

July 28, 2000

*Ms. Frances C. Stoner  
Director of Social Services  
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You have asked for my advice regarding the process for implementing “do not resuscitate” (“DNR”) orders in nursing homes. You posed three questions, which I shall paraphrase and address below. A premise of your questions is that the nursing home’s policy calls for CPR to be performed in all cases of arrest, unless a DNR order is on a resident’s chart. In effect, the facility has a “standing order” that CPR be performed.

1. If a resident with intact decision-making capacity decides against resuscitation efforts in the event of a cardiac or respiratory arrest, what should be done if the resident suffers an arrest before a physician enters a DNR order? As you put it, “What does one do during that ‘gray period’ when no order nor contact with the physician has occurred?”

In my view, under these unusual circumstances, CPR should not be attempted. Your question rightly presupposes that, despite an overall “standing order” that CPR be performed, a resident with intact decision-making capacity may decline CPR. The Nursing Home Residents’ Bill of Rights, reflecting common law principles, explicitly grants each resident a right both to participate in planning his or her care and treatment and to “[c]onsent to or refuse treatment ....”<sup>1</sup> Strictly speaking, a DNR order (that is, a order declaring that, contrary to the general policy, CPR is not to be attempted for a particular patient ) is not itself a decision but rather documents a resident’s prior decision to refuse this form of treatment.<sup>2</sup>

A DNR order, like other orders pertaining to the treatment of a resident, ordinarily is to be entered by the resident’s physician. The regulations governing nursing homes are reasonably clear on this point. One pertinent regulation states, for example, that nursing care is to be provided as needed to assure that residents receive “treatments ... as prescribed.”<sup>3</sup> Thus, for a resident with intact decision-making capacity, effective care planning has three stages: an informed consent process culminating in the resident’s decision about the overall direction of care, in light of the resident’s goals and priorities; entry of a set of physician

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<sup>1</sup>COMAR 10.07.09.08C(9) and (11).

<sup>2</sup>A DNR order can also result from a physician’s determination that CPR would be “medically ineffective,” as defined in the Health Care Decisions Act (§5-601(n) of the Health-General Article). This situation, which is not an element of your inquiry, is discussed in an advice letter from this office to Janicemarie K. Vinicky (December 16, 1999), available at [www.oag.state.md.us/Healthpol/index.htm](http://www.oag.state.md.us/Healthpol/index.htm).

<sup>3</sup>COMAR 10.07.02.12O(1).

orders consistent with the resident's decision; and the carrying out of those orders by the nursing staff and other health care professionals at the facility.

This theoretical construct can be made real only if a facility adopts well-designed procedures at each step. In terms of the issue that you present, procedures should be in place to minimize what you aptly term the “gray period” between the time of a resident’s refusal of CPR and the time that a DNR order is entered on the chart. In particular, the resident’s attending physician has a responsibility to be available to give an appropriate order. Documenting in this way the resident’s refusal of CPR is part of the attending physician’s duty to “prescribe a planned regimen of total resident care which is adequate and appropriate to meet the needs of the resident.”<sup>4</sup> If the attending physician is not available in the facility to write the order but is available to give an oral DNR order, the physician should promptly do so.<sup>5</sup> If the attending physician is simply unavailable, he or she has a duty to designate a relief physician, who could issue the order.<sup>6</sup>

Even the most efficiently designed procedures, I acknowledge, might still leave a short gap in time between the resident’s decision and the physician’s entry of a DNR order. In my view, the nursing home is *not* authorized to perform CPR during this period, since doing so would be contrary to the decision of the resident. I reach this conclusion for two reasons. First, the provision of the Health Care Decisions Act that authorizes emergency treatment without consent, §5-607 of the Health-General Article, is not applicable. This provision is aimed at an unanticipated emergency, when the patient “is incapable of making an informed decision” and someone “who is authorized to give the consent is not available immediately.” By contrast, the discussion of code status with a resident involves planning for an anticipated emergency; the resident *is* capable of making an informed decision and has done so by refusing to give consent for CPR. Second, the Health Care Decisions Act makes clear (in §5-613(b)) that, even when a health care provider has declined to comply with a patient’s instructions, the provider is not authorized to provide care to “a competent individual over the objection of that individual.” Performing CPR after the resident has just declined it would do exactly that.

Accordingly, it is my view that a facility’s CPR policy should incorporate a procedure for immediate documentation of a resident’s refusal of CPR. This documentation should be converted into a physician’s DNR order as soon as possible, but even prior to that time, the resident’s refusal of CPR should be honored.

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<sup>4</sup>COMAR 10.07.02.10(G).

<sup>5</sup>As discussed in a prior letter from this office, an oral DNR order is legally valid. Letter of advice to Donna M. Dorsey, Executive Director of the State Board of Nursing (October 28, 1999), available on the web page cited in note 2 above.

<sup>6</sup>Under COMAR 10.07.02.10J, “the attending physician shall make arrangements for the medical care of his patients when he is not available.”

2. Does a resident's refusal of CPR need to be documented in any particular way or be witnessed?

The documentation of a resident's refusal of CPR should be handled in the same way that a resident's wishes regarding other aspects of care are documented, in accordance with customary professional standards. There is no legal requirement for a particular type of documentation. Moreover, there is no requirement for witnesses if, as I understood your question, the context is a discussion with the resident aimed at obtaining informed consent for key aspects of the care plan during the resident's current stay in the facility. Of course, if the discussion involves general advance care planning with the object of creating an advance directive, then the witness requirements of the Health Care Decisions Act need to be adhered to.<sup>7</sup>

3. If a resident lacks decision-making capacity, what process is required prior to the entry of a DNR order?

If the resident had previously designated a health care agent in an advance directive, and the health care agent declines CPR on behalf of the resident, my conclusion and response to your first question apply here. The health care agent's decision should be implemented by a physician's DNR order as promptly as possible, and, in the interim, the health care agent's refusal of CPR should be documented and CPR should not be attempted.

If no health care agent has been designated, the situation is quite different. A surrogate decision maker, as you point out in your letter, may decline CPR only if the resident's attending physician and a consulting physician have certified that the resident is in one of the Act's three qualifying conditions (terminal condition, end-stage condition, or persistent vegetative state). Until that certification is made, CPR should be performed in accordance with the facility's general policy.<sup>8</sup> Once the certification is made, the surrogate may decline CPR if, in the surrogate's judgment, doing so would carry out the resident's wishes or be in the resident's best interest. If there were a gap between the time when the surrogate exercises the authority to decline CPR and the entry of the physician's DNR order, CPR should not be attempted.

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.

Jack Schwartz  
*Assistant Attorney General*

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<sup>7</sup>A discussion of the distinction between informed consent discussions and advance directive preparation is contained in a recent advice letter to Ms. Jean Seifarth (April 25, 2000), also available on the previously cited web page.

<sup>8</sup>As discussed in note 2 above, CPR should not be performed if it is properly deemed to be "medically ineffective."

*Director, Health Policy Development*