REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 6 - A-05

Subject: Universal Out-of-Hospital DNR Systems
(Resolution 5, A-04)

Presented by: Michael S. Goldrich, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Art L. Klawitter, MD, Chair)

At the 2004 Annual Meeting, the Medical Student Section introduced Resolution 5, "Universal Out-Of-Hospital DNR Systems," which directed the AMA to investigate and support the development of a standardized nationwide out-of-hospital Do Not Resuscitate (DNR) system. This resolution was referred to the Board of Trustees and assigned to the Council on Ethical and Judicial Affairs for report back to the House of Delegates.

OVERVIEW

Cardiopulmonary resuscitation (CPR) is an emergency lifesaving treatment that is capable of restoring function following cardiopulmonary arrest. In cases of arrest, the standard procedure is to initiate CPR. In certain instances, however, CPR may be contrary to patient preferences.

It is well established that patients have the right to refuse medical treatment, even if the refusal results in death. Opinion E-2.20, "Withholding or Withdrawing Life-Sustaining Medical Treatment," (AMA Policy Database) states that "[a] competent, adult patient may, in advance, formulate and provide a valid consent to the withholding or withdrawal of life-support mechanisms…." This Opinion also establishes the ethical responsibility of a physician to respect the patient's preference by stating that "[t]he principle of patient autonomy requires that physicians respect the decision to forego life-sustaining treatment of a patient who possesses decision-making capacity."[1] Understanding a patient's preferences regarding resuscitation is especially important when the patient has a progressive illness or if it is unlikely that resuscitation could restore cardiac or respiratory function.[2]

Prior to cardiopulmonary arrest, there are two mechanisms by which patients may document their preferences to withhold the use of life-sustaining treatment: a DNR order and an advance directive (AD). A DNR order to authorize the withholding of resuscitative treatment may be written by a physician to communicate the patient's wishes to others. Alternatively, an AD is an instruction developed by a patient that is intended to inform health care professionals and others of the patient's treatment preferences, which may include withholding emergency resuscitative efforts. Both a DNR order and an AD not to resuscitate (AD-DNR) involve similar ethical issues, and where appropriate, they are referred to collectively as "CPR refusals" in this report.

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If there is not a documented CPR refusal and if the patient is incapable of making a decision regarding resuscitation, this decision may be made by an authorized surrogate decision maker. Unilateral decisions from physicians to withhold resuscitation have become rare, because it is now customary for physicians to discuss the likely benefits and limitations of resuscitative efforts with patients or their surrogates. Nevertheless, in rare cases physicians may judge CPR to be clinically inappropriate.

HOSPITAL AND OUT-OF-HOSPITAL SETTINGS

The federal Patient Self-Determination Act of 1991 requires all health care agencies (hospitals, long-term care facilities, and home health agencies) receiving Medicare and Medicaid reimbursement to recognize the living will and durable power of attorney for health care as ADs.[3] Similar requirements exist in the accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations.[4] These institutions must ask patients whether they have ADs and must provide patients with educational materials about their rights under state law. If there is an AD, it is entered into the patient's medical record at that institution.

However, the patient's medical record is not readily available in out-of-hospital settings, including the patient's home, where 80 percent of cases of sudden death from cardiac causes occur.[5] In some states, the DNR order is not valid in out-of-hospital settings. North Carolina is the only state thus far to have established a statewide repository for ADs that is accessible over the internet (*See* Appendix C). Additionally, there are private registries that maintain DNR orders and ADs; however, it is unclear whether these registries are or could be consulted in an emergency situation.

Thus, in out-of-hospital settings, where medical records are not readily accessible, there is a significant possibility that a patient's preference regarding resuscitation will not be known and thus not honored.[6, 7, 8] This particularly affects patients with documented CPR refusals who are outside a hospital, because ambulance or rescue personnel generally have a legal obligation to institute life support measures if an existing AD is not readily available or is in a form that differs from that required by law.

An additional concern is presented by the widespread availability, outside of hospitals, of trained first responders and equipment such as automated external defibrillators, which can be used by health care providers or untrained individuals. There is, however, little if any guidance for citizens or emergency responders regarding the use of resuscitative measures relative to the existence, availability, and enforceability of documented CPR refusals.

