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Susan U. Ladwig

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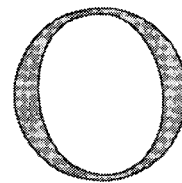
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Comparative Analysis of New Legislation in Florida, Illinois, and Wisconsin on Do-Not-Resuscitate Orders in Non-Hospital Settings

This article focuses on the history and application of one of the newest types of end-of-life decision-making documents.

By Susan U. Ladwig

Susan U. Ladwig, JD, MA, is an associate attorney with the Milwaukee, Wisconsin office of Reinhart, Boerner, Van Deuren, Norris & Rieselbach, S.C., where she is a member of the Employee Benefits Department. Ms. Ladwig graduated magna cum laude from Marquette University Law School in 2001. She was a member of the *Elder's Advisor Journal* for two years, and served as Articles Editor during the 2000-01 academic year.



Over the past twenty years there has been growing patient involvement in decision-making about end-of-life medical treatments. Every state has now given legal recognition to the use of advance directives for end-of-life treatments encompassed in such documents as living wills and durable powers of attorney for health care.¹ The federal government has also endorsed the participation of patients in healthcare decision-making through the passage of the Patient Self-Determination Act that became effective in December 1991 as part of the Omnibus Budget Reconciliation Act of 1990 (Act).² The Act covers all health care facilities that receive Medicaid or Medicare funding such as hospitals, nursing homes, home health agencies, and health maintenance organizations (HMOs). Under the Act, these organizations must provide patients with written information on their rights under state law to accept or refuse medical or surgical treatment, and their right to formulate advance directives regarding future medical treatment in case of their incapacity.³ While there is a continuing debate as to the success of the legislation in enhancing patient autonomy,⁴ the Act recognizes the right to self-determination and the importance of documenting a patient's treatment wishes.

This article focuses on the history and application of one of the newest types of end-of-life decision-making documents to receive statutory recognition by states—a do-not-resuscitate (DNR) order

operative in a non-hospital setting—as recently described in a comprehensive national survey by Charles P. Sabatino.⁵ By specifically examining statutes, health regulations, and emergency medical protocols in Florida, Illinois, and Wisconsin, this article explores how varying conceptual approaches influence the requirements for non-hospital DNR orders as they apply to elderly persons. Besides having distinct approaches to the DNR order, each of these states has recently adopted new statutes, regulations, or protocols for non-hospital DNR orders. The article also presents several cases providing judicial interpretation of statutory standards for DNR orders that address end-of-life issues affecting the elderly. The article concludes with recommendations for elder law attorneys who may be asked to counsel clients regarding the use of DNR orders in coordination with other types of advance directives.

A Historical View of the Use of DNR Orders

“Do not resuscitate”(DNR) or ‘no code’ orders are physicians’ orders which communicate to nursing and hospital staff that resuscitative measures are not be taken in the event a patient experiences a cardiopulmonary arrest.”⁶ Resuscitation treatments are usually distinguished from measures designed to sustain life, such as the use of artificial means of nutrition and hydration or measures to improve ventilation or cardiac function.⁷

Cardiopulmonary resuscitation (CPR) as a treatment for cardiac arrest is a relatively recent innovation and was first described in the medical literature in 1960, according to an article in the *New England Journal of Medicine* that traced the early history of the treatment.⁸ Six years after the first medical report on the treatment, the National Research Council of the National Academy of Sciences recommended instructing all medical and professional paramedical and allied health care personnel in the technique.⁹ By the 1970s, CPR was routinely administered to hospital patients who suffered a cardiopulmonary arrest. However, questions about the unexamined and indiscriminate use of CPR began to surface. In 1974, the National Conference on Standards for Cardiopulmonary Resuscitation and Emergency Cardiac Care reported that CPR was inappropriate in certain cases.¹⁰ A telling article published in the *New England Journal of Medicine* in 1976 suggested “withholding of life-sustaining

therapy, including CPR, from the terminally ill was an open secret in the medical profession.”¹¹

As the medical profession began to reexamine its use of CPR, the 1976 case of *In re Quinlan*¹² brought focus upon the right of patients to refuse medical treatment even though the lack of treatment may result in death.¹³ In this case, a hospital refused a father’s request to remove his adult daughter’s respirator even though she was in a vegetative state with no known cure.¹⁴ In a landmark decision, the Supreme Court of New Jersey recognized that there is a right to die under the unwritten constitutional right of privacy.¹⁵ Within two years of this highly publicized case, attitudes toward end-of-life decision-making began to change, and several states adopted statutes that formally recognized written statements by patients requesting that certain types of medical care be discontinued under certain medical situations.¹⁶

In 1988, New York enacted the first Orders-Not-to-Resuscitate statute after the New York State Task Force on Life and Law discovered that DNR orders were being issued covertly without the consent of the patient or family and that CPR was being given when medically inappropriate.¹⁷ The statute, which was very comprehensive, served as a model for legislation in states addressing the use of CPR and the entry of DNR orders in hospital settings.¹⁸ DNR orders had been openly acknowledged, and since January 1, 1988, all facilities that are accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) must have a policy on withholding resuscitative services.¹⁹

In the medical community, “CPR is the only form of life-sustaining treatment that is provided routinely without consent of the patient.”²⁰ In fact, CPR is provided unless there is a formal DNR order entered on a patient’s chart.²¹ For instance, the New York DNR statute presumes a patient’s consent to CPR unless there is an order not to resuscitate.²² The statutes in seven states (including New York) explicitly state that consent to CPR is presumed in absence of a DNR order or directive.²³ While in most circumstances a patient’s informed consent is legally required for medical treatment, under common law there is an emergency exception to informed consent when the patient is incapable of giving or receiving information.²⁴ In these cases, it is presumed that the patient would consent to treatment.²⁵ Some DNR statutes ignore the common law presumption,

however. For instance, the DNR statutes in Arkansas and Montana explicitly provide that absence of a DNR order or directive creates no presumption about the patient's intent to be resuscitated.²⁶

Several medical articles have questioned the use of CPR as a presumed treatment for elderly persons because of its medical ineffectiveness in certain cases and its overriding disregard for informed consent. One study published in the *New England Journal of Medicine* surveyed the attitudes of 163 elderly women toward CPR. It concluded that "although age alone does not preclude candidacy for CPR, the changed attitudes and values of old people are at least as germane to case selection as are any other considerations."²⁷ Another article published in *The Journal of the American Geriatrics Society* suggested eliminating the presumption for CPR administration for nursing home patients. The study reported limited benefits of CPR for nursing home patients because survival rates were as low as one percent.²⁸ The physicians found that despite CPR in the nursing home, the majority of patients died in the emergency room and most of those who were admitted to the hospital died within five days of admission.²⁹ The authors explained that "[c]urrent policy in nursing homes dictates that CPR be attempted on all residents unless a specific order to the contrary is written. Our results suggest that the many burdens of the policy far outweigh its benefits."³⁰

In contrast to this position, an article in the *Journal of Ethics, Law and Aging* recommended that DNR policies in nursing homes should be improved by including requirements for informed consent. A survey of 117 nursing homes showed that less than half included such protocols.³¹ The study concluded that apprising residents of risks, consequences, and procedures before they make a DNR decision helps to promote understanding and patient autonomy.³² Other suggestions for improving nursing home DNR policies included incorporating clear definitions of key terminology, documenting rationale for orders, requiring regular renewal orders with substantive discussions, and establishing effective protocols for transferring to hospitals.³³

While CPR is the presumed response to cardiac arrest, there has been a continuing evolution in state laws to allow qualifying patients to prevent resuscitation in various types of settings. One of the newest expansions of DNR orders permits their use in

non-hospital settings under legislation and protocols that have existed for less than ten years.³⁴ Although all states have statutorily recognized DNR orders in hospitals as well as end-of-life decisions in living wills since the 1970s, these documents are generally ineffective for the growing number of terminally ill patients who are cared for in their homes or in settings other than a hospital.³⁵ Despite being presented with a living will or durable powers of attorney for health care, emergency medical providers would resuscitate the patient.³⁶ Unwanted emergency resuscitations have also been cited as a problem for nursing homes when emergency medical providers cannot honor a DNR order presented by nursing home staff.³⁷ These problems arise because emergency medical providers, in most states, are legally required to provide emergency medical treatment, including CPR. They also have little time or legal training to investigate and verify the authority of advance directives and other documents.³⁸

