarded as seriously derelict by his peers. On the other end of the spectrum is the hopelessly terminal cancer patient whose expressed desire is for a dignified death. Repeatedly restarting his heart after each cardiac arrest would simply add a few minutes or days or weeks of suffering, and most physicians would consider resuscitation inappropriate in such a case.

We recognize that the law does not require physicians or hospitals to treat all patients alike, and we do not propose that it do so. Nor do we seek to define for doctors and their patients the appropriate circumstances in which to administer or withhold cardiopulmonary resuscitation. We do, however. urge the State to insure that the decision-making process is governed by explicit procedural safeguards to prevent the decision from being made carelessly, unilaterally or anonymously. The minimum safeguards which we recommend in this report are designed to insure, and to permit verification, that the decision not to resuscitate a patient is made only after a qualified physician has. with a reasonable degree of medical certainty, diagnosed an illness which would imminently and inevitably lead to death: has discussed the consequences of prolonging the dying process with the patient or a member of his family or other surrogate and secured his knowing and informed consent; and has permanently recorded the decision on the patient's medical chart subject. of course. to revocation.

Our concern over abuses in the DNR decision-making process was precipitated by the death of a certain elderly patient in the intensive care unit of a Queens hospital in 1981.[1] This patient's underlying illness was never definitively diagnosed, and neither she nor any member of her family was ever apprised that an order to withhold resuscitation had been contemplated or given. Nevertheless. a medical student, who may or may not have been acting on the instruction of a cardiologist, ceased to administer cardiopulmonary resuscitation himself and. according to

REPORT OF THE SPECIAL JANUARY THIRD ADDITIONAL 1983 GRAND JURY CONCERNING "DO NOT RESUSCITATE" PROCEDURES AT A CERTAIN HOSPITAL IN QUEENS COUNTY

[1]We have not identified the individuals or institution involved in this investigation out of respect for the privacy of the deceased patients and the constraints of Criminal Procedure Law section 190.85. subdivision 2(b). as it bears on those as to whom this report may be deemed critical.

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the nurses present, prevented them from calling the emergency code which would have summoned a special team of medical personnel to do so.

We found that the failure to put "no-code" orders into writing was the rule, not the exception, at this hospital. In order to avoid legal responsibility for such decisions, and for no other reason, hospital officials categorically prohibited any written mention of such orders on the patients' charts. Instead, they instituted a process of designating "no-code" patients by affixing so-called "purple dots" to file cards which were kept solely by the nurses and only until the particular patient died or was discharged, and which were not routinely seen by the physicians. As a result, the "no-code" order could never be attributed to any physician and the only record of it would disappear after it was carried out. Members of the hospital administration insisted, both at the time the procedure was initiated and in their testimony before the grand jury, that the prohibition against writing such orders was justified by uncertainty over the legality of "no-coding."

We found that this "purple dot" system virtually eliminated professional accountability, invited clerical error, and discouraged physicians from obtaining informed consent from the patient or his family. We do not accept the proposition that doubts about the legality of the "no-code" decisions justified making them in secret. At the same time, we have found that some of those doubts are shared by highly responsible members of the medical profession despite virtually universal agreement that such decisions are medically appropriate in certain limited cases. Again, without seeking to prescribe specific criteria for the difficult ethical and medical decisions which must ultimately be made by dying patients and their physicians within existing legal parameters, we strongly recommend that the State expressly acknowledge that DNR decisions are regularly made as a matter of medical necessity and recognize the prevailing legal view that carrying out such a decision does not, in and of itself, constitute a violation of the civil or criminal law. Only then, we believe, can the State legitimately and effectively call upon responsible physicians and hospitals to eliminate the kind of shocking procedural abuses we have found.

THE GRAND JURY'S FINDINGS

Part I: The Death of Maria M.

On January 11, 1981, seventy-eight-year-old Maria M. took ill with what appeared to her daughter to be a flu. Because Mrs. M.'s family physician was on vacation, she was brought to the emergency room of a local hospital. Based on a diagnosis of myelophthisis, atrophy of the spinal cord, the emergency room physician decided to admit her as a hospital patient.

Within two weeks, Mrs. M. also began showing difficulty breathing and was transferred to the intensive care unit. The physicians on the staff of the hospital, and there were several involved, were never able to ascertain the cause of that condition, but they recommended a tracheostomy, which would involve an incision in the throat so that Mrs. M. could be inhalated through a mechanical respirator. Her daughter consented to the operation, and it was performed on February 11, 1981.

The operation was, in the words of one of the hospital's inhalation therapists, a "very bad job." The incision was larger than necessary to insert the tracheostomy tube which connected Mrs. M. to the respirator, and the resulting gap was patched with gauze and cotton. A second operation, to visually examine the bronchial tubes and to insert a wider tracheostomy tube, was performed on March 18. Less than a week later, the staff physicians obtained the family's consent to perform a third operation, a gastrostomy, which would allow Mrs. M. to be fed, through tubes, directly into the stomach so that food would not pass into her lungs through a fistula which had developed in her throat.