Legislative solutions

Most states have enacted legislation to address patients' out-of-hospital preferences regarding resuscitation. However, these laws vary in their terminology, medical prerequisites, authorization requirements, methods of identification, and reciprocity with other states.[9] The lack of reciprocity among states is particularly problematic for many patients with documented CPR refusals because the patient's wishes may not be respected upon traveling outside the state.

The differences between state protocols regarding CPR refusals also have a significant impact on the potential liability imposed on persons present during the event triggering the need for resuscitative efforts. Many statutes confer immunity from liability due to the withholding of CPR in response to a CPR refusal. However, the statutes vary as to who is protected and under what

circumstances protection is conferred.[9] Additionally, some states provide immunity to persons who attempt resuscitation in good faith or when unaware of a CPR refusal. Unfortunately, data on the utilization of and compliance with CPR refusals are minimal. Among the states that collect data, most track only the number of CPR refusals or cards sent out, rather than the ones that are respected at the time of an emergency.[9]

RELEVANT AMA POLICY

Issues surrounding CPR refusals are well addressed in current AMA policy. AMA policy H-140.972, "Guidelines for the Appropriate Use of Do-Not-Resuscitate Orders," states: "The AMA will disseminate model state legislation which protects the rights of terminally and chronically ill patients to have their do-not-resuscitate wishes honored by emergency personnel in all out-of-hospital settings." Model legislation was created in 1998. The model legislation includes provisions for interstate reciprocity and immunity.

Opinion E-2.22, "Do-Not-Resuscitate Orders," states that patients "should be encouraged to express in advance their preferences regarding the use of CPR, and this should be documented in the patient's medical record." The Opinion further states, "The physician has an ethical obligation to honor the resuscitation preferences of the patient or the patient's surrogate." Opinion E-2.225, "Optimal Use of Orders Not-to-Intervene and Advance Directives," expresses a need for better availability and tracking of ADs in general, and for more uniform documents that can be honored in all states. Section (4) of Opinion E-2.225 specifically states that "central repositories should be established so that completed advisory documents, state statutory documents, identification of a proxy, and identification of the primary care physician, can be obtained efficiently in emergency and urgent circumstances as well as routinely."

ETHICAL CONSIDERATIONS

Just as a CPR refusal is considered binding in the hospital setting, a patient's preferences should also be honored when the patient is located outside of the hospital. A patient's right to self-determination is undermined when the location determines whether the patient's preference is respected.

Moreover, if physicians are unaware of their states' laws regarding CPR refusals, the appropriate directive might not be prepared and patients might not be provided this means of indicating their preferences regarding resuscitation.

A study in New York found that eight years after the enactment of non-hospital DNR legislation, a large minority of primary care physicians still did not use non-hospital DNRs for their patients. Less than half of the respondents who did use non-hospital DNR orders chose to utilize the official state form. This might explain the additional finding that a quarter of these respondents reported that their non-hospital DNR order had been ignored.[10] Similarly, a Washington state study found that sixty percent of the surveyed physicians did not know that there was a state law regarding out-of-hospital DNR orders.[11]

In the absence of uniform protocols across the states, much is at risk in medical crises that occur out-of-state. If emergency medical system (EMS) personnel perform resuscitation due to a failure to honor a CPR refusal, both patient and family suffer needless trauma, pain, and indignity.

The implementation of a uniform state law would create standard identification of CPR refusal. Also, a central repository would ensure portability across and reciprocity between jurisdictions. Most importantly, it could result in patient preferences being honored more frequently than they are currently.

Physician and Patient Responsibilities

It is critical that physicians discuss advance planning that includes potential CPR refusals when patients have a condition that significantly decreases the likelihood of a successful resuscitation or have a terminal condition. As part of such discussions with patients and their families, physicians should inform decision-makers of any limitations regarding out-of-hospital scenarios. Foremost, helping patients to understand state protocols requires that physicians be well informed about laws that govern CPR refusals. For example, physicians should explain the role of EMS personnel regarding CPR refusals in the course of responding to emergency calls. Patients and family members also should understand that an appropriate surrogate decision-maker has the authority to refuse resuscitative treatments when a patient lacks the capacity to make such health-care decisions. To protect the right of patients to refuse resuscitative treatments, physicians should advocate for a more systematic approach to honor patient preferences regardless of the setting in which the order or directive is invoked.