To help address these issues, during the past ten years more than forty states have adopted protocols for the use of non-hospital DNR orders, according to Sabatino's 1999 descriptive survey.³⁹ While most of the statutes are supplemented by guidelines, a few states have adopted protocols with no direct code provisions. The statutes embody diverse provisions for medical prerequisites, creation and revocation formalities, identification devices, reciprocity, surrogate issues, and immunity.⁴⁰ Sabatino concluded that the statutes showed confusion over the classification of non-hospital DNR orders as an advance directive or a doctor's order. He also found that the statutes generally addressed DNR orders with negative language and lacked consensus on the ideal type of identification device that must be presented to emergency medical personnel. As general recommendations, he noted that the DNR order processes should be simple, DNR protocols should be uniform across all types of care settings, and education should be provided for emergency medical personnel, health professionals, and the public to ensure the efficient implementation of non-hospital DNR protocols.⁴¹

A Comparison of Non-Hospital DNR Orders in Florida, Illinois, and Wisconsin

Diverse legislation on non-hospital DNR orders has developed in Florida, Illinois, and Wisconsin to address the problem of unwanted emergency

resuscitations. Florida first enacted legislation allowing non-hospital DNR orders in 1993 (amended in 1999) and Wisconsin in 1995 (amended in 1999). Legislation for non-hospital DNR orders in Illinois became effective in 2001. The statutes and regulations in the three states vary not only in their protocols and implementation, but also in their conceptual approach. Using Sabatino's survey as a springboard, this section compares the statutes and protocols using similar descriptive categories: statutory authority, emergency care guidelines, identification devices, standards for creation and revocation, medical prerequisites, surrogate/third-party authority, immunity, and reciprocity. Also reviewed is the interaction between non-hospital DNR orders and living wills.

Non-hospital DNR Orders in Florida

The conceptual approach to the non-hospital DNR order in Florida is evolving from an advance directive to a declaration that has its own identity. Interestingly, the 1996 version of the Florida Statute section 765.101(1) specifically included orders not to resuscitate in the definition of an advance directive; however, the inclusion was not carried forward in the 1999 revisions:

“Advance directive” means a witnessed written document or oral statement in which instruction are given by a principal or in which the principal's desires are expressed concerning any aspect of the principal's health care, and includes, but is not limited to, the designation of a health care surrogate, a living will, or an anatomical gift . . .⁴²

Among other revisions, Florida's 1999 End-of-Life legislation requires a special form for a non-hospital DNR order.⁴³ Despite these changes, the advance directive statutes in chapter 765 continue to govern DNR orders in regard to surrogate standards, revocation, penalties, and immunities as discussed below.

Statutory Authority

The specific authority for withholding resuscitation by an emergency medical provider upon presentation of a valid DNR order is set forth in Florida Statutes section 401.45(3). Without a DNR order, section 401.45(1) provides that consent to CPR is presumed. A number of other statutes authorize the

validity of DNR orders in various other health settings, (e.g., nursing homes, hospitals, hospices, etc.).⁴⁴ Specific regulations on Florida's non-hospital DNR order are contained in the Florida Administrative Code (F.A.C.) Rule 64E-2.031. This rule, amended and renumbered, was originally issued on November 11, 1993 as F.A.C. Rule 10-D66.325. It became effective in its new form on February 20, 2000, pursuant to 1999 legislation.⁴⁵

As explained on the website of the Florida Department of Health,⁴⁶ End-of-Life Care legislation was revised under Senate Bill 1890 during Florida's 2000 Legislative Session. The legislation extends the validity of non-hospital DNR orders across all health care settings, including hospitals. Although the legislation reaffirmed a physician's authority to write a DNR order on the patient's medical chart, an emergency medical provider may only honor a DNR order on the new standardized February 2000 Form 1896. In addition, the legislation authorized the Secretary of Health to develop and implement projects to study the feasibility of a DNR order registry, measure the impact of public education on end-of-life care issues and enhance the availability of data regarding DNR orders.⁴⁷

Emergency Care Guidelines

Under F.A.C. Rule 64E-2.031, an emergency medical technician or paramedic must withhold or withdraw CPR if (1) presented with an original or completed copy of the Florida Do Not Resuscitate Order Form or (2) if the miniature version of the form is presented or observed on the patient.⁴⁸ Additionally, the emergency provider shall provide “comforting, pain-relieving and any other medically indicated care, short of respiratory or cardiac resuscitation.”⁴⁹ The emergency medical provider must verify the identity of the patient and ensure that a copy of the form or device accompanies the patient in transport.⁵⁰

Identification Devices

As noted, Florida uses its DNR order form as an identification device for emergency medical providers. The DNR Order Form 1896 is printed on yellow paper and has the words “Do Not Resuscitate Order” printed in black and displayed across the top of the form. A duplicate reproduced on yellow paper or a miniature version of the form is also valid. The miniature form is about the size of a

social security card and may be worn on a chain around the neck or clipped to clothing.⁵¹ Lamination is suggested for protecting the device against damage.⁵² Under prior regulations, emergency medical providers honored a special bracelet worn by patients as a DNR order.⁵³

Creation and Revocation Standards

The Florida DNR order form and the identification device (if used) must be signed by the patient's physician and the patient. If the patient is incapable of providing informed consent, the form and/or the device must be signed by the patient's health care surrogate or proxy (as defined in Florida Statutes section 765.101), guardian or person acting pursuant to a durable power of attorney.⁵⁴ Although F.A.C. Rule 64E-2.031 does not provide detailed requirements for informed consent, the regulations, as well as the order form, reiterate that the patient's signature is "[b]ased on informed consent."⁵⁵ Patients may request the DNR order form directly from the Florida Department of Health.⁵⁶ Under F.A.C. Rule 64E-2.031(6), the DNR order may be revoked at any time by the patient (if signed by the patient). The same revocation right is given to the patient's surrogate, proxy, court-appointed guardian, or the person acting under a durable power of attorney. The revocation may be "in writing, by physical destruction [of the form], by failure to present it or by orally expressing a contrary intent" pursuant to the revocation procedures for advance directives under section 765.104.⁵⁷

Medical Prerequisite and Policies

No medical prerequisites are set forth in F.A.C. Rule 64E-2.031 for the issuance of a DNR order for patients with decisional capacity. However, a patient-oriented document on the Florida Department of Health website, modified in December 2000, states that DNR forms "are *generally used* by someone who is suffering from a terminal condition, end-stage condition or is in a persistent vegetative state" and advises principals to consult their physician or attorney to determine "if a DNRO would be appropriate for you."⁵⁸ Technically, under 1999 End-of-Life legislation, it appears that principals who are able to provide informed consent are no longer limited to the qualifying conditions as set forth in section 765.101 on advance directives:

- (4) "End-stage condition" means a condition that is caused by injury, disease, or illness which has resulted

in severe and permanent deterioration, indicated by incapacity and complete physical dependency, and for which, to a reasonable degree of medical certainty, treatment of the irreversible condition would be medically ineffective.

(12) "Persistent vegetative state" means a permanent and irreversible condition of unconsciousness in which there is:

- (a) The absence of voluntary action or cognitive behavior of any kind.
- (b) The inability to communicate or interact purposefully with the environment.

(17) "Terminal condition" means a condition caused by injury, disease, or illness from which there is no reasonable medical probability of recovery and which, without treatment, can be expected to cause death.

Incapacitated patients who are unable to provide informed consent must meet the medical prerequisites defined above, because surrogates and proxies act pursuant to section 765.101.⁵⁹

The non-hospital DNR order in Florida also has other features that conceptually set it apart from an advance directive. Unlike a living will, the DNR order requires neither witness signatures nor the separate examination of the patient by an attending physician and a consulting physician.⁶⁰ Prior to the 1999 End-of-Life legislation, the non-hospital DNR order required similar documentation.⁶¹ Now, under F.A.C. Rule 64E-2.031(3), the order requires the signature of only one physician.