Mrs. M.'s medical chart revealed no definitive diagnosis as to the cause of her breathing difficulty, and none of the physicians who testified was able to attribute it to any terminal illness.[2] No one ever suggested to Mrs. M. or any of the members of her family who visited her regularly that cardiopulmonary resuscitation or any other life-sustaining procedures might be withheld.

Mrs. M.'s views on the subject cannot, of course, be conclusively determined. But she was coherent, and able to communicate with her daughter by writing notes and with the nurses by speaking for brief periods when the respirator was detached. When she wrote to her daughter, Mrs. M. expressed her eagerness to return home and, if necessary, to acquire her own respirator for that purpose. On the other hand, she often became agitated and on several occasions disconnected the tubing attaching her to the respirator, thereby triggering a loud alarm which alerted the nurses to reattach the tubing before any harm was done. One of the nurses, who at various times heard Mrs. M. say both that she wanted to go home and wanted to die, thought that she was disconnecting the tubing deliberately because she did not want to live. Another nurse thought that it was simply the result of fidgeting. Mrs. M. did not communicate with her daughter when she came to visit on the evening of March 26, 1981, but her daughter thought that she appeared much improved, an observation confirmed by a member of the nursing staff. It was to be the last night of Mrs. M.'s life.

At about 1:00 a.m. on March 27, the telemetry monitor at the nurses' station, which kept track of Mrs. M.'s heart beat, showed that it had slowed to sixty beats per minute, a condition known as bradycardia. The nurse who noticed this reading immediately summoned a medical student who was on duty in the intensive care unit.[3] Both responded

[2] The admitting diagnosis of myelophthisis was never confirmed or treated.

[3] Hospital protocol required at least one fully licensed physician to be on duty somewhere in the hospital during the nighttime hours. However, neither he nor the resident assigned to the intensive care unit, who had been graduated from medical school but not licensed to practice in New York, was available to respond to this emergency.

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to Mrs. M.'s room. Each saw that Mrs. M. had again become detached from her respirator. In addition, the disconnected tube had been tucked behind and up under her pillow and the alarm switch for the respirator had been turned off.

The medical student began administering closed chest massage while the nurse reconnected the tubing. Another nurse arrived and asked the student whether she should call a "Code 33" emergency, the hospital's signal for all available personnel to respond and administer cardiopulmonary resuscitation and any necessary ancillary services. As the nurse started to do so, the student indicated that Mrs. M. was not to be coded. According to the testimony of both nurses, the medical student said, "What am I doing? She's a no-code," and then ceased the cardiac massage.

The medical student first testified that he could not recall "no coding" being mentioned during the incident. He later changed his testimony, asserting that someone — in "all the confusion" he did not know who—had asked him whether Mrs. M. was a "no-code," to which he responded, "A no-code? Not as far as I know at all." The student testified that the reason he did not affirmatively direct that a "Code 33" be called was that he had summoned assistance from the resident assigned to the intensive care unit and he believed that the situation could be handled by the two of them without any additional help. He also stated that Atropine and at least one other drug were administered, a fact which neither nurse recalled and which is not documented on any of the charts.

The resident testified that the call which he received from the student was not to aid in saving Mrs. M.'s life, but "to pronounce [her] dead." When the resident arrived at the intensive care unit a few minutes later, the student was out in the hall. Upon entering Mrs. M.'s room, the resident discovered that her heart was still beating, although by then quite faintly. He made a desperate effort to revive her, but did not succeed.

The resident and the medical student described the circumstances of Mrs. M.'s death to one of the two senior residents who came on duty the next morning. After hearing the facts, the senior resident rebuked the student for his failure to summon help and to continue resuscitation until it arrived. When he repeatedly demanded an explanation as to why a "code" was not called, the student remained silent. Neither resident questioned the nurses in any detail and therefore never heard their description of what the student said and did. One of the nurses, however, subsequently asked the student why he treated Mrs. M. as a "no-code" and he answered that the order to do so had been transmitted to him orally by a cardiologist.

The cardiologist was also called to testify before the grand jury, but denied leaving such an order in this or any other case. He explained that while he had, on occasion, made an on-the-spot decision to cease resuscitating a patient where he did not believe it to be medically sound to continue, he never left standing orders which would bar another physician from calling a "Code 33." The nurse in charge of the intensive care unit also stated that advance determinations of that sort were not made as to patients in that unit, because the concept of receiving intensive care was inconsistent with a diagnosis of terminal illness.

