Medical Education Systems, Inc.

Do Not Resuscitate

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Do-Not-Resuscitate

Learning Objectives

Upon successful completion of this course, you will be able to:

- Define what is meant by this term
- Identify the conditions under which it applies
- Identify the specifics which exist under such an order

On the medicine wards, you will come across patients who have a "Do-Not-Resuscitate" order on their chart. You will also be in situations where you are asked to discuss with a patient whether they want to or should have resuscitation following a cardiac arrest or life-threatening arrhythmia. Like many other medical decisions, deciding whether or not to resuscitate a patient who suffers a cardiopulmonary arrest involves a careful consideration of the potential likelihood for clinical benefit with the patient's preferences for the intervention and its likely outcome. Decisions to forego cardiac resuscitation are often difficult because of real or perceived differences in these two considerations

GUIDELINES FOR PHYSICIANS
Concerning Do Not Resuscitate (DNR) Orders For Patients Located Outside of a Hospital Or Long Term Care Nursing Facility

PURPOSE To provide a process for allowing patients to choose comfort measures over life support procedures by Emergency Medical Services (EMS) personnel in case of cardiac and/or respiratory arrest for designated patients who are located outside of a hospital or long term care nursing facility.

DEFINITIONS: DNR Order A physician's order for a patient indicating that no Basic or Advanced cardiac life support efforts (as herein defined)1/ will be initiated in the event of cardiac and/or respiratory arrest.

Valid DNR Order Form (see below) The attached form is valid if it is completed and signed by the patient/surrogate and the patient's attending physician. Legible photocopies are acceptable. DNR Bracelet (Optional) A DNR bracelet is a Medical Society of New Jersey (MSNJ)-approved, official, distinctive, and easily recognizable medical bracelet worn on the wrist, or on the ankle signifying that the patient has an effective DNR order in place. Such a bracelet shall be accepted by EMS and other medical providers as conclusive evidence that the patient has a valid DNR order in effect and resuscitative treatment should be withheld.

Basic Life Support (BLS) BLS is the phase of emergency care that includes recognition of cardiac and/or respiratory arrest, access to the EMS system, and basic CPR. Basic CPR is the attempt to restore spontaneous circulation using the techniques of chest wall compressions and pulmonary ventilation.

Advanced cardiac life support (ALS) This term refers to attempts at restoration of spontaneous circulation using basic CPR PLUS advanced airway management, endotracheal intubation, mechanical ventilation, defibrillation and intravenous medications. EMS Personnel First responders (police/fire/ others trained in CPR); emergency medical technicians staffing ambulance services (paid or volunteer); mobile intensive care paramedics; nurses who staff mobile intensive care units.

Surrogate Decision Maker The parent/guardian of a minor child; closest relative of an adult patient lacking decision making capacity; the legal proxy as contained in an advance directive; or the court appointed guardian of a judicially declared incompetent patient.

GUIDELINE

A. Respect for the Wishes of Patient and Family

1. Unless a DNR order is written by a physician for a patient found to be in cardiac and/or respiratory arrest outside the hospital or long term care facility, full resuscitative efforts will be initiated by EMS personnel.

2. When deciding whether to write a DNR order, the physician(s) shall not overrule the wishes of the patient/surrogate.

3. A DNR order may be revoked at any time by the patient or another in his/her presence at his/her direction by the cancellation or destruction of the DNR Form and bracelet; or, by an oral expression by the patient of intent to revoke; or, by the patient's attending physician or at the direction of the surrogate decision-maker.

B. Criteria for DNR orders

1. The DNR order is requested by a mentally competent, informed, adult patient, or for the incompetent or minor patient by the closest relative, the court appointed guardian or the surrogate decision-maker.

2. In considering the appropriateness for a patient/surrogate request for an out-of-hospital DNR order, factors such as the following warrant discussion with the patient/surrogate:
a. The life-sustaining treatment is likely to be ineffective or futile, or is likely to merely prolong an imminent dying process;
b. The patient is permanently unconscious;
c. The patient is in a terminal condition; or
d. There is a chronic debilitating disorder or the burdens of resuscitation significantly outweigh the benefits.
e. Such other factors as may be unique to the patient's condition.

C. Relation to other care: A DNR order enhances the professional responsibility to provide comfort and all other needed care.

RECOMMENDED PROCEDURE

A. Basic Procedure

1. Obtain written informed consent from the patient or surrogate.

2. Complete Out-of-Hospital DNR Order Form. Place copy of same in patient's medical record. Give several copies to patient and/or family and caregivers outside the hospital/nursing home.