Surrogate/Third-Party Authorization

If an incapacitated patient has a qualifying medical condition, a surrogate or proxy under section 765.101, a guardian, or a person acting pursuant to a durable power of attorney may sign the DNR order Form 1896.⁶² A "[s]urrogate" means any competent adult expressly designated by a principal to make health care decisions on behalf of the principal upon the principal's incapacity.⁶³ The surrogate may only make health care decisions for the principal that he or she believes the "principal would have made under the circumstances if the principal were capable of making such decisions."⁶⁴ This decision-making standard is termed "substituted judgment."⁶⁵

A proxy may also sign a DNR order if the patient is incapable of informed consent. A proxy is a "competent adult who has not been expressly

designated to make health care decisions for a particular incapacitated individual, but who, nevertheless, is authorized . . . to make health care decisions on behalf of the principal upon the principal's incapacity."⁶⁶ The proxy may be the patient's spouse; an adult child; a parent; an adult sibling; an adult relative who has exhibited special concern for the patient, maintained regular contact with the patient and is familiar with the patient's activities, health, and religious or moral beliefs; or a close friend.⁶⁷ Based on a substituted judgment standard, a proxy's decision to withhold or withdraw life-prolonging procedures must be "supported by clear and convincing evidence that the decision would have been the one the patient would have chosen had the patient been competent."⁶⁸

Immunity/Penalties

Although the presumption is that a person may not be denied CPR, an emergency medical provider in Florida may withhold or withdraw resuscitation from a patient without civil liability or criminal prosecution if he or she is presented with a valid DNR order form. The immunity applies if the provider "has not engaged in negligent or unprofessional conduct."⁶⁹ Immunity was recently expanded through revised legislation to include not only emergency medical personnel but also health care facilities and their personnel if they honor a DNR order executed pursuant to the statutes. The expansion of immunity to facilities honoring the standard form may result in fewer transports to hospitals (i.e., hospital emergency departments, nursing homes, home health agencies, assisted living facilities, hospices, adult family-care homes, and emergency medical services).⁷⁰

Penalties for violating a valid DNR order include fines, civil damages, loss of license, etc.⁷¹ Knowing or intentional violations are a misdemeanor of the second degree.⁷² Penalties for surrogates and proxies are specified in chapter 765. Damaging an advance directive without the principal's consent is a felony of the third degree. Any person who falsifies the advance directive of another or who willfully conceals personal knowledge of a revocation commits a felony in the second degree.⁷³

Reciprocity

Under Florida law, an advance directive validly executed in another state in compliance with the law of that state will be recognized in Florida.⁷⁴ However, F.A.C. Rule 64E-2.031 and information

provided by the Florida Department of Health website clearly indicates that emergency medical personnel will honor only DNR Order Form 1896.

DNR Orders and Living Wills

Because Florida law recognizes both non-hospital DNR orders and living wills, the question arises whether the inclusion of a DNR order in a living will would be honored if presented to an emergency medical provider. Under Florida law, emergency medical providers will withhold or withdraw resuscitation with evidence of a DNR order, and "[a]n order not to resuscitate, to be valid, must be on the form adopted by rule of the department [of health]."⁷⁵ Reasonably, a living will or other document that contains a DNR order is not likely to be honored in a non-hospital setting.

An explanation of Florida's policy on the relationship of DNR orders and living wills is provided in an online document prepared by the Florida Department of Health. The document explains that a "living will is a document that instructs, as specifically as possible, what care and treatment the person wishes under certain circumstances. A DNRO is . . . part of a prescribed medical treatment plan and must have a physician's signature."⁷⁶ These comments again emphasize the conceptual differences between the non-hospital DNR order and the advance directive.

Non-hospital DNR Orders in Illinois

Developed by the Illinois Department of Public Health, a new standardized statewide DNR order form was initiated in Illinois in 2001 for use in non-hospital settings.⁷⁷ Each emergency system in the state must develop a new DNR policy in accordance with new regulations of the Department of Public Health.⁷⁸ Even with the new developments in DNR orders for non-hospital settings, conceptually the DNR order in Illinois appears to be a combination of an advance directive and medical treatment, rather than an independent document. For instance, the DNR order is listed along with the living will and power of attorney for health care in a recent statute on advance directive information and in a *Statement of Illinois Law on Advance Directives* available on the website of the Department of Public Health.⁷⁹ The non-hospital DNR order also maintains its status as a medical treatment. Under a key provision in the new DNR order form, a physician has the same rights as the principal to revoke the order.⁸⁰

Statutory Authority

The Emergency Medical Services (EMS) Act of the Illinois Compiled Statutes authorizes licensed emergency medical providers to honor DNR orders and powers of attorney for health care.⁸¹ The specific protocols for non-hospital DNR orders are set forth in regulations from the Department of Public Health.⁸² These regulations mandate policies that must be developed by each EMS system in Illinois and approved by the Department of Public Health.⁸³ Significantly interrelated with non-hospital DNR orders are statutes in the Health Care Surrogate Act. This Act defines the circumstances under which surrogate decision makers may make health care decisions for those persons who do not have health care agents or advance directives, including decisions to forgo life-sustaining treatment without judicial involvement.⁸⁴

Emergency Care Guidelines

Under Department of Public Health regulations, "DNR refers to the withholding of cardiopulmonary resuscitation (CPR), electrical therapy to include pacing, cardioversion and defibrillation; tracheal intubation, and manually or mechanically assisted ventilations, unless otherwise stated on the DNR order."⁸⁵ Presumably, pain and comfort care may be administered, although it is not explicitly stated in the regulation. The policies of each EMS must also include procedures for withholding CPR in situations "where explicit signs of biological death are present."⁸⁶ As another care regulation, emergency medical providers must make a reasonable attempt to verify the identity of the patient named in the valid DNR order.⁸⁷

Identification Devices

A valid DNR order must be written on a brightly colored orange form provided by the Department of Public Health (or reproductions on similarly colored paper). Illinois has not authorized any other types of identification devices.⁸⁸ The statewide DNR order form is available on the website of the Department of Public Health.⁸⁹

Creation and Revocation Standards

Patients or their agents or surrogates may create a non-hospital DNR order. The new Illinois DNR order form includes the name of the patient, name and signature of the attending physician, effective date, and the words "Do Not Resuscitate." Evidence of the patient's informed consent will be shown by

either the signature of the patient, legal guardian, durable power of attorney for health care agent, or surrogate decision maker. Because the document is considered an advance directive, the signatures of two witnesses are also required.⁹⁰ Physicians are given considerable authority in the revocation of a non-hospital DNR order. Revocation of a written DNR order shall be made only if the order is physically destroyed or verbally rescinded by the physician who gave the order, or physically destroyed or verbally rescinded by the person who gave written consent to the order.⁹¹

Medical Prerequisites and Policies

The regulations from the Department of Public Health do not address the medical prerequisites needed to create a DNR order, but must be coupled with the Illinois Health Care Surrogate Act for an interpretation of the requirements. The Act states that "[i]f a patient is an adult with decisional capacity, then the right to refuse medical treatment or life-sustaining treatment does not require the presence of a qualifying condition."⁹² According to an analysis by Rebecca O'Neill, patients with decisional capacity or agents under a durable power of attorney for healthcare may consent to a DNR order as they would to any other medical treatment.⁹³ If a surrogate initiates a DNR order under the Health Care Surrogate Act, the patient must have a qualifying condition as defined below:⁹⁴

"Qualifying condition" means the existence of one or more of the following conditions in a patient certified in writing in the patient's medical record by the attending physician and by at least one other qualified physician:

- (1) "Terminal condition" means an illness or injury for which there is no reasonable prospect of cure or recovery, death is imminent, and the application of life-sustaining treatment would only prolong the dying process.
- (2) "Permanent unconsciousness" means a condition that, to a high degree of medical certainty, (i) will last permanently, without improvement, (ii) in which thought, sensation, purposeful action, social interaction, and awareness of self and environment are absent, and (iii) for which initiating or continuing life-sustaining treatment, in light of the patient's medical condition, provides only minimal medical benefit.