The medical student notified Mrs. M.'s family of her death, and he asked her daughter to come in to speak with doctors in the intensive care unit. When she did so, the doctors assured her that they had done "everything they could do" for her mother and sought permission to perform an autopsy. Mrs. M.'s daughter refused. A few nights later, she received an anonymous phone call from someone identifying herself as a nurse employed at the hospital and apprising her that her mother had died "unnecessarily" because "a no-code was sent out."

Pursuant to a court order secured on behalf of the grand jury, an autopsy was ultimately performed on Mrs. M.'s body. The Chief Medical Examiner of the City of New York found the cause of death to be "cardiac arrest following disconnection from the respirator." Although responsibility for that disconnection cannot be determined, the credible evidence is inconsistent with any notion that Mrs. M. committed suicide. To do so, she would have had to flip the alarm switch while still connected to the respirator. Her physical size and frail condition, the distance involved, and the barrier posed by the bed rails precludes such a feat. In addition, she would then have had to disconnect the respirator tube and neatly tuck it up behind and under her pillow. In short, we found no evidence to suggest that Mrs. M. intentionally sought to take her own life on March 27, 1981.

Part II: No coding and "Purple Dots"

In the course of our inquiry into Mrs. M.'s death, it became clear that the confusion concerning her DNR status was the direct result of a deliberate hospital policy to avoid leaving any tangible evidence of "no-code" orders. The express purpose of this policy was to insulate the institution and its medical staff from any legal consequences which might flow from their action or inaction. It became readily apparent that this institutionalized practice, and its compromising effect on a life-and-death decision-making process which could potentially affect hundreds of patients, presented a problem which transcended even the tragedy of Mrs. M.'s death.

As early as June of 1979, over a year-and-a-half before Mrs. M. died, a committee comprised of the hospital's top medical and nursing personnel, under the chairmanship of its director of medicine, formally discussed whether notes should be kept to reveal which patients "should not be coded." The minutes of that meeting reflect an awareness that coding was a problem which faced "hospitals around the country" and a particular concern with protecting the hospital staff "where litigation was involved." The committee resolved to turn to the hospital's insurance company and to lawyers employed by its "risk management consultant" for advice. The chief of surgery, meanwhile,

proposed that "a color-coded tag could be placed on these charts which would indicate that a code should not be called." The minutes go on to state that: "Administration will review this procedure with nursing."

When the same committee met a month later, the executive vice-president of the hospital was present. According to the minutes, he "reported that he has reviewed the recent literature regarding written orders for coding terminally ill patients and he again requested that no formal note be entered in the charts." The executive vice-president was an attorney, not a physician, and the testimony confirms that his request was intended solely to minimize legal exposure. No medical or ethical justification for not putting "no-code" orders into written form was ever suggested. It was also clear that this "request" was not optional. As one internal memorandum instructed: "Written no-code orders are of doubtful legality and are, therefore, not permitted."

An inhalation therapist, according to the minutes of this meeting, then suggested "writing out these orders on the nurses plan. It was pointed out that these plans are discarded after the patient leaves the hospital and they are not always available. Removable color coded tags were again discussed."

Although the specific proposal for color-coded tags was nominally tabled at this meeting, the associate director of nursing, who was present at both meetings, thereafter initiated the distribution of "purple dots"—small, colored, commercially available, adhesive-backed paper discs—which she and other supervisors instructed the nurses to attach to the "Kardex" file of patients whom the doctors orally designated as not to be "coded." These files, essentially large index cards, were the sole responsibility of the nursing staff and thus the "purple dot" could not be attributed to either the physician who gave the order or the one who carried it out. In addition, the cards were routinely discarded after the patient died, and therefore no record of the decision would be available after its implementation.

Many of the nurses were deeply concerned over the absence of any institutional DNR standards, noting, for example, that a doctor on the day shift might want a patient "coded" while a doctor on the night shift—who, as in Mrs. M.'s case, might not even be a licensed physician—would decide to treat the same patient as a "no-code." There was no review; procedure and no formal method by which a "no-code" order could be revoked if the patient went into remission. The policy of the hospital, according to the testimony of the chief of surgery, was "not to have a policy," other than anonymity.

There was also no officially formulated policy which required physicians to obtain consent from, or even inform, the patient or his family before the "no-code" order was given. The chief of surgery could only describe a general practice at the hospital of communicating with every patient's family "as much as possible." Because of the lack of documentation, it is impossible to determine to what extent, if any, explicit discussions of "no-coding" were held, or with whom, but it is clear that the practice was ad hoc and that Mrs. M.'s family, for one, was never consulted. The failure to uniformly involve patients and their families in the DNR decision-making process was the logical consequence of the standing policy not to leave evidence which might be used against the hospital in a law suit.

Some of the nursing staff also criticized the "purple dot" system as an unreliable method of transmitting "no-code" orders. One complaint was that the system was not secure: the dots could be readily purchased, or even just picked up off a desk: and many people, including the television concessionaire, had access to the nurses' "Kardex." Some of the nurses also feared that the dots could be put on the wrong card, or dislodge and stick onto a different card, and reports of similar errors had circulated among the nurses.