It is essential that physicians discuss preferences regarding resuscitation with patients or their surrogates. They should also educate patients who have CPR refusals regarding the implications and potential limitations of their preferences under their state's law. Patients may need to take measures, such as wearing or carrying a bracelet or other form of identification that make their preferences available at all times.

CONCLUSION

The AMA has policies that accomplish the goals of Resolution 5, A-04, "Universal Out-of-Hospital DNR Systems," including model legislation that can help create uniform laws nationwide. Through proper dissemination of this model legislation, for example, through the National Conference of Commissioners on Uniform State Laws, the AMA can help to standardize out-of-hospital DNR orders, and establish reciprocity in their implementation across the states.

In the process of reviewing this matter, the Council on Ethical and Judicial Affairs has reconsidered E-2.22 and offers changes to improve its content to better reflect the above considerations.

RECOMMENDATION

The Council on Ethical and Judicial Affairs recommends that the following recommendations be adopted in lieu of Resolution 5 (A-04) and that the remainder of this report be filed:

1. That Policy H-140.972 be rescinded, because sections 1-7 of the policy are duplicates of the ethical opinion to which changes are now being proposed, and sections 8-9 are being replaced by recommendation 3, below. (Rescind Policy)

1 2. That the Council on Ethical and Judicial Affairs' proposed replacement of Opinion E-2.22,
2 "Do Not Resuscitate Orders," be filed at the 2005 Interim Meeting. (Directive to Take
3 Action)
4
5 3. That the American Medical Association seek greater standardization and reciprocity
6 among states of DNR and AD-DNR legislation, and that the AMA model legislation "An
7 Act Concerning Out-of-Hospital Do-Not-Resuscitate Orders," be widely disseminated and
8 submitted to the National Conference of Commissioners on Uniform State Laws.
9 (Directive to Take Action)

Fiscal Note: Staff cost estimated at less than $500 to implement.

APPENDIX A

E-2.22 Do-Not-Resuscitate Orders – tracked version

When a patient suffers cardiac or respiratory arrest, attempts ~~Efforts~~ should be made to resuscitate the patients~~, who suffer cardiac or respiratory arrest~~ except when ~~circumstances indicate that~~ cardiopulmonary resuscitation (CPR) ~~would be inappropriate or~~ is not in accord with ~~the desires or best interests of~~ the patient's expressed desires or is clinically inappropriate.

All ~~P~~patients ~~at risk of cardiac or respiratory failure~~ should be encouraged to express in advance their preferences regarding the extent of treatment after cardiopulmonary arrest, especially patients at substantial risk of such an event.~~use of CPR, and this should be documented in the patient's medical record. These~~ During discussions regarding patients' preferences, physicians should include a description of the procedures encompassed by CPR. ~~and, when possible, should occur in an outpatient setting when general treatment preferences are discussed or as early as possible during hospitalization.~~ Patients' preferences should be documented as early as possible and sould be revisited and revised as appropriate.

~~The physician has an ethical obligation to~~ An advance directive stating a patient's refusal of CPR should be honored independently of whether the patient is in or out of a hospital. ~~the resuscitation preferences expressed by the patient.~~ When patients refuse CPR, ~~P~~physicians should not permit their personal value judgments ~~about quality of life~~ to obstruct ~~the~~ implementation of the refusals. ~~a patient's preferences regarding the use of CPR.~~

If a patient ~~is incapable of rendering~~ lacks the ability or cannot communicate a decision regarding the use of CPR, a surrogate decision maker may make a decision ~~may be made by a surrogate decision maker,~~ based upon the previously expressed preferences of the patient. ~~or, i~~If such preferences are unknown, decisions should be made in accordance with the patient's best interests. If no surrogate decision maker is available, an attending physician contemplating a "Do Not Resuscitate" order (DNR) should consult another physician or a hospital ethics committee, if one is available. (See Opinion 8.081, "Surrogate Decision Making.")