- (3) “Incurable or irreversible condition” means an illness or injury (i) for which there is no reasonable prospect of cure or recovery, (ii) that ultimately will cause the patient’s death even if the life-sustaining treatment is initiated or continued, (iii) that imposes severe pain or otherwise imposes an inhumane burden on the patient and (iv) for which initiating or continuing the life-sustaining treatment, in light of the patient’s medical condition, provides only minimal medical benefit.⁹⁵

Although the Act does not expressly include resuscitation within a listing of life-sustaining treatments, it is implied within the definition of life-sustaining treatment as “any medical treatment, procedure, or intervention that, in the judgment of the attending physician, when applied to a patient with a qualifying condition, would not be effective to remove the qualifying condition or would serve only to prolong the dying process.”⁹⁶

Surrogate/Third-Party Authorization

As previously noted, surrogate decision-making is limited to the creation or revocation of DNR orders for patients who lack decisional capacity and advance directives. The Illinois Health Care Surrogate Act defines “surrogate decision makers” as adult individuals who are identified by the attending physician in accordance to the Act and who are willing to make medical treatment decisions on behalf of a patient who lacks decisional capacity.⁹⁷ The Act specifies that surrogate decisions involving the withdrawal of life-sustaining treatment require that the patient have a qualifying condition.⁹⁸

Surrogates, in order of priority, include the patient’s guardian, spouse, adult child, parent, adult sibling, adult grandchild, close friend, and the patient’s guardian of the estate.⁹⁹ A close friend must provide an affidavit to the attending physician that he or she is a close friend who wants to become involved in the patient’s healthcare and who is familiar with the patient’s activities and beliefs. The affidavit must specify the facts that substantiate the relationship.¹⁰⁰

The standard for making surrogate decisions is “conforming as closely as possible to what the patient would have done or intended under the circumstances.”¹⁰¹ The surrogate may consider the patient’s personal, philosophical, religious, moral, and ethical beliefs, or be guided by living wills or other documents that are not revoked but invalid

because of technicalities. If the patient’s wishes cannot be discerned, then the surrogate must weigh “the burdens on and benefits to the patient of the treatment against the burdens and benefits of that treatment as well as views of family and friends that the patient may have considered if able to act for herself or himself.”¹⁰² Consequently, the Act provides that a surrogate should first use a substituted judgment standard. If this standard is unrevealing, then the surrogate may use the best interest standard.¹⁰³ When the provisions of the Act are complied with, the attending physician may implement a decision to forgo life-sustaining treatment on behalf of the patient. A physician, however, may refuse to implement the decision if she or he believes it violates the Act or for “reasons of conscience or other personal views or beliefs.”¹⁰⁴

Immunity/Penalties

Neither the Emergency Medical Services Act of the Illinois Compiled Statutes¹⁰⁵ nor the DNR order policy regulations from the Department of Public Health¹⁰⁶ explicitly provides immunity to emergency medical providers who honor valid DNR orders. Implied immunity may be gleaned from the recognition of the EMS protocol as part of the standard of practice along with general and partial immunity granted in other parts of the EMS code.¹⁰⁷ Health care providers who follow the provisions of the Health Care Surrogate Act will not be subject to claims based on lack of patient consent or to criminal prosecution for unprofessional conduct. The Act does not protect providers from negligence claims in carrying out their duties. Likewise, surrogates are protected from criminal prosecution or any claim based on lack of surrogate authority if they act with due care and in accordance with the Act.¹⁰⁸ The Act provides no specific penalties for violations of its provisions.¹⁰⁹

Reciprocity

The Emergency Medical Services Act of the Illinois Compiled Statutes and Department of Public Health regulations are silent on whether emergency medical providers must honor valid DNR order forms from other states. However, the recognition of a DNR order form that is unfamiliar to the emergency medical provider would be unlikely in light of the movement toward a standardized form that was purposely developed to ease identification in emergency situations.

DNR Orders and Living Wills

The Emergency Medical Services Act of the Illinois Compiled Statutes authorizes licensed emergency medical providers in Illinois emergency systems to honor DNR orders and powers of attorney for health care.¹¹⁰ However, the regulations on DNR orders from the Department of Public Health state that a living will by itself cannot be recognized.¹¹¹ Thus, an individual who has a living will or a living will within a power of attorney for health care should also create a DNR order with a physician's signature to assure that CPR will be withheld by an emergency medical provider.

Non-hospital DNR Orders in Wisconsin

Wisconsin first enacted legislation recognizing non-hospital DNR orders in 1995, by permitting the issuance of standardized DNR bracelets to qualified patients. Often termed the "bracelet bill," Wisconsin's legislation on non-hospital DNR orders is designed to serve the needs of those elderly patients who are cared for at home and who desire to forgo CPR.¹¹² Overall, Wisconsin's non-hospital DNR order has its own identity and is conceptually and statutorily independent, in large part, from an advance directive or a physician's order.

Statutory Authority

Wisconsin's non-hospital DNR order is authorized under sections 154.17(1), 154.19(2)(b), and 154.27 of the Wisconsin Statutes. Additionally, the Wisconsin Department of Health and Family Services (Division of Public Health) provides specific regulations and procedures for emergency medical providers to follow when honoring non-hospital DNR orders.¹¹³ The Division of Public Health is revising its regulations to reflect two major recent legislative changes: (1) the ability of guardians and agents with a health care power of attorney to request or revoke a DNR order, and (2) the legal option of using a metal or plastic DNR bracelet.¹¹⁴

Emergency Care Guidelines

The DNR order is defined as a written order that directs emergency providers not to attempt CPR for those persons whom the order is issued.¹¹⁵ Emergency medical providers must honor a DNR order, as evidenced by a patient wearing a DNR bracelet, unless the bracelet is defaced or the order revoked.¹¹⁶

Resuscitation under Wisconsin law means CPR or any component of CPR. The components are described as "cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, administration of cardiac resuscitation medication and related procedures. Resuscitation does not include the Heimlich maneuver or similar procedures used to expel an obstruction from the throat."¹¹⁷ The emergency medical provider may also provide comfort care such as the administration of oxygen, clearing the airway, controlling bleeding, positioning for comfort, providing emotional support, and providing pain medication and splinting.¹¹⁸

Identification Devices

Wisconsin's DNR bracelet is statutorily defined as a standardized identification bracelet of uniform size, color, and design approved by the Division of Public Health that includes the inscription "Do-Not-Resuscitate" and signifies that the wearer has obtained a DNR order.¹¹⁹ Therefore, the bracelet gives legal notice of the order.¹²⁰ As one option, the bracelet may be a clear, standard hospital-type bracelet of at least an inch wide. The bracelet insert form must include the words "Do Not Resuscitate" printed in blue, the state seal of Wisconsin, and, on the left side, the patient's name, address, date of birth, and gender in font size eight or greater. The physician who issues the DNR order is responsible for completing the bracelet insert and must place his or her name, business phone, and original signature on the right-hand side of the insert form.¹²¹ Physicians may obtain bracelet inserts from the Division of Public Health.

Under an amended statute, the Division of Health may also approve a metal bracelet. The metal bracelet must be developed and distributed by a commercial vendor, include an emblem that displays an internationally recognized medical symbol on the front and the words "Wisconsin Do-Not-Resuscitate-EMS" and also include the qualified patient's first and last name on the back. Vendors must have a doctor's order for the bracelet prior to distributing it to the patient.¹²²

Creation and Revocation Standards

The creation of a DNR order by an adult patient under Wisconsin statutes involves several steps. First, the patient (or if incapacitated, the patient's

guardian or health care agent¹²³) must contact the patient's attending physician or a person under the direction of the attending physician.¹²⁴ An attending physician is defined as a licensed physician who has the primary responsibility for the treatment and care of the patient.¹²⁵ The attending physician or the physician's designee must provide the patient with written information about the resuscitation procedures that the patient has chosen to forgo and the methods by which the patient may revoke the DNR order. The physician or the designee must document the medical condition that qualifies the patient for the DNR order in the patient's medical records. After the physician or the designee writes the DNR order, the patient or guardian/agent must sign the order. Then, either the physician affixes the bracelet to the wrist of the patient, or the patient receives a form to order the bracelet from a vendor.¹²⁶ As noted, Wisconsin accepts only vendors that require a physician's DNR order before distributing the bracelet.¹²⁷

A patient may revoke a DNR order at any time by expressing his or her desire to the emergency medical provider; by defacing, burning, cutting, or destroying the DNR bracelet; or by removing the bracelet or by asking another to remove the bracelet. As soon as possible after the revocation, a patient must notify his or her attending physician so that the patient's medical records may be changed. The revocation, however, is effective regardless of the notification.¹²⁸ General provisions on DNR orders provide that "the desire of the patient to be resuscitated supercedes the effect of the DNR order at all times."¹²⁹

A recent amendment has also given a guardian or health care agent of the patient a right to revoke the bracelet on behalf of the patient by directing emergency medical personnel to resuscitate the patient.¹³⁰ Regulations under Division of Public Health had provided that the patient's desire not to be resuscitated was controlling:

If a member of the patient's family or friend of the patient request that resuscitative measures be taken, that person's request does not supercede the do-not-resuscitate order for the patient if the patient is wearing a valid do-not-resuscitate bracelet and has not revoked the order.¹³¹

The Division of Public Health is currently revising its regulations to meet the new law that became

effective in 1998.¹³² Jane Barclay Mandel notes that the practical application of the provision is difficult because emergency medical providers must determine if the patient is incapacitated and if the person providing the revocation is the patient's guardian or health care agent. Because there is little time for investigation, emergency medical providers will likely resuscitate the patient unless the person demanding resuscitation states that he or she has no legal authority.¹³³

Medical Prerequisite and Policies

The Wisconsin statute has a restrictive listing of medical conditions that are required before any patient (competent or incapacitated) may create a DNR order:

A "qualified patient" means a person who has attained the age of 18 and to whom any of the following condition applies:

(a) The person has a terminal condition.