This potential danger was illustrated by the "Kardex" of a Medicaid patient named Daisy S., who died at the hospital on January 5, 1982. The card, which was preserved by a nurse, had two purple dots affixed to it. The grand jury was not able to determine the origin of either dot because all of the doctors who were significantly involved in treating Mrs. S. denied any knowledge of these dots. They were also divided over whether she even had any condition which was necessarily terminal. The nurses could not attribute the "no-code" designation to anyone. The testimony presents no reasonable explanation why any patient would have been intentionally "no-coded" more than once. If the second dot was placed or fell on Mrs. S.'s "Kardex" by accident, it could have just as readily ended up on the file of some other patient who would otherwise be resuscitated.[4]

One other aspect of the DNR system at this hospital that was particularly troublesome to the nurses was the fact that they were responsible for documenting the decisions which the doctors were unwilling to put in writing. As the testimony of Daisy S.'s physicians vividly demonstrated, the doctors were able to deny any knowledge of questionable "purple dot" orders. If anyone was to be held accountable, it would very likely be the nurses who actually put the dots on the files. The potential for shifting blame on that basis was highlighted by the testimony of the chief of surgery — the original proponent of the color-coding system — who told the grand jury that the oral "no-code" directives issued by the physicians were nothing more than "suggestions, if you will, to the nurse . . . [who] is perfectly at liberty to call in the code if she desires to call in the code."

This latter statement is not consistent with the weight of the credible testimony of the nurses and other physicians concerning standard hospital protocol. For example, nurses were not even permitted to dispense aspirin without the

[4] The occasion to resuscitate Mrs. S. did not arise. She was found dead, apparently from sepsis, a blood infection, when a nurse entered her room during routine rounds.

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permission of a physician. The nurses at Maria M.'s bedside who did not call in a "Code 33" were following what they reasonably perceived as the order of the student whom the hospital left in charge of making medical decisions. They cannot in fairness be criticized for not overruling their superior, especially where hospital policy made it impossible for them to authoritatively determine, then or ever, whether a responsible, licensed physician had ever left a DNR order, let alone why it was made or with whose consent.

Part III: The State's duty to recognize and address the DNR issue.

In March of 1983, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical Research published a lengthy report entitled, "Deciding to Forego Life-Sustaining Treatment." The report does not remotely support concealing or distorting the responsibility for decisions not to resuscitate patients, but it does confirm that the medical profession is legitimately concerned about the legality of such decisions. Both the report, and a commission consultant who testified before this grand jury, have emphasized that the absence of explicit legal recognition of "do not resuscitate" orders as a valid medical option discourages many physicians from giving them, despite the fact that they are almost universally regarded within the profession as medically and ethically justified under carefully limited circumstances.

This uncertainty as to the legality of DNR orders was described by the consultant as particularly acute in New York, attributable in part to the prevalence of civil litigation and in part to the broad discretion vested in dozens of independent local prosecutors. He further suggested that this grand jury was "part of the problem" because of the erroneous perception that this investigation was initiated, in the words of the President's Commission, because the "Attorney General's Office disapproved DNR orders being written for elderly, incompetent patients." President's Commission Report at 238.

The President's Commission did not propose specific legislation or rules. Rather, it cited with approval the growing number of hospitals and medical societies which, in one case in consultation with a local bar association, are currently codifying and improving the way in which decisions not to resuscitate are reached. The Commission essentially concluded that so long as the operative standards reflect the appropriate values — recognition of the patient's right to self-determination; medical commitment to maximizing the patient's physical well-being; and equity among patients similarly situated — the decision-making process will operate best without legislative constraints or judicial second-guessing. That conclusion, however, is premised upon hospitals having "an explicit policy on the practice of writing and implementing DNR orders. In the absence of an established mechanism, decision-making might fail to meet the requirements of informed consent or the responsibility for making and carrying out the decision might be assigned to an inappropriate person." *Id.* at 248-49.

We have found that the established mechanism, at least at this Queens hospital, not only failed to satisfy those basic concerns but actively subverted them by discouraging discussion and diffusing accountability. It is that finding which leads us to recommend State-imposed safeguards for the decision-making process.

We believe that the State, without prescribing or second-guessing medical or ethical judgments in individual cases, can and should establish such procedural safeguards. The federal government has recently promulgated DNR guidelines for the 172 medical centers operated by the Veterans Administration and the 12,000 physicians, 30,000 registered nurses and 30,000 aides and licensed practical nurses employed by it throughout the country. The premise of the Veterans Administration guidelines is that while the essential function of a hospital is to save lives, there are, in the case of a terminal illness, legitimate medical and humanitarian decisions which can be made concerning the moment and mode of death, especially when the patient asks that his suffering not be prolonged unnecessarily. The specific protocols are left to individual facilities or regional groups, but each is required to promulgate general policy standards and definitions of terminal illnesses; to take cognizance of the wishes of the patient, or, if he is incompetent, of his family or other surrogate; and, most specifically, to assure that if a "do not resuscitate" decision is reached, "the order *must be written* into the patient's medical record by the attending physician, rather than a house officer or resident" (emphasis in original). The full text is annexed to this report as Appendix I.