~~If, in the judgment of the attending physician, it would be inappropriate to pursue CPR, the attending physician may enter a do-not-resuscitate (DNR) order into the patient's record. Resuscitative efforts should be considered inappropriate by the attending physician only if they cannot be expected either to restore cardiac or respiratory function to the patient or to meet established ethical criteria, as defined in the Principles of Medical Ethics and Opinions 2.03, "Allocation of Limited Medical Resources," and 2.095, "The Provision of Adequate Health Care." When there is adequate time to do so, the physician must first inform the patient, or the incompetent patient's surrogate, of the content of the DNR order, as well as the basis for its implementation. The physician also should be prepared to discuss appropriate alternatives, such as obtaining a second opinion (eg, consulting a bioethics committee) or arranging for transfer of care to another physician.~~If a patient (either directly or through an advance directive) or the patient's surrogate request resuscitation that the physician determines would not be medically effective, the physician should seek to resolve the conflict through a fair decision-making process, when time permits. (See Opinion 2.037, "Medical Futility in End-of-Life Care.") In hospitals and other health care organizations, medical staffs or, in their absence, medical directors should adopt and

disseminate policies regarding the form and function of DNR orders and a process for resolving conflicts.

DNR orders, as well as the basis for their implementation, should be entered by the attending physician in the patient's medical record.

DNR orders and a patient's advance refusal of CPR ~~only~~ preclude only resuscitative efforts ~~in the event of~~ after cardiopulmonary arrest and should not influence other medically appropriate interventions, such as pharmacologic circulatory support and antibiotics, unless they also are specifically refused.~~therapeutic interventions that may be appropriate for the patient.~~ (See Opinion 2.225, "Optimal Use of Orders-Not-to-Intervene and Advance Directives.") (I, IV, VIII)

Issued March 1992 based on the report "Guidelines for the Appropriate Use of Do-Not-Resuscitate Orders," adopted December 1990 (*JAMA*. 1991; 265: 1868-1871). Updated June 1994 and June 2005.

E-2.22 Do-Not-Resuscitate Orders – clean version

1 When a patient suffers cardiac or respiratory arrest, attempts should be made to resuscitate the
2 patient, except when cardiopulmonary resuscitation (CPR) is not in accord with the patient's
3 expressed desires or is clinically inappropriate.

4 All patients should be encouraged to express in advance their preferences regarding the extent of
5 treatment after cardiopulmonary arrest, especially patients at substantial risk of such an event.
6 During discussions regarding patients' preferences, physicians should include a description of the
7 procedures encompassed by CPR. Patients' preferences should be documented as early as possible
8 and should be revisited and revised as appropriate.

9 An advance directive stating a patient's refusal of CPR should be honored independently of
10 whether the patient is in or out of a hospital. When patients refuse CPR, physicians should not
11 permit their personal value judgments to obstruct implementation of the refusals.

12 If a patient lacks the ability to make or cannot communicate a decision regarding the use of CPR, a
13 surrogate decision maker may make a decision based upon the previously expressed preferences of
14 the patient. If such preferences are unknown, decisions should be made in accordance with the
15 patient's best interests. If no surrogate decision maker is available, an attending physician
16 contemplating a "Do Not Resuscitate" order (DNR) should consult another physician or a hospital
17 ethics committee, if one is available. (See Opinion 8.081, "Surrogate Decision Making.")

18 If a patient (either directly or through an advance directive) or the patient's surrogate requests
19 resuscitation that the physician determines would not be medically effective, the physician should
20 seek to resolve the conflict through a fair decision-making process, when time permits. (See
21 Opinion 2.037, "Medical Futility in End-of-Life Care.") In hospitals and other health care
22 organizations, medical staffs or, in their absence, medical directors should adopt and disseminate
23 policies regarding the form and function of DNR orders and a process for resolving conflicts.

24 DNR orders and a patient's advance refusal of CPR preclude only resuscitative efforts after
25 cardiopulmonary arrest and should not influence other medically appropriate interventions, such as
26 pharmacologic circulatory support and antibiotics, unless they also are specifically refused. (See
27 Opinion 2.225, "Optimal Use of Orders-Not-to-Intervene and Advance Directives.") (I, IV, VIII)

28 Issued March 1992 based on the report "Guidelines for the Appropriate Use of Do-Not-Resuscitate
29 Orders," adopted December 1990 (*JAMA*. 1991; 265: 1868-1871). Updated June 1994 and June
30 2005.

APPENDIX B

H-140.972 Guidelines for the Appropriate Use of Do-Not-Resuscitate Orders

In order to provide assistance to physicians in managing the care of patients for whom CPR may not be appropriate, the AMA has updated its resuscitation guidelines, as follows: (1) Efforts should be made to resuscitate patients who suffer cardiac or respiratory arrest except when circumstances indicate that CPR would be futile or not in accord with the desires or best interests of the patient.