3. Instruct patient and/or caregivers as to the use of the Out-of-Hospital DNR Order Form and as to the appropriate means of displaying the Out-of-Hospital DNR Form, i.e. placed prominently in the home in areas such as the patient's headboard, bed stand, bedroom door or refrigerator.

4. Additionally, a patient may choose to wear an appropriately recognized DNR bracelet. The bracelet shall be considered a valid indication for Out-of- Hospital DNR. The physician shall inform the patient/surrogate of the availability of DNR bracelets as an additional means of alerting EMS personnel and the means to obtain them. If the DNR order is revoked, provide instructions for the destruction of the order and the removal of the bracelet.

B. Additional Recommendations Regarding Documentation of Order
It is recommended that the physician place a note in the patient's office medical chart about the DNR order, which should include the following information:

a. Diagnosis
b. Reason for DNR order
c. Patient's capacity to make decision
d. Documentation that discussion of DNR status has occurred and with whom.

C. Revocation of DNR Orders
A DNR order may be revoked at any time by the patient or another in his/her presence at his/her direction by the cancellation or destruction of the DNR Form and bracelet; or, by an oral expression by the patient of intent to revoke; or, by the patient's attending physician or at the direction of the surrogate decision-maker.

'Do Not Attempt Resuscitation' Orders in the Out-of-Hospital Setting

This Policy Resource and Education Paper is an explication of the Policy Statement 'Do Not Attempt Resuscitation' (DNAR) in the Out-of-Hospital Setting.

Overview

Emergency medical providers often care for patients in cardiac arrest, and numerous ethical dilemmas may be encountered, including conflicting family opinions, unreasonable requests by bystanders, lack of availability of advance directives, and others.[1,2] Protocols regarding the withholding of resuscitative efforts vary widely among states and EMS jurisdictions within states. Such protocols should address many issues including justification, specificity, patient participation, inclusion of minors, futility, portability, utilization of healthcare resources, and responsibility for pronouncing death.[3]

As of 2002, 42 states had statewide out-of-hospital DNR protocols.[4] Of those, 34 were specifically authorized by statute, usually supplemented by regulation or guidelines. Eight states had implemented protocols solely through regulations or guidelines without a change in their legal code. Eight states and the District of Columbia had no statewide protocol in place. Of the 42 protocols, 39 are physician orders requiring physician signature (7 states require only a physician signature, while in 32 states both physician signature and patient endorsement of the DNAR order are required). Three protocols are patient-initiated advance directives and are valid with a witnessed patient signature, no physician involvement required.

The significance of advance directives and their role in health care at the end of life has been previously demonstrated.[5,6,7,8,9] Unfortunately, despite efforts to increase public awareness of advance directives, including public education, education within the medical community, and legal mandates, (such as, the 1991 Federal Patient Self-Determination Act), only a minority of patients have completed advance directives.[10,11,12,13] When available, advance directives can be valuable in ascertaining and following patient wishes for end of life care. Yet, completing standard advance directives do no address resuscitation issues arising in the out-of-hospital setting.

In deference to basic ethical principles, some states and some organizations' suggested statutes have focused on providing comfort care while forgoing ***only*** resuscitative interventions. Such documents, (e.g., Comfort Care DNR Order, 'Physician Orders for Life-Sustaining Treatment [POLST], Comfort One®, CPR directive, Arizona's prehospital advance directive statute,[14] and others) emphasize the need for comfort and caring during the dying process.

In both out-of-hospital and hospital settings, current resuscitation techniques generally fail in patients with comorbid illness, terminal cancer, and other irreversible disease states, when they suffer a cardiopulmonary arrest. Public opinion polls echo awareness of these findings, claiming the majority of Americans oppose life support in scenarios of terminal illness or permanent unconsciousness.[15] Despite public and professional agreement regarding the low likelihood of success in such situations, the medicolegal compact to attempt resuscitation, in the absence of a valid DNAR decision, continues to be sanctioned by society and supported by EMS providers as the standard of care. Other exceptions to this custom include when there is irrefutable evidence

of death, (e.g., decapitation) or when a decision to withhold resuscitation efforts is made by a licensed physician.

The basic format of Out-of-Hospital DNAR policy should conceptualize the primacy of patient autonomy and respect for persons. Operational protocols must address the practical aspects of implementation. For example, EMS providers should determine whether their patients have valid directives and if so, act in compliance with them.

