I. **PURPOSE**

To specify the procedures to follow when the most appropriate medical therapy would be not to attempt resuscitation of a patient in the event of a cardiopulmonary arrest.

II. **PRINCIPLES**

1. Maintaining life is a major goal of health care. Hence, cardiopulmonary resuscitation (CPR) has historically been instituted automatically when a cardiac and/or respiratory arrest occurs. However, while CPR is appropriate in the prevention of death of patients who would wish to live and for whom CPR has a reasonable likelihood of success, it is not indicated when the patient or surrogate in conjunction with the patient's physician decides to forgo CPR as a result of the patient's underlying disease processes, especially when the chance of successful resuscitation and recovery are remote.

2. Adults who possess decision-making capacity have the right to direct the course of their own medical treatment. Therefore, they may refuse these automatic life-saving procedures as long as they fully understand the implications of this choice. Resuscitative efforts against the patient's wishes in these circumstances may violate an individual's legal and/or ethical right to self-determination and constitute battery.

3. Physicians must provide accurate and adequate information to their patients/appropriate surrogates about the disease, prognosis with or without treatment, as well as available treatment options and risks, including the efficacy or lack thereof of CPR, so that patients can make informed decisions on their own behalf.

4. The decision to forgo resuscitation in the event of cardiopulmonary arrest has no automatic additional implication for any other treatment decision.

5. Healthcare professionals must make every effort to relieve the terminally ill patient's pain and suffering and to emotionally support the patient, as well as the family and concerned others.

6. Healthcare professionals are not required to provide medical treatment which violates their conscience or professional judgment, so long as they are able to assist patients or
patients' surrogates in arranging for alternative care under such circumstances.

III. POLICY

1. Cardiopulmonary resuscitation must be initiated for patients who suffer cardiac and/or pulmonary arrest unless the Procedures (below) for a Do Not Attempt Resuscitation (DNAR) order have been completed.

2. The decision to forego CPR by a competent adult patient with decision-making capacity will be followed.

3. If the patient lacks decision making capacity or has been declared legally incompetent, the decision to forego CPR by the person lawfully authorized to consent for the patient (such as the minor's parent or legal guardian, or the patient's conservator, spouse, or attorney in fact pursuant to a Durable Power of Attorney for Healthcare or Advance Healthcare Directive), will be followed unless the decision appears to be medically inappropriate for a minor patient or appears to be in violation of the patient's advance directive, previously stated words, presumed preferences, or the best interest of the patient. In these latter circumstances, the physician is to consult with the Office of Risk Management at ext. 5676 (pager 714-318-2335).

4. If the physician feels ethically unable to comply with the patient's wish to forego CPR or to have it, it is the physician's responsibility to attempt to resolve the conflict. (See dispute resolution section of Policy: Life Sustaining Treatment IV.E.)

5. Oral orders for DNAR are not acceptable except temporarily in emergency circumstances.

6. DNAR Orders in the Operating Room and Post Anesthesia Care Unit (PACU) and during Interventional Radiologic and other similar procedures:
   a. Intraoperative arrest is the cessation of effective circulation and/or effective respiration during anesthesia and surgery. Correcting this condition may require cardiac compression, artificial ventilation and other resuscitative measures.
   b. Consent for DNAR, is to be separate from the consent for surgery or other procedures.
   c. Treatment for intraoperative arrest may, like other treatments, be refused by competent patients or by the appropriate surrogate of patients who do not have decision-making capacity.
   d. A patient's decision to refuse intraoperative resuscitation does not imply limits on other forms of care, such as intensive care. A DNAR order does not prohibit use of effective therapies to counter adverse pre-arrest effects of anesthesia.
   e. When a patient with a DNAR order requires a surgical or other intervention, the surgeon and an anesthesiologist, must discuss with the patient or surrogate the handling of the DNAR order with additional discussion by the attending, if appropriate. Discussion should include information about the goals of surgery or other intervention for the patient, about the likelihood of requiring resuscitative measures due either to the patient's pre-existing condition and/or related to the anesthesia management required, and possible outcomes and risks with and without resuscitation. If cardiovascular instability would require lighter anesthesia in the presence of a DNAR order than if there were a CPR order, the patient should be so informed.
   f. If the patient desires to have a DNAR order honored during surgery, a DNAR Order, including the Basis and Justification, must be completed by the surgeon.
and/or attending physician or anesthesiologist and attached to the preoperative
order form. This order covers treatment in the operating room and recovery
room. If the DNAR order is not rewritten prior to surgery, it is assumed to be
suspended until rewritten postoperatively. Whenever possible this should be
documented by an explicit order for CPR in operating and recovery rooms.

g. The surgeon performing the surgery shall advise relevant staff regarding plans to
honor or to suspend a DNAR order in the operating room and/or recovery rooms.
h. Physicians and other health professionals who, for reasons of conscience, are
unable to honor a patient's refusal of resuscitation should withdraw from the case
so that others can assume care. The physician must assure the patient that he/she
will not be abandoned, and that the DNAR order will be honored.