The New York State Medical Society has developed similar guidelines concerning the decision not to resuscitate. They are not binding, but are designed to encourage hospital medical staffs and governing bodies to be sure that the determination is made by an attending physician, after discussion with appropriate supervisory members of the hospital staff, and based upon sufficient knowledge as to the seriousness of the patient's medical condition. These guidelines provide that if a patient is capable of making a judgment, the decision not to resuscitate should be made jointly by both the physician and the patient; and that if the patient is incapable, close family members should be consulted. As in the Veterans Administration guidelines, there is a specific provision that once the decision is reached, it "shall be written as a formal order by the attending physician" and "the facts and circumstances relevant to this decision shall be recorded by the attending physician in the progress notes. A verbal or telephone order cannot be justified, and should not be done." The full text is annexed as Appendix II.

Despite these guidelines, the president-elect of the Society testified, many physicians still do not feel comfortable writing such an order in the absence of official recognition of the DNR decision as a legitimate medical

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option. He stated that while the Society does not consider it desirable for government to tell physicians what specific circumstances justify the writing of "do not resuscitate" orders, it would be altogether appropriate for the State to codify the Society's standards as to the decision-making process and, in particular, its strict ban on verbal orders.

The New York State Hospital Association and its Greater New York counterpart have also studied the matter, and unanimously concluded, in the words of its representative, "that it would be far better for everyone concerned if there was a clear set of regulations and guidelines." In 1982, the Board of Governors of the latter group explicitly recognized that it was "simply unfair" for a nurse to be put in the "untenable position" of having to follow an unwritten "no code" order from a physician without any legal guidelines. The Board of Directors accordingly directed the Greater New York Hospital Association's vice-president to write to the State Commissioner of Health to urge regulatory guidance. The letter noted the Medical Society guidelines, stressed the Association's willingness to participate in the rule-making process, and specifically asked the Commissioner to refer the matter to the State Hospital Review and Planning Council. A similar letter was sent by the president of the State Hospital Association. No official response was ever received.

We believe that the public interest urgently warrants a governmental response to these concerns. We believe this response should reflect the reality that "do not resuscitate" orders are regularly given by responsible physicians in circumstances regarded as medically and ethically appropriate and should expressly recognize the prevailing legal view that carrying out such an order does not, in and of itself, violate the criminal or civil law. Responsible physicians should not have to ignore their own best medical judgments or the wishes of their suffering and terminally ill patients out of an unjustified fear of legal consequences. At the same time, the enormous significance of such life-and-death decisions cannot be minimized, and appropriate procedures must be established to assure that they are not made carelessly, unilaterally or anonymously.

We accordingly propose the following recommendations:

RECOMMENDATIONS

The Grand Jury proposes the following legislative, administrative and executive action in the public interest:

1. WE RECOMMEND that the State Legislature enact basic standards to regulate the procedures by which physicians decide whether cardiopulmonary resuscitation should be withheld from terminally ill patients, and authorize and direct the Commissioner of Health to promulgate specific regulations to implement and enforce such standards.

This legislation should expressly acknowledge that DNR decisions are unavoidable under the current state of scientific and medical technology, wherein the dying process can be prolonged against the wishes of the patient or his family and beyond the point of any medical or ethical justification.

Further, without necessarily attempting to define the circumstances under which such decisions may be appropriate, the legislation should formally recognize the prevailing legal view that withholding cardiopulmonary resuscitation does not, in and of itself, violate the criminal or civil law.

At the same time, the significance of such DNR decisions, and the demonstrated potential for abuse, require governmental safeguards to assure that these decisions are not made carelessly, unilaterally or anonymously and that they are accurately and permanently documented. Therefore, the legislation should establish, at a minimum, the following basic standards:

1. that such decisions shall be reached jointly by a responsible, licensed physician and the patient or, if the patient is not competent, a family member or other appropriate surrogate;
2. that such decisions shall be made only after the physician has, with a reasonable degree of medical certainty, diagnosed the underlying illness as incurable or untreatable and expected to result in imminent death;
3. that the patient or his surrogate shall be meaningfully apprised of the nature of that illness and its consequences;
4. that if an affirmative decision is reached to withhold cardiopulmonary resuscitation, an order to that effect shall be entered permanently in writing on the medical chart of the patient by a licensed physician who participated in the decision-making process; and
5. that such a decision shall be readily revocable by the physician or the patient or surrogate in the event of a remission or for any other reason.