This document is not intended to establish criteria to determine whether resuscitative efforts should be initiated in individual patients. Such decisions should be made prior to EMS system activation. Unfortunately, family and surrogate discomfort with the home death and dying experience, as well as the lack of timely out patient palliative care planning in the majority of end-of-life situations, continues to place EMS personnel in the difficult position of first response. Therefore, when EMS observes expected signs and symptoms of anticipated death, this needs to be transmitted to nurses and doctors at the hospital interface, to facilitate medical community conversations with patients and families regarding death. Such communication may help reduce 911 calls prior to an expected death in a dying patient. Nor does this document address the type of specific out-of-hospital DNAR document to implement, which reflects prevailing political and professional standards. The following guidelines suggest principles for developing protocols to allow out-of-hospital care providers to withhold CPR.

Guidelines for Developing the Out-of-Hospital DNAR Policy:

To ensure maximum coherence and compliance, a comprehensive out-of-hospital DNAR policy should be endorsed by the widest possible jurisdiction, (local, regional, state), and the medical community, including the EMS governing body. Whenever feasible, legislative support for such a policy should be sought.

The Out-of-hospital DNAR policy should:

1. Note the established fact that current basic and advanced life support interventions may not be appropriate or beneficial in certain clinical settings;
- Develop a means to educate the public about the appropriate use of 911 following *expected* deaths.
- Establish the fact that comfort care and palliative care are affirmative actions for patients with DNAR orders. These appropriate interventions, (e.g., hospice or respite care) DO NOT require EMS activation, and often can be arranged by calling the patient's physician in anticipation of death.
- Develop a means to educate healthcare workers on topics of Advance Directives, including information on local out-of-hospital DNAR, community hospice alternatives, and bereavement services.
2. Establish consensus on the ideal identification device for DNAR directive to assure continuity of care across settings;
3. Reiterate that initial resuscitative attempts are usually indicated when the patient's wishes are not known;
4. Define the conditions under which an out-of-hospital DNAR order can be considered;

including its use in long term care settings and in the emergency department.

5. Define which patients have the decisional capacity to agree to a DNAR order and whether surrogates can sign such orders.
6. Establish a mechanism for determining the precedence of various directives (e.g., Living Will, Durable Power of Attorney for Healthcare, Out-of-Hospital Advance Directive (DNAR).
7. Develop a statutory prioritized list of surrogates to use when there are no advance directives and the patient's decisional capacity is impaired.
8. Consider language acknowledging the growing home hospice movement as concern children and incorporate provisions for document use in minors.
9. Establish that the decision not to attempt resuscitation must be an informed decision made by the patient or surrogate;
10. Identify the information that should be contained in the DNAR order and the authority that will be responsible for developing such a mechanism;
11. Identify the clinical procedures that are to be provided and those withheld in the adherence with the DNAR order, or specify which authority will verify adherence.
12. Define the exact manner in which the DNAR order is to be followed, including the role of on-line medical direction. Each system should ensure that a communication path to access on-line medical direction is immediately available, when necessary.
13. Establish legal immunity provisions for those who implement DNAR orders in good faith.
14. Establish data collection and protocol evaluation to perform periodic operational assessments;
15. Identify permissible exceptions to compliance with DNAR out-of-hospital directives. For example:

- The patient is able to revoke a written directive at any time.
- The EMS personnel can cancel the out-of-hospital DNAR order if there are doubts about the document's validity.
- The EMS personnel can provide CPR if it is necessary for provider safety.

16. Out-of-Hospital DNAR policy should also include a mechanism for ensuring the proper pronouncement of death, for disposition of the decedent's body, and a mechanism for referral for grief counseling. The medical examiner/coroner, police, and EMS providers should be involved in these arrangements.
17. DNAR policy should also include procedures for ensuring that organs or tissues that have been donated by the decedent can be procured appropriately.

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Advance Directives and Do Not Resuscitate Orders

What is an advance directive?

An advance directive tells your doctor what kind of care you would like to have if you become unable to make medical decisions (if you are in a coma, for example). If you are admitted to the hospital, the hospital staff will probably talk to you about advance directives.

A good advance directive describes the kind of treatment you would want depending on how sick you are. For example, the directives would describe what kind of care you want if you have an illness that you are unlikely to recover from, or if you are permanently unconscious. Advance directives usually tell your doctor that you don't want certain kinds of treatment. However, they can also say that you want a certain treatment no matter how ill you are.

Advance directives can take many forms. Laws about advance directives are different in each state. You should be aware of the laws in your state.

What is a living will?

A living will is one type of advance directive. It is a written, legal document that describes the kind of medical treatments or life-sustaining treatments you would want if you were seriously or terminally ill. A living will doesn't let you select someone to make decisions for you.

What is a durable power of attorney for health care?