(b) The person has a medical condition such that, were the person to suffer cardiac or pulmonary failure, resuscitation would be unsuccessful in restoring cardiac or respiratory function or the person would experience repeated cardiac or pulmonary failure within a short period before death occurs.

(c) The person has a medical condition such that, were the person to suffer cardiac or pulmonary failure, resuscitation of that person would cause significant physical pain or harm that would outweigh the possibility that resuscitation would successfully restore cardiac or respiratory function for an indefinite period of time.¹³⁴

Definitions in section 154.01 of the Wisconsin Statutes that apply to the withdrawal of life-sustaining procedures as documented in living wills provide some additional insight. A terminal condition is defined as an incurable condition caused by an injury or illness that will result in imminent death. A persistent vegetative state, statutorily defined as a condition that results in the irreversible loss of all cognitive functioning,¹³⁵ is not expressly listed as a qualifying condition for a DNR order. It appears that a persistent vegetative state must meet the criteria of either section (b) or (c) above to qualify as a medical prerequisite.

Surrogate/Third-Party Authorization

As noted, recent Wisconsin DNR legislation provides expanded powers for guardians or health care agents of incapacitated patients that may make it difficult for emergency medical providers to assess the legal authority of third parties in emergency situations. Guardians and health care agents may create a DNR order on behalf of an incapacitated qualified patient or may revoke the patient's existing DNR order. An emergency medical provider must honor a guardian's or health care agent's verbal request for resuscitation even though the patient is wearing a valid DNR bracelet. In this case, the emergency medical provider must promptly remove the DNR bracelet. The guardian or health care agent may also deface, burn, cut, or remove the bracelet.¹³⁶

The DNR statute is silent on the standard to be used by third parties to create or revoke a DNR order. General decision-making standards for health care agents are set forth in Chapter 155 of the Wisconsin Statutes (Power of Attorney for Health Care). A health care agent "shall act in good faith consistently with any valid declaration executed by the principal under subch. II of 154 [Declarations to Physicians]."¹³⁷ In the absence of a directive, the standard is to "act in the best interests of the principal."¹³⁸ The best interests standard also applies to health care decision-making by guardians.¹³⁹

Immunity/Penalties

Physicians, emergency medical providers, first responders, health care professionals, or emergency health facilities may not be held criminally or civilly liable or charged with unprofessional conduct for withholding or withdrawing resuscitation from a patient who has a DNR order. Emergency medical providers also face no liability for failing to act upon a revocation of an order unless they had actual knowledge of the revocation. Likewise, there is no liability if the emergency medical provider fails to honor a DNR order if he or she in good faith believed the order to be revoked.¹⁴⁰

Wisconsin imposes stiff penalties on those who knowingly violate a patient's DNR orders or revocation of those orders. Any person, including an emergency medical provider, who willfully conceals, defaces, or damages a DNR bracelet without the patient's consent may be fined up to \$500 and/or imprisoned for not more than thirty days. A \$10,000 fine and/or possible imprisonment for not

more than fifteen years will be imposed if a person intentionally causes the withholding or withdrawal of CPR contrary to the patient's wishes, forges or transfers a DNR bracelet, or conceals the revocation of the DNR order. Those who directly or indirectly coerce, threaten, or intimidate an individual to create a DNR order may receive up to a \$500 fine and/or up to thirty days imprisonment.¹⁴¹

Reciprocity

The DNR statutes are silent on whether a non-hospital DNR order from another state may be honored by emergency medical providers. However, under its general provisions for declarations to physicians, Wisconsin will enforce a valid document from another state that authorizes the withholding or withdrawal of life-sustaining procedures if the document is consistent with Wisconsin laws.¹⁴² As noted in the next section, the DNR statutes appear to recognize DNR orders in living wills. Conceivably, this recognition could extend to documents from other states. In a practical application, determining whether a DNR order from another state is consistent with Wisconsin laws is difficult.

DNR Orders and Living Wills

The Wisconsin statute on DNR orders expressly provides that it "does not impair or supersede . . . [a] persons right to withhold or withdraw resuscitation."¹⁴³ Therefore, DNR orders contained in living wills or in a power of attorney for health care document would also be valid in emergency situations. In addition, these documents could possibly outline DNR desires to include broader circumstances than those required in the statute.¹⁴⁴ Considering liability concerns, it is unlikely that emergency medical providers would honor these documents.

Summary of DNR Criteria in Florida, Illinois, and Wisconsin

The statutes and protocols examined in this article illustrate how varied states may be in their approaches to non-hospital DNR orders. Although Florida, Illinois, and Wisconsin seek to provide individuals with greater flexibility in effecting their own health decisions, their statutes and protocols take varying approaches to identification devices, medical prerequisites, surrogate authority, revocation, reciprocity, and the interrelationship of DNR orders with other types of advance directives.

The most striking variation centers on medical prerequisites for creating DNR orders for patients having decisional capacity. In Illinois, statutory interpretation has led to a conclusion that there are no qualifying medical conditions for a patient who is able to give informed consent to a DNR order.¹⁴⁵ Likewise, in Florida, public information provided on the Department of Health website indicates that strictly defined medical prerequisites possibly may not apply for patients with decisional capacity who wish to create a non-hospital DNR order.¹⁴⁶ Wisconsin has the most restrictive requirements, in that qualifying patients by statute must have a terminal condition, a condition in which resuscitation would be futile because cardiac failure would occur again in a short time, or a condition in which the pain or harm of resuscitation would outweigh its advantages.¹⁴⁷ As another difference, Wisconsin statutorily requires specific procedures to ensure informed consent upon the creation of a DNR order. Physicians or their designees must provide patients with written information about resuscitation procedures as well as revocation procedures.¹⁴⁸

Advance directives are crucial in Wisconsin in that third-person authority to create or revoke a non-hospital DNR order extends only to health care agents and guardians. Both Florida and Illinois set forth provisions allowing for DNR decision-making by non-agents such as spouses, children, and even close friends.¹⁴⁹

Although the recognition of non-hospital DNR orders in documents other than state-approved forms or devices provides flexibility for patients, it creates a serious problem for medical providers who need clear signals in an emergency situation. For instance, in Wisconsin, DNR orders such as living wills and powers of attorney for health care apparently may be honored by emergency medical personnel even though the patient does not have a DNR bracelet.¹⁵⁰ Both Florida and Illinois are more explicit in requiring the statewide-approved form for non-hospital emergencies.¹⁵¹

Overall, all three states have designed a relatively simple statewide form for creating a DNR order that is available from physicians or the Department of Public Health. These three states permit surrogates to create and revoke a DNR order for incapacitated patients with qualifying medical conditions and provide immunity from liability for emergency medical providers who follow statutory and regulatory

guidelines for DNR orders. In addition, these states have updated their statutes and protocols and emphatically provide that patients with decisional capacity may revoke their DNR order at any time.

Recent Cases Interpreting Statutory Standards for DNR Orders

DNR case law to date, in large part, relates to DNR orders in hospital settings because of the relative newness of DNR orders in non-hospital settings. Generally, DNR orders result in court cases where providers seek a declaratory judgment to approve a decision whether to issue a DNR order for an incapacitated patient with no advance directives. Less frequent are cases that seek damages from providers for injuries caused by actions or omissions of a DNR order.¹⁵² This section briefly reviews four recent cases involving the interpretation of statutory provisions imposing standards for issuance of DNR orders for elderly patients.