8. Transfers To Other Facilities

When a patient with a DNAR order is to be transferred to another facility, the
continuance of the order shall be discussed by the attending physician with the patient or
surrogate and the accepting physician. If it is the wish of the patient/surrogate to have
the DNAR order remain in effect during and after transfer, the attending shall document
in the transfer note that the patient currently has a DNAR order and that the
patient/surrogate wishes the DNAR order to remain in effect on transfer to the accepting
facility and unless it has been rescinded in the interim upon transfer back to this hospital
until the DNAR order can be reviewed.

REFERENCES

The Council On Ethical and Judicial Affairs of the AMA C.A.H.H.S., Chapter 5.3:(4), 1991. JCAHO -
Standard R.P. 4.4; 1992; "Resuscitative, ventilatory, and oxygenation support equipment is available for
patients of all sizes served by the hospital."

ACCP/SCCM Consensus Panel. Ethical and moral guidelines for the initiation, continuation, and
withdrawal of intensive care. Chest (1990); 97:949-958

Date Written; 11/96
Previous Revisions: 03/99, 03/04, 08/07, 02/08

ATTACHMENT: Do Not Attempt Resuscitation Orders

AUTHOR: UCI Medical Ethics Committee

APPROVALS: Reviewed/No Changes 02/27/11
Medical Ethics Committee 03/26/08
Critical Care Committee 04/17/08
Policy Review Committee 05/20/08
Performance Improvement Committee 06/11/08
Medical Exec Committee 06/16/08
Governing Body Committee 06/16/08
Attachment “A”

PROTOCOL AND DOCUMENTATION

1. The patient's attending physician must write and sign the initial DNAR order on the DNAR order form, which details inclusion or exclusion of specific items during acute resuscitation efforts. The DNAR order refers to acute resuscitation CPR only, and does not preclude any other treatment. The specific limits of care should be detailed. Simply writing "DNAR" is not acceptable. It is vital that the written orders are not misinterpreted. This may be facilitated by asking the involved staff to read the order directly for clarity. Specific orders must be written if other treatments (e.g., pre-arrest interventions such as pressors for hypotension, antiarrhythmics, oxygen or ventilation for dyspnea) are to be limited or withheld.

2. When a resident is acting as a surrogate for the attending physician, the orders should be confirmed by the nurse accepting the order indicating that this order represented a specific and direct oral communication with the attending physician or, if he/she is unavailable, by the attending physician covering for him or her; and, further the orders should be countersigned by the attending physician of record, usually within 24 hours.

3. The circumstances surrounding the initiation of the DNAR order must be documented on the DNAR order sheet. This documentation note must be written or countersigned by the attending physician. When the attending is unavailable, the house officer responsible for the patient's treatment, with the verbal concurrence of the attending, may write the progress note. The attending must concur with this note within 24 hours by signing both parts of the DNAR Order Sheet. If the attending no longer concurs with this note, he/she should indicate why at that time, and make appropriate changes to the DNAR orders. This documentation must include at least the following:
   a. Diagnosis and condition;
   b. Prognosis;
   c. Patient's capacity for decision making;
   d. Summary of discussions with patient, family, and/or concerned others, as appropriate.
   e. Any available patient preference documents (e.g., Durable Power of Attorney for Health Care, Directive to Physicians, Living Will, Advance Health Care Directive);
   f. Basis of decision to forgo resuscitation;
   g. Delineation of any other treatment limitations: Whenever a DNAR order is written, it is generally advisable to write orders specifying what should be done if the patient should develop hypotension, an arrhythmia, or respiratory embarrassment or distress. This is often very helpful to others caring for the patient including consultants, physicians, house staff and nurses.

In addition, a summary of relevant consultation(s) with other physicians, nurses, social workers, ethics consultant or Ethics Committee should be included.

4. Exceptions to explicit patient consent for DNAR.

The physician should refer to the University of California, Irvine Healthcare Informed Consent Policy for exception to the general requirement of obtaining a patient's informed consent.
5. Once written and appropriately documented, the ordering physician must promptly inform the house staff, the charge nurse and other appropriate health care providers involved in the patient’s care that a DNAR order has been written.