A durable power of attorney (DPA) for health care is another kind of advance directive. A DPA states whom you have chosen to make health care decisions for you. It becomes active any time you are unconscious or unable to make medical decisions. A DPA is generally more useful than a living will. But a DPA may not be a good choice if you don't have another person you trust to make these decisions for you.

Living wills and DPAs are legal in most states. Even if they aren't officially recognized by the law in your state, they can still guide your loved ones and doctor if you are unable to make decisions about your medical care. Ask your doctor, lawyer or state representative about the law in your state.

What is a do not resuscitate order?

A do not resuscitate (DNR) order is another kind of advance directive. A DNR is a request not to have cardiopulmonary resuscitation (CPR) if your heart stops or if you stop breathing. (Unless given other instructions, hospital staff will try to help all patients whose heart has stopped or who have stopped breathing.) You can use an advance directive form or tell your doctor that you don't want to be resuscitated. In this case, a DNR order is put in your medical chart by your doctor. DNR orders are accepted by doctors and hospitals in all states.

Should I have an advance directive?

By creating an advance directive, you are making your preferences about medical care known before you're faced with a serious injury or illness. This will spare your loved ones the stress of making decisions about your care while you are sick. Any person 18 years of age or older can prepare an advance directive.

People who are seriously or terminally ill are more likely to have an advance directive. For example, someone with terminal cancer might write that she does not want to be put on a respirator if she stops breathing. This action can reduce her suffering, increase her peace of mind and increase her control over her death. However, even if you are in good health, you might want to consider writing an advance directive. An accident or serious illness can happen suddenly, and if you already have a signed advance directive, your wishes are more likely to be followed.

How can I write an advance directive?

You can write an advance directive in several ways:

- Use a form provided by your doctor.
- Write your wishes down by yourself.
- Call your health department or state department on aging to get a form.
- Call a lawyer.

- Use a computer software package for legal documents.

Advance directives and living wills do not have to be complicated legal documents. They can be short, simple statements about what you want done or not done if you can't speak for yourself. Remember, anything you write by yourself or with a computer software package should follow your state laws. You may also want to have what you have written reviewed by your doctor or a lawyer to make sure your directives are understood exactly as you intended.

When you are satisfied with your directives, the orders should be notarized if possible, and copies should be given to your family and your doctor.

Can I change my advance directive?

You may change or cancel your advance directive at any time, as long as you are considered of sound mind to do so. Being of sound mind means that you are still able to think rationally and communicate your wishes in a clear manner. Again, your changes must be made, signed and notarized according to the laws in your state. Make sure that your doctor and any family members who knew about your directives are also aware that you have changed them.

If you do not have time to put your changes in writing, you can make them known while you are in the hospital. Tell your doctor and any family or friends present exactly what you want to happen. Usually, wishes that are made in person will be followed in place of the ones made earlier in writing. Be sure your instructions are clearly understood by everyone you have told.

'Do not resuscitate' vs. 'allow natural death'

Could three words change the way severely ill patients and their loved ones think about death?

Spiritual leaders and some medical staff at hospitals across the USA believe so, and they are reconsidering how they pose one of life's toughest questions:

Do you want to sign a "Do Not Resuscitate" form?

When they ask, family members often balk. They believe they are giving up, condemning a loved one to death.

Some are now asking the question a different way:

Do you want to allow natural death?

Do not resuscitate. Allow natural death. Both phrases are uttered at the same time — the moment when doctors believe they have exhausted treatment options and death is inevitable.

LOOKING BACK: In a crisis, DNR requests don't always work
NEW WARFARE: Some military families face a long goodbye

But Lee Memorial Health System specialists in Fort Myers, Fla., are finding semantics do matter.

"More often than not, the body language of the family will soften" when the phrase "allow natural death" is used, says the Rev. Cynthia Brasher, spiritual services director. "It shifts the burden."

Specific meaning for 'do not resuscitate'

A study published last year in the *Journal of Medical Ethics* measured how often nurses, student nurses and people with no health care backgrounds would endorse allowing death to progress when they were approached with the phrase "do not resuscitate" vs. "allow natural death." The nurses were likely to support the dying process regardless, but all three groups reported a greater likeliness to forgo resuscitation if "allow natural death" was used.

Some intensive care doctors say the words "do not resuscitate" can't yet disappear. That phrase carries a specific command to the attending medical team.

Razak Dosani, head of Lee Memorial Hospital's intensive care unit, says "do not resuscitate" means doctors will not perform cardiac resuscitation. But they will do everything up to that point. That might not be what the family or patient really wants. "Allow natural death" suggests doctors will offer only comfort measures, because any other aggressive treatment, such as intubation, may only prolong death.

Intensive-care doctors believe adding new terminology will help families with their decision.

