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E-Mail

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Harold B. Bob, M.D.
Suite 200
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Dear Dr. Bob:

I am writing in response to your inquiry about a hospital's practice of refusing to honor an oral "do not resuscitate" (DNR) order issued by telephone from an attending physician who is not present at the hospital.

According to your e-mail message, "Acute hospitals are routinely by policy refusing to accept verbal DNR orders from physicians." You described situations in which, while you were away from the hospital where one of your patients was under care, you learned of an advance directive or had a conversation with family members that led you to telephone the hospital to issue a DNR order. Yet, your inquiry continued, a nurse declined to accept your oral order, and a house staff physician was unavailable to write an order. You pointed out a prior advice letter from this Office in which we advised that nursing homes had clear legal authority to accept oral DNR orders and, indeed, might be liable for refusing to do so, and you asked whether the legal situation is different in hospitals.

To begin with the factual implication of your inquiry: Only a detailed review of policies would disclose the extent to which Maryland hospitals in fact disregard oral DNR orders made by telephone, and I have no such comprehensive information. I know, however, of hospitals that *do* accept oral DNR orders under the circumstances described in your letter. Consequently, the practice is by no means universal. Yet, to whatever extent it does occurs, it is legally problematic.

The advice letter to which you refer, to Donna M. Dorsey, Executive Director of the State Board of Nursing (October 28, 1999),[1] discussed the various pathways by which a DNR order might be authorized under the Health Care Decisions Act and pointed out the risk to a patient's rights and well-being if facility policies blocked the carrying out of this aspect of health care decision making: "Once a legally authorized decision to forgo attempted CPR has been made, a DNR order should be promptly entered.... [A]ny significant delay in the entry of the DNR order puts the patient at risk of being subjected to the very intervention that has been rejected. A facility's policies and procedures for translating health care decisions into operational orders should honor these decisions, not frustrate them." This reasoning applies as much to hospitals as to nursing homes, and to the actions of attending physicians and other health care professionals.

To be sure, the 1999 advice letter also referred to a regulation, applicable to nursing homes but not hospitals, that explicitly endorses the use of "verbal" (i.e., oral) medical orders, together with a procedure for documenting such orders and later verifying them. The fact that no comparable regulation applies to hospitals, however, does not imply that there is any legal impediment to hospitals' accepting oral orders, including oral DNR orders. To the contrary: The absence of any regulation leaves hospitals free to develop their own policies about oral orders – provided that the policies are consistent with other legal obligations, including the obligation not to impose unwanted medical interventions.

So, for example, I understand that some hospitals have a policy of refusing to accept an oral order (DNR or any other) from a physician *who is physically present* at the hospital, because they prefer the greater precision of written orders when it is quite feasible to get them.[2] There is no legal objection to this policy. Likewise, hospitals are free to fashion their own reasonable criteria for documenting and later authenticating an oral DNR order.

What hospitals may not do, in my view, is categorically refuse to accept a DNR order telephoned in by a patient's attending physician. If such a policy resulted in a patient's being subjected to CPR efforts contrary to an advance directive or other decision validly made under the Health Care Decisions Act, the hospital not only would lose the protection of the

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[1] This letter may be found at the following Internet location: http://www.oag.state.md.us/Healthpol/dnr.pdf

[2] Obviously, such a policy does not apply in emergencies or in the midst of surgery or other procedures.

Act's immunity provision, which requires good-faith efforts to comply with the Act, but also would face a significant risk of liability for battery. Under these circumstances, the hospital would also be subject to adverse regulatory attention.

I hope that this letter of advice, although not an Opinion of the Attorney General, is fully responsive to your inquiry. Please let me know if I may be of further assistance.

Very truly yours,

Jack Schwartz
Assistant Attorney General
Director, Health Policy Development