(2) Physicians should discuss with appropriate patients the possibility of cardiopulmonary arrest. Patients at risk of cardiac or respiratory failure should be encouraged to express in advance their preferences regarding the use of CPR. These discussions should include a description of the procedures encompassed by CPR and, when possible, should occur in an outpatient setting when general treatment preferences are discussed, or as early as possible during hospitalization, when the patient is likely to be mentally alert. Early discussions that occur on a nonemergent basis help to assure the patient's active participation in the decision-making process. In addition, subsequent discussions are desirable, on a periodic basis, to allow for changes in the patient's circumstances or in available treatment alternatives that may alter the patient's preferences.

(3) If a patient is incapable of rendering a decision regarding the use of CPR, a decision may be made by a surrogate decision-maker, based upon the previously expressed preferences of the patient or, if such preferences are unknown, in accordance with the patient's best interests.

(4) The physician has an ethical obligation to honor the resuscitation preferences expressed by the patient or the patient's surrogate. Physicians should not permit their personal value judgments about quality of life to obstruct the implementation of a patient's or surrogate's preferences regarding the use of CPR. However, if, in the judgment of the treating physician, CPR would be futile, the treating physician may enter a do-not-resuscitate order into the patient's record. When there is adequate time to do so, the physician must first inform the patient, or the incompetent patient's surrogate, of the content of the DNR order, as well as the basis for its implementation. The physician also should be prepared to discuss appropriate alternatives, such as obtaining a second opinion or arranging for transfer of care to another physician.

(5) Resuscitative efforts should be considered futile if they cannot be expected either to restore cardiac or respiratory function to the patient or to achieve the expressed goals of the informed patient.

(6) DNR orders, as well as the basis for their implementation, should be entered by the attending physician in the patient's medical record.

(7) DNR orders only preclude resuscitative efforts in the event of cardiopulmonary arrest and should not influence other therapeutic interventions that may be appropriate for the patient.

(8) Hospital medical staffs should periodically review their experience with DNR orders, revise their DNR policies as appropriate, and educate physicians regarding their proper role in the decision-making process for DNR orders.

(9) The AMA will disseminate model state legislation which protects the rights of terminally and chronically ill patients to have their do-not-resuscitate wishes honored by emergency personnel in all out-of-hospital settings. (CEJA Rep. D, I-90; Res. 231, A-97; Reaffirmed: Res. 203, A-01)