2. WE RECOMMEND that the Commissioner of Health, pursuant to his already existing statutory authority and pending the enactment of the legislation proposed in Recommendation 1 above, promulgate regulations embodying the minimum basic standards enumerated in that recommendation.

These standards can be promulgated, for example, by appropriate amendment of the "Patients' Rights" provisions of the rules and regulations of the Department of Health. 10 NYCRR §405.25. These provisions already set forth the rights of hospital patients to receive complete current information about their diagnosis, treatment and prognosis; to receive information necessary for them to give informed consent to the proposed method of treatment; and to be able to intelligently choose to refuse such consent where it is lawful to do so. These rights can readily be extended to situations where the diagnosis is of an illness which is reasonably certain to result in imminent death; where the proposed course of treatment involves withholding the use of cardiopulmonary resuscitation; and where the patient or his surrogate is called upon to consent or refuse to

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consent to such a decision. The further requirement of memorializing the DNR decision on the patient's chart is merely designed to assure that the diagnosis has been responsibly arrived at and discussed, and that the patient's right to self-determination has been honored.

3. **WE RECOMMEND** that the Commissioner of Health further consider whether additional regulatory safeguards should be adopted to assure accountability in this decision-making process, and, if necessary, hold public hearings to assist him in developing such guidelines. Among the additional safeguards which should be considered are:

1. the extent to which the physician with primary accountability for making the decision not to resuscitate should be obligated, before writing the DNR order, to consult with or seek approval from other members of the hospital staff, particularly in cases where more than one physician has treated the patient:
2. the extent to which that order should be subject to periodic review, and by whom; and
3. the extent to which the entire decision-making process and the identity of the other participants should be memorialized in writing.

4. **WE RECOMMEND** that the Governor stimulate dialogue and coordinate cooperation among the various branches and agencies of government, and between them and the medical profession and the public at large, so that the profound issues surrounding the use of cardiopulmonary resuscitation can be fully discussed, understood and evaluated, and any potential abuses eliminated.

William A. Gallagher
Foreman

Dated: Queens. New York, February 8. 1984

APPENDIX I

Veterans Administration
Department of Medicine and Surgery
Washington, D.C. 20420 August 25, 1983

TO: Regional Directors; Directors, VA Medical Center Activities, Domiciliary, Outpatient Clinics, and Regional Offices with Outpatient Clinics

SUBJ: Guidelines for "Do Not Resuscitate" (DNR) Protocols within the VA

1. As it has in the past, the Veterans Administration remains committed to the principle of supporting and sustaining life, employing new life-saving or life-supporting techniques and therapeutic measures in so doing. However. medical science has made us realize that in some instances the implementation of therapeutic decisions and the application of medical technology may not cure a patient's disease or disability or reverse a patient's course. Some patients who suffer from a terminal illness and are incurable may reach a point where application of additional measures would become not only unwanted but medically unsound. In such cases, the physician is seen as not preventing death, but merely deferring the moment of its occurrence. The significant medical problems then are no longer therapeutic, in the strict sense of curing or treating. but rather ones of choice among degrees of treatment, involving decisions relating to control over the moment and mode of dying. In this connection, the responsible physician faces the problem of determining that continued maximal efforts constitute a reasonable attempt at prolonging life or that the patient's illness has reached such a point that further intensive, or extensive, care is in fact merely postponing the moment of a death which is otherwise imminent.
2. The basic policy of the Veterans Administration continues to be that of providing the highest quality medical care to its patients and beneficiaries, with the objective of sustaining life and practicing in conformity with the highest ethical and medical standards. It is imperative that our Medical Centers and their professional staffs and personnel remain committed to this purpose. However, this commitment should not be so strong as to overwhelm a dying patient's decisions or undermine his/her well-being or his/her right of self-determination.
3. Therefore, it is appropriate that Medical Districts and/or individual Medical Centers consider for adoption protocols for application within that Medical District/ Medical Center, to deal with the issues involved when terminally ill patients request that Do Not Resuscitate (DNR) orders be placed in their medical records and/or that they not be resuscitated in the event of a cardiopulmonary arrest. Even though such a protocol may have been adopted, it will continue to be VA policy that CPR will be administered to every patient who sustains a cardiopulmonary arrest, where the medical record does not contain a DNR order that fully complies with the Medical District/Medical Center established policy. However, it is acknowledged that there will be those cases where, in the exercise of sound medical judgment, a licensed physician who knows the patient may appropriately give an instruction not to institute resuscitation at the bedside of a patient who has just experienced an arrest. Such cases would involve patients who were considered terminal. where death was imminent or expected and where resuscitative efforts would most likely have been fruitless. It may be appropriate to communicate these concerns to physicians responsible for the immediate care of the patient. in the absence of the physician who knows the patient.