In *In re Estate of Austwick*, the Illinois Appellate Court interpreted a section of the Illinois Health Care Surrogates Act (“IHCSA”) dealing with statutory requirements that govern a guardian’s decision to consent to a DNR order on behalf of an elderly patient.¹⁵³ In this case, an eighty-one-year-old disabled woman, through the Legal Advocacy Service of the Illinois Guardianship and Advocacy Commission, petitioned the probate court to terminate the DNR order in her medical chart at the nursing home where she was residing. She also petitioned for the removal of her public guardian because he failed to follow the procedures of IHCSA when consenting to the DNR order on her behalf. After the trial court ordered the DNR order removed, the public guardian argued on appeal that Mrs. Austwick had decisional capacity when she first consented to the DNR order and that IHCSA authorizes a guardian to consent to a DNR order on behalf of a patient.¹⁵⁴

The Appellate Court found that IHCSA authorizes a surrogate decision maker to forgo life-sustaining treatment for a patient only when the patient lacks decisional capacity and has a qualifying condition. The court concluded that Mrs. Austwick did not have a qualifying condition because she was not terminally ill, irreversibly comatose, or in a persistent vegetative state. Further, her adjudication as disabled did not overcome the presumption under IHCSA that she has decisional capacity.¹⁵⁵

In a related case, the Appellate Court of Illinois reviewed whether Mrs. Austwick had decisional capacity to refuse electroconvulsive therapy (ECT) as a treatment for depression. The administration of ECT was also sought on her behalf by her public guardian.¹⁵⁶ Interestingly, the court held that she did not have the capacity to refuse treatment and reconciled the two court decisions as follows:

We recognize at first glance our holding may seem to conflict with a related case involving Mrs. Austwick in deciding whether to forgo life-sustaining treatment . . . However, in that case we were interpreting the Health Care Surrogate Act (HCSA), which states that a person is presumed to have decisional capacity to forgo life-sustaining treatment unless her attending physician states otherwise and one other physician concurs. No such statements appear in Mrs. Austwick's medical records, and therefore we held that under the HCSA we must presume she has decisional capacity.¹⁵⁷

The court determined that Mrs. Austwick's incapacity was established in the ECT hearing through the testimony of one physician. Because of conflicting testimony, the court held that the trial court erred in determining that ECT was in Mrs. Austwick's best interest.

Both *Austwick* cases illustrate the dangers that may arise with surrogate decision-making. The guardian, in these cases, believed he was making a well-intentioned decision in the best interest of his ward. However, IHCSA first requires the surrogate to use substituted judgment when making a DNR decision. If there are no indications of the patient's desires, then the decision may be made under the best interests standard that weighs the benefits to and burdens on the patient in light of what a reasonable person would choose.¹⁵⁸

The *Austwick* cases also stand for several propositions. First, elderly persons should be presumed to have decisional capacity with a legal right to participate in their own medical decision-making. Physical deterioration cannot automatically be equated with diminished mental capacity. Second, when acting on behalf of an incapacitated person, surrogates must carefully follow the legal standards set forth for protecting the principal's best interests. Surrogates do not have unrestricted discretion. Finally, medical decisions for elderly persons should not be made solely on the basis of the person's age.

Some researchers have found that physicians are more likely to issue a DNR order for older patients than younger patients when all other conditions are equal.¹⁵⁹ Whether such decisions are based on ageism or on sound medical reasons, the laws in Florida, Illinois, and Wisconsin define explicit medical and legal circumstances for consent to a DNR order on behalf of an incapacitated person.

In the case of *In re Finn*, a lower New York court found that a DNR order issued under article 29-B of New York Public Health Laws did not meet the medical prerequisites of the statute.¹⁶⁰ Although Leonard B., a sixty-seven-year-old profoundly retarded man, lacked the capacity to make a decision regarding the DNR order, his physician erred in writing the order because his medical condition did not meet the prerequisites for a surrogate-initiated DNR order. The New York law provides that a surrogate may obtain a DNR order for an incompetent patient only if "(i) the patient has a terminal condition, (ii) the patient is permanently unconscious, (iii) resuscitation would be medically futile or (iv) resuscitation would impose an extraordinary burden on the patient in light of the patient's medical condition and expected outcome of resuscitation for the patient."¹⁶¹ The court found that the first three conditions did not apply to Leonard and held that the final condition was constitutionally vague because it failed to define the meaning of an extraordinary burden.¹⁶² An appeals decision concurred that the DNR order was improper but vacated the lower court's judgment that the New York Public Health Law was unconstitutionally vague.¹⁶³

Despite the appeals decision, this case raises questions about the clarity of statutory standards for determining whether resuscitation would be medically ineffective or medically futile. These statutes focus on situations in which the treatment is not beneficial because of the resulting pain or harm it may cause to the patient or because the patient's medical condition will result in death despite life-sustaining treatment. To avoid attacks for vagueness, state legislatures should be working with medical professionals and attorneys to develop more precise legal standards for medical futility, situations where the use of CPR would be futile.¹⁶⁴

Conclusion and Recommendations

In light of recent criticisms of the Patient Self-Determination Act in creating awareness of advance

directives,¹⁶⁵ there is a definite need for more public outreach aimed at elderly persons and their families. To fill this gap, it is important for elder law attorneys to make special efforts to apprise their clients of new state laws on non-hospital DNR orders and their interrelationship with other types of end-of-life documents. As illustrated in the above cases, elderly persons are often dealt with in a paternalistic manner. Even if elderly patients have expressed their end-of-life choices to family, friends, or their physicians, surrogates may not be bound to consider these wishes. In Wisconsin, it appears that a health care agent or guardian may even supercede a valid non-hospital DNR order.¹⁶⁶ To avoid the prospect of an unwanted resuscitation in a non-hospital setting, attorneys must help their clients understand the im-

portance of formalizing their end-of-life decisions prior to loss of capacity.

Elder law attorneys also have an important role in helping develop clearer statutory language relating to the benefits versus burden test of medical futility. Much of the concern with this issue arises when a surrogate requests a DNR order on behalf of an incapacitated patient who has no written advance directives.

In summary, whenever advising a client regarding health care decisions, an attorney must understand not only the law but also how it interacts with the client's personal situation, values and beliefs. With this in mind, the attorney will be able to work with the client to develop an integrated and coordinated plan that best reflects the client's wishes and right to self-determination.

Endnotes

1. Nat'l Conference of Comm'rs on Uniform State Laws, *Uniform Health-Care Decisions Act* Prefatory Note (1994).
2. 42 U.S.C.A. § 1395 cc(f). See also BARRY R. FURROW ET AL., HEALTH LAW 1114 (3d ed. 1997).
3. 42 U.S.C.A. § 1395cc(f)(1)(A)(i)-(ii); BARROW ET AL., *supra*, note 2.
4. Proposed legislation, entitled Advance Planning and Compassionate Care Act of 1999, was introduced in the 106th Congress (H.R. 1149; S. 628) as an effort to strengthen provisions of the Patient Self-Determination Act. As noted in the Congressional Record, since the passage of that legislation a study by the Robert Wood Johnson Foundation "found that less than half of hospitalized patients who had advanced directives had even talked with any of their doctors about having a directive and only about one-third had their wishes documented in their medical records." 145 Cong. Rec. E 499 (Mar. 18, 1999) (statement of Rep. Levin). See also Elizabeth H. Bradley et al., *Public Information and Private Search: Evaluating the Patient Self-Determination Act*, J. OF HEALTH POL. POL'Y & L. 239, 240 (April 1999).
5. Charles P. Sabatino, *Survey of State EMS-DNR Laws and Protocols*, 27 J. L. MED. & ETHICS 297, 297 (1999). Sabatino's survey found that, as of September 1999, forty-two states have adopted protocols for the use of non-hospital DNR orders. *Id.* The comprehensive survey of state laws compares medical prerequisites, DNR order formalities, identification devices, reciprocity, statewide uniformity, surrogacy issues, immunity, and data collection and evaluation. *Id.* at 297-307.
6. Frances Meehan, *DNR Orders—Judicial Authorization or Statutory Mandate?*, 24 AM. HEALTH LAWS' ASS'N J. OF HEALTH L. 144, 144 (1991).
7. *Id.*
8. John A. McClung et al., *Legislating Ethics—Implications of New York's Do-Not-Resuscitate Law*, 323 NEW ENG. J. OF MED. 270, 270 (1990) (citing W. B. Kouwenhoven et al., *Closed-chest Cardiac Massage*, 173 JAMA 1064 (1960)).
9. *Id.* (citing Statement by the Ad Hoc Committee on Cardiopulmonary Resuscitation of the Div. of Medical Sciences, Nat'l Academy of Sciences Nat'l Research Council, *Cardiopulmonary Resuscitation*, 198 JAMA 372 (1966)).
10. *Id.* (citing *Standards for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiac Care (ECC)* 227 JAMA Supp. 833 (1974)).
11. *Id.* (citing C. Fried, *Terminating Life Support: Out of the Closet!*, 295 NEW ENG. J. MED. 362 (1976)).
12. 355 A.2d 647 (N.J. 1976).
13. FURROW ET AL., *supra* note 2, at 1106.
14. 355 A.2d at 655.