6. A DNAR order should be reviewed (and the order renewed on the order sheet, if appropriate).
   a. at least every two weeks, or
   b. when requested by the patient, or his/her surrogate decision-maker(s), or
   c. when requested by any health care professionals involved in the patient's care or
   d. when a different attending physician than the one who concurred in the original DNAR order, assumes responsibility for the care of the patient; or
   e. when a patient previously lacking decision-making capacity regains this capacity; or
   f. when there is substantive improvement in the patient's prognosis.
   g. at discharge and upon readmission
   h. when the length of stay is significantly increased

7. A DNAR order must be revoked at any time when a patient requests that the order be revoked. If this occurs, a single line should be drawn through the current DNAR order and the word “revoked” written including date, time and signature.

8. After routine review of a DNAR order, House staff involved in the on-going care of the patient may renew a DNAR order on the order sheet after consultation with the patient's attending physician. When a resident is acting as a surrogate for the attending physician, the orders should be confirmed by the nurse accepting the order indicating that this order represented a specific and direct oral communication with the attending physician or, if he/she is unavailable, by the attending physician covering for him or her; and, further the orders should be countersigned by the attending physician of record, usually within 24 hours.

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<thead>
<tr>
<th>RESPONSIBLE PERSON(S)/DEPT</th>
<th>PROCEDURE</th>
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<tbody>
<tr>
<td>Physician</td>
<td>A. Assessment of patient's decision-making capacity to understand and to consent to a DNAR order.</td>
</tr>
<tr>
<td></td>
<td>1. A person may be legally competent (age of majority not under a conservatorship) and lack decision-making capacity.</td>
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<td>2. Decision-making capacity is dependent upon the patient's ability to understand the nature and severity of the illness, and ability to make informed and deliberate choices about the consequences of refusing or agreeing to cardiopulmonary resuscitation.</td>
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<td>3. A previous finding of legal incompetence does not imply automatically a lack of decision-making capacity. A patient may have a conservator but not have been denied by the court the right to make health care decisions.</td>
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<td>4. If the patient's decision-making capacity is in doubt, a consultation from Psychiatry or Neurology, may be requested. In addition, when feasible the patient's family or friends should be asked their opinions.</td>
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B. If the patient possesses adequate decision-making capacity and no disagreement exists between the patient and the attending physician, the DNAR order may be written by following the protocol and documentation described above.

If a conflict exists between a competent informed patient and the family, the family will be informed that the patient's wishes will be followed unless the patient changes his/her mind. Whenever possible, the family will be offered support and assistance to attempt to understand or to accept the patient's choices.

C. If a patient currently lacks decision-making capacity and either:

1. has previously expressed preferences in a valid Advance Health Care Directive or Durable Power of Attorney for Health Care and has not rescinded the document subsequently, these preferences shall be followed; unless the attending physician has reason to believe that the document no longer reflects the patient's wishes;

   OR

2. has previously expressed preferences verbally to the attending physician, to other physicians or health care providers, to the family or concerned others, these preferences shall be followed unless there is reason to believe these statements no longer reflect the patient's wishes; The patient's stated preferences should be documented in the patient chart;

   OR

3. has not previously made oral or written statements that would allow substituted judgment about resuscitation, and the attending physician and the patient's family and concerned others agree that a DNAR order would serve the patient's best interest, this decision shall be followed.

D. If a conflict exists, the Office of Risk Management should be consulted (ext. 5676 or pager 714-318-2335).

E. If the patient is a minor:

1. Under the law a person becomes legally competent when eighteen years of age (or earlier, if self-sufficient, emancipated, or if the minor patient is seeking treatment for certain medical conditions specified by law). However younger patients should participate in the decision to initiate a DNAR order in a manner appropriate for their age and maturity.

2. The decision of the parent(s) should be followed in all but rare circumstances, but the assent of the child must be sought if the child has decision making capacity.

3. A minor should not be denied medically appropriate treatment. If the minor's parents desire to withhold or
withdraw medically appropriate care, the attending physician shall contact the Office of Risk Management for consultation (ext. 5676 or pager 714-318-2335).

4. If conflicts exist between parents, between parent(s) and child, between parent(s) and physicians, between child and physician, every effort to resolve these must be made. If no resolution is reached within a reasonable period of time, the Risk Management Office is to be contacted for assistance and if appropriate, the Ethics Committee may be consulted.

F. Wards or Conservatees of the Orange County Public Guardian may not have DNAR orders without prior discussion with the Public Guardian. Telephone: (714) 567-7660 (Monday-Friday, 8:00 A.M. - 5:00 P.M.); or (714) 834-7200 (Monday-Friday, after 5:00 P.M., weekends and holidays.)

G. Physicians contemplating DNAR orders should discuss this possibility with other members of the health care team involved in the care of the patient.