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4. DNR protocols established by VA Medical Districts/individual Medical Centers should contain certain specific items:
   a. An introductory policy statement which sets the tone and delineates specific ethical, legal and medical considerations that may apply;
   b. Specific definitions of such terms or phrases as DNR, resuscitation, terminal illness, and imminent death;
   c. A patient classification scheme, to delineate the class of patients to whom the policy applies;
   d. A description of the patient's (or patient's surrogate's i.e., legally appointed guardian's or representative's) role, with respect to the competent, the incompetent, and the comatose patient, as well the patient hospitalized within a state which has a "Natural Death" or "Death with Dignity" statute;
   e. A description of the family role, where it is relevant;
   f. Requirements for consultation, consensus, or committee involvement;
   g. Requirements for the DNR order itself and who may write it;
   h. Requirements for the accompanying note in the Progress Notes and who may write it;
   i. Limits for time duration of the DNR order and provisions for its review;
   j. Requirements for other or additional medical care, short of resuscitation; and
   k. Requirements for flagging or otherwise highlighting the medical record in such a way as to indicate the entry of a DNR order therein.

5. The following suggestions or recommendations are made with respect to the items listed above:

Definitions:

The terminally ill patient may be defined as one whose underlying condition is considered to be medically incurable or untreatable, in terms of currently available technology, and whose death as a result of the natural history of his/her disease process or medical problem is considered imminent, that is, expected to occur during the course of the current hospitalization. In addition the definition might also apply to those situations where the physician determines that resuscitation would be of no benefit to the patient, because the natural course of the patient's medical condition would result in death imminently and the institution of resuscitative measures, if successful, would only postpone the moment of death for a brief period of time, that is for matter of a few hours or days.

Patient's Role:

Where the patient is competent and alert, and understands the implications of his/her diagnosis and prognosis, the DNR decision should be reached by the patient after discussion with the physician primarily responsible for his/her care. If the patient requests that a DNR order not be written, or instructs that resuscitative measures should be instituted, no DNR order should be written or considered by the treating team.

The patient should be encouraged to discuss the subject with family members before making this decision. However, there are some situations where a competent, alert patient might for one reason or another elect not to inform family members of this decision nor to seek their concurrence. Under the circumstances, patient privacy and confidentiality require that those wishes be respected and honored and that the family not be informed or involved. However, the patient should still be encouraged in this circumstance to involve the family in the decision.

Where the patient is comatose or otherwise incompetent, or incapable of making his/her decision, the decision should be reached after consultation with the patient's surrogate. or in the absence of such an individual, appropriate family member(s) and the physician.

Should the patient's surrogate or family member(s) disagree with the DNR order, no such order will be written. In the event there is question as to the patient's competence, psychiatric consultation should be obtained. Should the responsible physician feel that he/she cannot in good conscience and sound medical judgment comply with the patient's (or patient's surrogate's or family's) wishes regarding resuscitation, that physician should arrange to transfer the patient's care to another physician capable of appropriately and skillfully handling the patient's medical problems, who can so comply.

In situations where an incompetent or comatose patient has no surrogate (legally appointed guardian or representative) or family members, and the treating staff (including the attending physician) feels that a DNR order is appropriate, consultation should be undertaken with the Director/Chief of Staff and the District Counsel for appropriate court order to be obtained, permitting such a DNR order.

States With "Natural Death Laws:"

If the patient resides in a state where statute permits a directive to an attending physician regarding "death with dignity," "right to die," "living will," or similar provisions, prior exercise of that statutory right by a patient may be considered as evidence of that patient's wishes regarding DNR orders, prior to the occurrence of coma or incompetence. However, the absence of such a declaration or directive should not be considered as an indication that the patient would not have wanted a DNR order written unless there is evidence of his/her *specific* wishes in that regard. Where the relevant state statute provides additional requirements to be met

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regarding diagnosis, prognosis, informing the patient, recordation, witnesses, etc., the requirements of state law should be followed, where they are not inconsistent with the provisions of this circular.

Consultation and Other Physician Involvement:

The individual with specific responsibility for determining the propriety of considering a DNR order in a particular case is the senior attending physician in charge of the patient's care, *not* a house officer. In this context, the ultimate DNR decision should be reached by the patient after discussion with the senior physician in charge of his/her care (staff or attending physician). Medical decisions regarding the patient's diagnosis or prognosis should be reached by a consensus of the medical treatment team. In larger hospitals, this will mean the attending or staff physician, involved house staff, and whatever consultants may be involved in the patient's care (oncologists, cardiologists, etc.). In smaller hospitals, where house staff is not involved with the patient's care and consultants of that level are not readily available, the decision should be reached by the patient's attending or staff physician and the Chief of Service/Chief of Staff. In those situations where there may be some doubt concerning the propriety of a DNR order or the accuracy of the patient's diagnosis or prognosis, a medical ethics or prognosis committee or similar body may convened on an ad hoc basis to help resolve the problem.