15. *Id.* at 664.
16. FURROW ET AL., *supra* note 2, at 1106.
17. Meehan, *supra* note 6.
18. FURROW ET AL., *supra* note 2, at 1144; N.Y. PUB. HEALTH LAW § 2960 *et seq.* (Consol.).
19. Meehan, *supra* note 6.
20. FURROW ET AL., *supra* note 2, at 1143.
21. ALAN MEISEL, THE RIGHT TO DIE § 9.4, at 544 (2d ed. 1995, 2000 Supp.); FURROW ET AL., *supra* note 2, at 1143.
22. *See* N.Y. PUB. HEALTH LAW § 2962 (1) (Consol.).
23. *See* MEISEL, *supra* note 21, § 9.19 at 567. The states include Colorado, Florida, Georgia, Idaho, New York, West Virginia, and Wyoming.
24. LAWRENCE A. FROLIK & ALISON McCHRISTAL BARNES, ELDERLAW 539 (2d ed. 1999) (citing ALAN MEISEL, THE RIGHT TO DIE 56 (2D ED. 1995)).
25. *Id.* at 542 (citing *Dunham v. Wright*, 423 F.2d. 940, 941 (3rd Cir. 1970)).
26. Meisel, *supra* note 21, at 568. *See* ARK. CODE ANN. § 20-13-905(d); MONT. CODE ANN. § 50-1-104(4).
27. Arnold Wagner, M.D., *Cardiopulmonary Resuscitation in the Aged: A Prospective Survey*, 310 NEW ENGL. J. OF MED. 1129, 1130 (1984). The reported study surveyed 163 elderly women regarding their attitude toward CPR and found only eleven who wanted CPR in case of a cardiac arrest, seventy-seven who did not want CPR, sixty-four who wanted a physician to decide, ten who were incompetent, and one who did not return the survey.
28. Gary E. Applebaum, M.D. et al., *The Outcome of CPR Initiated in Nursing Homes*, 38 J. AM. GERIATRICS SOC'Y, 197, 200 (1990). However, several studies have found that advanced age is not unfavorable to a successful outcome. *See e.g.*, R.S. Gulati et al., *Cardiopulmonary Resuscitation of Old People*, 2 LANCET 267 (1983).
29. Applebaum, *supra* note 28, at 198.
30. *Id.*
31. Leslie Walker et al., *Do-Not-Resuscitate Orders in Nursing Homes: Institutional Policies and Practices*, 1 J. ETHICS LAW. & AGING 97, 101 (1995).
32. *Id.* at 104. There is a continuing debate about when physicians are legally required to obtain informed consent when withholding CPR or writing a DNR order. The traditional view holds that physicians are required to obtain informed consent to write a DNR order. An emerging view holds that informed consent is necessary only when physicians recommend a procedure to a patient or surrogate. *See* MEISEL, *supra* note 21, § 9.5 at 547-48 and Supp. at 140. However, there is legal risk in a physician "unilaterally writing a DNR order without consulting the patient or surrogate." *Id.* § 9.6, at 555.
33. Walker, *supra* note 31, at 104.
34. Sabatino, *supra* note 5, at 297.
35. *Id.*
36. *Id.*
37. Walker, *supra* note 31, at 103.
38. Jane Barclay Mandel, *Wisconsin's Do Not Resuscitate Bracelet Law Raises Legal and Medical Issues*, 70-Dec. WIS. LAW. 14, 15 (1997).
39. Sabatino, *supra* note 5, at 297.
40. *Id.* at 298-301.
41. *Id.* at 312.
42. FLA. STAT. Ch. 765.101(1).
43. Ch. 401.45(3)(a).
44. Ch. 395.1041, 400.142, 400.4255, 400.487, 400.6095, 400.621, 401.35.
45. FLA. ADMIN. CODE ANN. r. 64E-2.031 (see history).
46. Fla. Dept. of Health, *Do Not Resuscitate Orders*, available at <http://www.doh.state.fl.us/ems/1general/6resuscitate/dnro.htm> (last modified Dec. 2000).
47. *Id.*
48. FLA. ADMIN. CODE ANN. r. 64E-2.031 § (1)(a)-(b).
49. R. 64E-2031 §5.

50. R. 64E-2031 §§ 4-5.
51. Fla. Dept. of Health, *supra* note 46.
52. FLA. ADMIN. CODE ANN. r. 64E-2.031 § 2(a)-(b).
53. Raymond L. Parri, *If I Call 911, Is My Living Will Any Good? The Living Will v. the DNRO*, 60 FLA. BAR J. 82, 82 (1996).
54. FLA. ADMIN. CODE ANN. r. 64E-2.031 § 3.
55. Fla. Dept. of Health, DH Form 1896 Fla. Do Not Resuscitate Order (Rev. Feb. 2000). *See also* FLA. ADMIN. CODE ANN. r. 64E-2.031 § 3.
56. Fla. Dept. of Health, *supra* note 46.
57. FLA. ADMIN. CODE ANN. r. 64E-2.031 § 6.
58. Fla. Dept. of Health, *Do Not Resuscitate Orders, supra* note 46 (emphasis added). According to the Department of Health, neither FLA. ADMIN. CODE ANN. r. 64E-2.031 nor FLA. STAT. ch. 401.45(3)(a) reflects medical prerequisites to create a non-hospital DNR order for patients with decisional capacity. Previously, the same medical bases that apply to withholding or withdrawing life-prolonging procedures under a living will had to be present for the creation of a non-hospital DNR order. *See also* The Fla. Bar, *Florida Guardianship Practice* § 3.9 (1998).
59. FLA. ADMIN. CODE ANN. r. 64E-2.031 § 3.
60. FLA. STAT. ch. 765.302; 765.306.
61. Parri, *supra* note 53, at 83, citing previous regulation FLA. ADMIN. CODE ANN. r. 10D-66.325(3)(b),(d) (1995).
62. FLA. ADMIN. CODE ANN. r. 64E-2.031 § 3; *see also* FLA. STAT. 765.205(1)(c) specifically giving surrogates the authority to create a DNR order.
63. FLA. STAT. ch. 765.101(16).
64. Ch. 765.205(1)(b).
65. *See* FROLIK & BARNES, *supra* note 24, at 584, noting that the doctrine of substituted judgement means “that the surrogate health care decisionmaker substitutes the intent, desires, and values of the patient for his or her own when making a medical care decision for the patient. In theory, substituted judgement permits the patient to ‘control’ the decision.”
66. FLA. STAT. ch. 765.101 (15).
67. Ch. 765.401(1).
68. Ch. 765.401(3).
69. Ch. 401.45 (3)(b).
70. Fla. Dept. of Health, *supra* note 46. *See also* Fla. Dept. of Health, DH Form 1896 Fla. Do Not Resuscitate Order (Rev. Feb. 2000).
71. FLA. STAT. ch. 401.45.
72. Ch. 395.1041(5). The absence of a DNR order, however, does not preclude a physician from withholding or withdrawing CPR as otherwise permitted by law. Ch. 395.1041 (3)(1).
73. Ch. 765.1115(1)-(2).
74. Ch. 765.112.
75. Ch. 401.45(3)(a).
76. *See* Fla. Dept. of Health, *supra* note 46.
77. ILL. ADMIN. CODE tit. 77, § 515.380(e). The form has been available for use on the Department of Public Health’s website since March 2001, although its official effective date is July 1, 2001. *See* Ill. Dept. of Pub. Health, State of Illinois Do Not Resuscitate (DNR) Order, *available at* <http://www.idph.state.il.us> (last visited Mar. 2001).
78. Tit. 77 § 515.380(a).
79. 20 ILL. COMP. STAT. 2310/2310-600; Ill. Dept. of Pub. Health, *Statement of Illinois Law on Advance Directives, available at* <http://www.idph.state.il.us/public/books/advdir4.htm> (last visited Mar. 2001).
80. ILL. ADMIN. CODE tit. 77, § 515.380 (g)(1).
81. 210 ILL. COMP. STAT. 50/3.55(c).
82. ILL. ADMIN. CODE tit. 77, §§ 515.380 (a)-(m).
83. Tit. 77 § 515.380(a).
84. 755 ILL. COMP. STAT. 40/5.
85. ILL. ADMIN. CODE tit. 77, § 515.380(a).