APPENDIX C

State	Authorization *Citation or Reference*	*Terminology*
AMA Model	*Available from AMA's Advocacy Resource Center*	Out-of-Hospital Do-Not-Resuscitate Orders
Alabama	Ala. Admin. Code rr. 420-2-1-.19, 420-2-1.28	Do Not Attempt to Resuscitate Order
Alaska	Alaska Stat. § 18.12.035 and 18.12.010-.100; Alaska Admin. Code 7 § 16.010 and 16.020	Comfort One Bracelet
Arizona	Ariz. Rev. Stat. § 36-3251	Prehospital Medical Care Directive
Arkansas	Ark. Code Ann. §§ 20-13-901 to -908; www.emsarkansas.com/dnr_regs.pdf	EMS-DNR Order
California	Cal. Prob. Code §§ 4780-4786; Calif. Code Regs. Tit. 22, § 87924; www.emsa.ca.gov/aboutemsa/dnr.asp	Pre-hospital DNR
Colorado	Colo. Rev. Stat. §§ 15-18.6-101 to -108; www.cdphe.state.co.us/op/regs/healthpromotion/101502.pdf	CPR Directive
Connecticut	Conn. Agencies Regs. §§ 19a-xxx-1 to -9	DNR Transfer Form/Bracelet
Delaware	Del. Code Ann. Tit. 16, § 9706(h)	Prehospital Advanced Care Directive
D.C.	48 D.C. Reg. 27	Comfort Care Order
Florida	Fla. Admin. Code Ann. R. 64E-2.031; Fla. Stat. Ann. § 401.45	Do Not Resuscitate Order
Georgia	Ga. Code Ann. §§ 31-39-1 to -9	DNR Order
Hawaii	Haw. Rev. Stat. § 321-229.5	Comfort Care Only DNR
Idaho	Idaho Code §§ 56-1021 to -1035; Idaho Admin. Code r. 16.02.03.400	Comfort One DNR Order
Illinois	755 Ill. Comp. Stat. § 40/65; Ill. Admin. Code tit. 77, § 515.380	DNR Order
Indiana	Ind. Code Ann. §§ 16-36-5-1 to -28	Out of Hospital DNR Declaration and Order
Iowa	Iowa Code §§ 144A.7A to .11	Out of Hospital DNR Order
Kansas	Kan. Stat. Ann. §§ 65-4941 to 4949; Kan. Admin. Regs. §109-14-1	DNR Directive (or Order)
Kentucky	Ky. Rev. Stat. Ann. § 311.623; Ky. Rev. Stat. Ann. § 311.625	EMS DNR Order
Louisiana	La. Rev. Stat. Ann. §§ 40:1299.58.1 to .10	DNR Identification Bracelet
Maine	http://www.state.me.us/dps/ems/docs/MEMS%20protocols%20(7-1-2002).PDF	EMS Comfort Care/DNR Order
Maryland	http://www.miemss.org/Protocol2004Update.pdf	EMS-DNR Order
Massachusetts	http://www.mass.gov/dph/oems/comfort/ccprot2a.htm	Comfort Care DNR Order
Michigan	Mich. Comp. Laws. Ann. §§ 333.1051 to .1067	DNR Order
Minnesota	NONE	
Mississippi	NONE	
Missouri	Mo. Code Regs. Ann. Tit. 19, §§ 30-40.303	Out of Hospital DNR Request
Montana	Mont. Code Ann. §§ 50-10-101 to -107; Mont. Admin. R. §§ 37.10.101, 37.10.104	Comfort One Form
Nebraska	NONE	
Nevada	Nev. Rev. Stat. §§ 450B.410 to .590; Nev. Admin. Code §§ 450B.950, 450B.955, 450B.960	DNR Identification
New Hampshire	N.H. Rev. Stat. Ann. § 153-A:5; N.H. Rev. Stat. Ann. § 137-H:1	DNR Form or Bracelet
New Jersey	N.J. Stat. Ann. § 26:2H-68; N.J. Admin. Code tit. 10, § 10.8-2.2	Out-of-Hospital DNR Order
New Mexico	N.M. Admin. Code tit. 7, § 27.6.8	EMS-DNR Order
New York	N.Y. Pub. Health Law §§ 2960-2977	Non-hospital DNR Order
North Carolina	N.C. Gen. Stat. § 90-21.17; N.C. Gen. Stat. § 130A-465	DNR Form
North Dakota	NONE	
Ohio	Ohio Rev. Code Ann. §§ 2133.21 to .26; Ohio Admin. Code § 3701-62-01 to -14	DNR Order
Oklahoma	Okla. Stat. tit. 63 §§ 3131.1 to .14	DNR Consent Form
Oregon	Or. Admin. R. 847-035-0030	POLST Form
Pennsylvania	Pa. Cons. Stat. Ann. Tit. 20, §§ 54A01-54A13; 28 Pa. Code §§ 1051.1 and .101	Out-of-hospital nonresuscitation
Rhode Island	R.I. Gen. Laws. §§ 23-4.11-14	Comfort One Order
South Carolina	S.C. Code Ann. §§ 44-78-10 to -65	EMS-DNR Order
South Dakota	NONE	
Tennessee	Tenn. Code Ann. §§ 68-140-601 to -604	EMS-DNR Form
Texas	Tex. Health & Safety Code Ann. §§ 166.081 to .101; 25 Tex. Admin. Code § 157.25	Out-of-hospital DNR Order
Utah	Utah Code Ann. § 75-2-1105.5	EMS-DNR Directive
Vermont	NONE	
Virginia	Va. Code Ann. § 54.1-2987.1, -2988, -2989, -2982; 12 Va. Admin. Code §§ 5-66-10 to -80	Durable DNR Order
Washington	Wash. Rev. Code Ann. § 43.70.480	EMS-No CPR Directive
West Virginia	W. Va. Code §§ 16-30C-1 to -16	Do Not Resuscitate Card
Wisconsin	Wis. Stat. Ann. §§ 154.17 to .29	DNR Order
Wyoming	Wyo. Stat. §§ 35-22-201 to -208	CPR Directive/Comfort One

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