Entry of the DNR Order:

After it has been determined that a DNR order is appropriate in a particular case and the foregoing requirements have been met, the order *must be written* into the patient's medical record by the attending physician, rather than a house officer or resident. A verbal or telephone order for DNR is not justifiable as sound medical or legal practice. Once the order has been entered, it is the responsibility of the attending physician to ensure that the order and its meaning are discussed with appropriate members of the hospital staff, particularly the nursing staff, so that all involved professionals understand the order and its implications.

Accompanying Entry In The Progress Notes:

At the time a DNR order is written, a companion entry should be made in the progress notes, which includes at a minimum the following information: the diagnosis, the prognosis, the patient's wishes (when known), the wishes of patient's surrogate or family member(s), where relevant, and the consensual decisions and recommendations of the treating team and consultants, with documentation of their names. In addition, there should be some reference concerning the patient's competency, where the decision was based on his/her concurrence, and applicable documentation of any "informed consent."

Where the competent patient has requested that his/her family not be involved in or informed of his/her decision, as noted above, the patient's decision and request for confidentiality should be documented in the medical record by a disinterested third party, not a member of the treatment team, e.g., a patient ombudsman or representative, a representative of Medical Administration Service, etc.

Review of the Order:

The protocol should specify the process of review for such a DNR order, and how often review should be carried out. Obviously, any time there is a significant change in the patient's medical condition, the order would automatically become void. As in any medical situation, a DNR order may be rescinded at any time by the physician at the specific request of the patient, patient's surrogate, or family member.

Related Medical Care:

It is important that all involved understand the fact that a DNR order is compatible with maximal therapeutic efforts short of resuscitation, and that the patient is entitled to receive vigorous support in all other therapeutic modalities, even though a DNR order may have been entered. It may be appropriate then, in these circumstances, to write onto the order sheet those medical efforts which will be maintained to relieve suffering and assure patient comfort, including basic nursing care (body cleanliness, mouth care, positioning); adequate analgesia; suction; intake for comfort, including hydration; and oxygen for comfort. Merely because a DNR order has been entered into a patient's record does not mean that there is justification for ignoring the patient or providing him/her less than humanistic care and concern for his/her welfare and comfort.

Conclusion:

DNR protocols can be developed to effectively deal with the trauma and suffering that frequently accompany the circumstances in which such orders are written. These protocols must give fair consideration to the patient's medical needs, the social and psychological needs of the patient's family, the legal rights and responsibilities of physician and patient, the professional needs of hospital administration and staff, and applicable state law. With the assistance of all involved, and District Counsels, sound protocols can be developed and implemented. Obviously, no patient shall be considered for a DNR order in anticipation of possible problems such as might occur as the result of unforeseen difficulties during hospitalization or as a result of surgery or in any case where the patient is not terminally ill. Under no circumstances should DNR orders be written where they are in compliance only with a request for "assisted suicide" or voluntary euthanasia. "Do Not Resuscitate" does not mean that

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the medical staff will take any affirmative steps to "hasten the patient on his/her way." All parties including all levels of providers should try to provide and improve acceptable therapeutic options available to the dying patient.

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APPENDIX II

Guidelines for Hospitals and Physicians on "Do Not Resuscitate," Medical Society of the State of New York

The following are intended only to be guidelines for physicians and hospitals. Hospital medical staffs and governing bodies are encouraged to develop policies consistent with their respective by-laws and rules and regulations.

Definition

DNR (Do Not Resuscitate) means that, in the event of a cardiac or respiratory arrest, cardiopulmonary resuscitative measures will not be initiated or carried out.

Background

1. An appropriate knowledge of the serious nature of the patient's medical condition is necessary.
2. The attending physician should determine the appropriateness of a DNR order for any given patient.
3. DNR orders are compatible with maximal therapeutic care. A patient may receive vigorous support in all other therapeutic modalities and yet a DNR order may be justified.
4. When a patient is capable of making his own judgments, the DNR decision should be reached consensually by the patient and physician. When the patient is not capable of making his own decisions, the decision should be reached after consultation between the appropriate family member(s) and the physicians. If a patient disagrees, or. in the case of a patient incapable of making an appropriate decision, the family member(s) disagree a DNR order should not be written.

Implementation

1. Once the DNR decision has been made, this directive shall be written as a formal order by the attending physician. A verbal or telephone order for DNR cannot be justified as a sound medical or legal practice.
2. It is the responsibility of the attending physician to insure that this order and its meaning are discussed with appropriate members of the hospital staff.
3. The facts and considerations relevant to this decision shall be recorded by the attending physician in the progress notes.
4. The DNR order shall be subject to review at any time by all concerned parties on a regular basis and may be rescinded at any time.

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