86. Tit. 77, § 515.380(c).
87. Tit. 77, § 515.380(h).
88. Tit. 77, § 515.380(e).
89. See 20 ILL. COMP. STAT. 2310/2310-600(b)(5) and *supra* note 77.
90. *Id.* Although ILL. ADMIN. CODE tit. 77, § 515.380 does not specify the requirement for two witness signatures, the EMS Division of the Department of Public Health advised that the DNR order is considered an advance directive. The new form, therefore, follows the witness requirements outlined for advance directives (e.g., living wills). See 755 ILL. COMP. STAT. 35/3.
91. Tit. 77, § 515.380(g).
92. 755 ILL. COMP. STAT. 40/15; see also 755 ILL. COMP. STAT. 40/20 (a).
93. Rebecca J. O'Neill, *Surrogate Health Care Decisions for Adults in Illinois—Answers to the Legal Questions That Health Care Providers Face on a Daily Basis*, 20 LOY. U. CHI. L. J. 411, 446-47 (1999). Based on an analysis of the definitions in 755 ILL. COMP. STAT. 40/10, O'Neill concludes "although persons with decisional capacity do not have a qualifying condition as defined under the Health Surrogate Act, they have the authority to consent to DNRs." Unless there is limiting language in a durable power of attorney for health care, an agent may also consent to a DNR order "even though the principal does not have a qualifying condition under the Health Care Surrogate Act." *Id.*
94. 755 ILL. COMP. STAT. 40/15; see also O'Neill, *supra* note 93, at 447.
95. 755 ILL. COMP. STAT. 40/10.
96. *Id.*; see also O'Neill, *supra* note 93, at 446-47.
97. 755 ILL. COMP. STAT. 40/10.
98. 40/20 (b)(1).
99. 40/25(a) (1)-(8).
100. 40/10.
101. 40/20 (b)(1).
102. *Id.*
103. *Id.* See also Mark Stephen Bishop, *Crossing the Decisional Abyss: An Evaluation of Surrogate Decision-Making Statutes as a Means of Bridging the Gap Between Post-Quinlan Red Tape and the Realization of an Incompetent Patient's Right to Refuse Life-Sustaining Medical Treatment*, 7 ELDER L. J. 153 (1999) (providing a comprehensive review of surrogate decision-making under the Illinois Health Care Surrogate Act).
104. 755 ILL. COMP. STAT. 40/20 (f). A physician who is unable to comply with a decision to forgo life-sustaining support for personal reasons must promptly notify the administration of the health care facility. 755 ILL. COMP. STAT. 40/35.
105. 210 ILL. COMP. STAT. 50/3.55.
106. ILL. ADMIN. CODE tit. 77, § 515.380 (a)-(m).
107. Sabatino, *supra* note 5, at 303.
108. 755 ILL. COMP. STAT. 40/30(b)-(c).
109. O'Neill, *supra* note 93, at 463.
110. 210 ILL. COMP. STAT. 50/3.55.
111. ILL. ADMIN. CODE tit. 77, § 515.380 (f).
112. Mandel, *supra* note 38, at 15.
113. WIS. ADMIN. CODE HFS §§ 125.01-125.05.
114. Wis. Dept. of Health and Family Services, *Statement of Scope of Proposed Rules: 535 Wis. ADMIN. REG. 17* (July 31, 2000), available at <http://www.dhfs.state.wi.us/news/rules> (last visited Mar. 2001).
115. WIS. STAT. § 154.17(2).
116. § 154.19(3)(a); WIS. ADMIN CODE HFS § 125.05(3).
117. WIS. STAT § 154.17(5).
118. WIS. ADMIN. CODE HFS § 125.05(2)(d).
119. WIS. STAT. § 154.17(1).
120. Mandel, *supra* note 38, at 15-16.
121. WIS. ADMIN CODE HFS § 125.04.
122. WIS. STAT. § 154.27.

123. § 154.225(2).
124. § 154.19(2).
125. § 154.01(1).
126. § 154.19(1)-(2).
127. § 154.27(2).
128. § 154.21 (1)-(2).
129. § 154.25 (6m).
130. § 154.225.
131. WIS. ADMIN. CODE HFS § 125.05 (4).
132. *See supra* note 114 and accompanying text. Both Florida and Illinois also provide for verbal revocation by surrogates, but the authority appears to be more restricted than in Wisconsin. In Illinois, only those surrogates or proxies who gave written consent to a DNR order may revoke it. ILL. ADMIN. CODE tit. 77, § 515.380(g). In Florida, revocation by surrogates follows the requirements established for advance directives. *See* FLA. ADMIN. CODE ANN. r. 64E-2.031 § 6. A revocation cannot contravene the previously expressed intent of the principal. *See* FLA. STAT. § 765.205.
133. *See* Jane Barclay Mandel, *Legislature Revises State's Do-Not-Resuscitate Law*, 71-June WIS. LAW. 2, 2 (1998).
134. WIS. STAT. § 154.17(4). The physician cannot issue a DNR if he or she knows the patient is pregnant. *Id.* § 154.19(1)(e).
135. § 154.01(5m).
136. § 154.225; *see also* Robert J. Best, *Legal Guardians' Authority to Consent to Do-Not-Resuscitate Orders*, ELDER'S ADVISOR, Fall 1999 at 9, 13-14 (reviewing Wisconsin cases on surrogate decision-making).
137. § 155.20(5).
138. *Id.*
139. *See* *In re Guardianship of L.W.*, 482 N.W.2d 60, 69 (Wis. 1992). In this case, the Supreme Court of Wisconsin found that the best interests standard applied to a guardian's decision to withdraw or withhold life-sustaining medical treatment for an incompetent patient who was in a persistent vegetative state. The patient had no living will or power of attorney for health care. However, the Supreme Court of Wisconsin refused to extend this holding to incompetent patients who are not diagnosed as being in a persistent vegetative state in *In re Guardianship of Edna M.F.*, 563 N.W.2d 485 (Wis. 1997). As noted earlier in this text's discussion of medical prerequisites for a DNR order, it is unclear whether a persistent vegetative state is a qualifying condition under the Wisconsin statute. *See supra*, note 135.
140. WIS. STAT. § 154.23(1)-(3).
141. WIS. STAT. § 154.29; WIS. ADMIN CODE HFS § 125.05 (6).
142. WIS. STAT. § 154.11(9).
143. *Id.* § 154.25(4)(a).
144. BETSY ABRAMSON ET AL., *ADVISING OLDER CLIENTS AND THEIR FAMILIES* at § 15.103 (State Bar of Wis. CLE Book 1998 with 2000 Supp.).
145. *See* O'Neill, *supra* note 93 and accompanying text.
146. *See* Fla. Dept. of Health, *supra* note 58 and accompanying text.
147. *See supra* note 134 and accompanying text.
148. WIS. STAT. § 154.19(2)(a).
149. *See supra* notes 67 and 99.
150. *See* ABRAMSON ET AL., *supra* note 144 and accompanying text.
151. *See supra* notes 75 and 111 and accompanying text.
152. Lawrence W. Vernaglia, J.D., *Annotation, Propriety of, and Liability Related to, Issuance of Enforcement of Do Not Resuscitate (DNR) Orders*, 46 ALR 5th 793, 799 (1997).
153. 656 N.E.2d 773, 775 (Ill. App. Ct. 1995), *mod. and reh'g denied* 656 N.E.2d. 779, (1995).
154. *Id.* at 776.
155. *Id.*

156. *In re Austwick*, 656 N.E.2d 779, 781-82 (Ill. App. Ct. 1995).
157. *Id.* at 783.
158. 755 ILL. COMP. STAT. 40/20(b)(1); *see supra* notes 101-103 and accompanying text.
159. *See generally* Marshall B. Kapp, J.D., M.P.H., *De Facto Health-Care Rationing by Age: The Law Has No Remedy*, 19 J. OF LEGAL MED. 323, 331 (1998).
160. 625 N.Y.S.2d 809, 812 (N.Y. Sup. Ct. 1995), *mod., aff'd*, *Finn v. Leonard C.*, 221 A.D.2d 896 (N.Y. App. Div. 1995).
161. *Id.*
162. *Id.* at 813. The court explained that the “‘extraordinary’ burden provision of the statute opens the door to the treatment of the mentally and developmentally disabled as second-class citizens and any perceived possible diminution in their ‘quality of life’ could be a basis for the denial of lifesaving treatment.” *Id.*
163. *Finn v. Leonard C.*, 221 A.D.2d at 897.
164. *See generally* George P. Smith, II, *Utility and the Principle of Medical Futility: Safeguarding Autonomy and the Prohibition Against Cruel and Unusual Punishment*, 12 J. CONTEMP. HEALTH L. & POL’Y J. 1, 10-13 (1995)(reviewing definitions of medical futility). *See also* Mark Strasser, *The Futility of Futility?: On Life, Death and Reasoned Public Policy*, 57 Md. L. Rev. 505, 523-24 (1998).
165. *See supra* note 4.
166. *See Mandel, supra* note 133 and ABRAMSON ET AL., *supra* note 144, at Supp. § 15.103.