Only about 20% of Americans have advanced directives leaving their loved ones to make the call if they are too sick to do so. Brasher says she knows of only one other hospital in Florida — the Miami Children's Hospital — that uses similar terminology.

It is not clear, she says, how many other health organizations across the country use it, but enough are doing so to pique the interest of scholars who are studying how words affect end-of-life decisions.

"Our argument is it's more humane and more compassionate," Brasher says.

Debate drives discussions about death

The semantic shift is a sliver of a broader question: how to talk about death, disease and the limitations of medicine.

The conversations are more crucial than ever as doctors amass an arsenal of technologies to keep people alive — and a growing list of ethical dilemmas about the nature of life artificially supported.

"Allow natural death" isn't a new concept.

Samira Beckwith, CEO of Hope Hospice in Fort Myers, says a statewide task force a decade ago looked at adopting the language on its Do Not Resuscitate forms. That didn't happen, Beckwith says, but it got health care providers talking. Hope Hospice providers use "allow natural death," along with other terminology, to make sure patients and family understand their options.

"Our greatest responsibility is to listen to the person and find the language that is best understood by them," Beckwith says.

St. David's Health Care in Texas adopted the "allow natural death" terminology eight years ago, championed by the manager of spiritual care, the late Rev. Chuck Meyer, and his successor, the Rev. Amy Donohue-Adams.

"I think people are much more comfortable with that," says Donohue-Adams, who first introduced the switch at the system's Round Rock Medical Center in Texas. "They hear 'allow natural death' and say, 'Well, that's exactly what we want. We want a death that is as natural as possible.' "

Frank Chessa, director of clinical ethics at Maine Medical Center, understands the rationale but questions its usefulness. He argues the phrase isn't specific enough.

" 'Allow natural death' to my ears is ambiguous between 'do not resuscitate' and 'comfort measures only,' " Chessa says.

He suggests using no such terminology but rather explaining patients' options with specific examples of potential life-prolonging therapies.

Many hospitals, Chessa says, are using lengthy, specific end-of-life order sets to decide on everything from CPR to dialysis to intubation to blood transfusions.

Dosani and Marilyn Kole, the Lee Memorial medical director for intensive care, say explaining terminology, options and implications of their choices will allow family members to make the best decisions for their loved ones.

"That's one of the things lacking in our medical community," Dosani says. "We need to take time and educate."

A do-not-resuscitate (DNR) order placed in a person's medical record by a doctor informs the medical staff that cardiopulmonary resuscitation (CPR—see First Aid: First-Aid Treatment) should not be performed. This order has been useful in preventing unnecessary and unwanted invasive treatment at the end of life.

Doctors discuss with patients the possibility of cardiopulmonary arrest (when the heart stops and breathing ceases), describe CPR procedures, and ask patients about treatment preferences. If a person is incapable of making a decision about CPR, a surrogate may make the decision based on the person's previously expressed preferences or, if such preferences are unknown, in accordance with the person's best interests.

A DNR order does not mean "do not treat." Rather, it means only that CPR will not be performed. Other treatments (for example, antibiotic therapy, transfusions, dialysis, or use of a ventilator) that may prolong life can still be provided. Treatment that keeps the person free of pain and comfortable (called palliative care) should always be given.

Most states also provide for special do-not-resuscitate orders that are effective outside of hospitals, wherever the person may be in the community. These are called out-of-hospital DNR orders, Comfort Care orders, No CPR orders, or other terms. Generally, they require the signature of the physician and patient (or patient's surrogate), and they provide the patient with a visually distinct quick identification form or bracelet or necklace that emergency medical services personnel can identify and comply with. These orders are especially important for terminally ill people living in the community who want only comfort care and no resuscitation if their heart or breathing stops. Living wills and durable powers of attorney for health care are not generally effective in emergency situations.

Sample Form:

PREHOSPITAL MEDICAL CARE DIRECTIVE

(side one)

IN THE EVENT OF CARDIAC OR RESPIRATORY ARREST, I REFUSE ANY RESUSCITATION MEASURES INCLUDING CARDIAC COMPRESSION, ENDOTRACHEAL INTUBATION AND OTHER ADVANCED AIRWAY MANAGEMENT, ARTIFICIAL VENTILATION, DEFIBRILLATION, ADMINISTRATION OF ADVANCED CARDIAC LIFE SUPPORT DRUGS AND RELATED EMERGENCY MEDICAL PROCEDURES.

Patient: _____ Date: _____

(Signature or mark)

Attach recent photograph here or provide all of the following information below:

Date of Birth _____
Sex _____ Race _____
Eye Color _____
Hair Color _____

PHOTO

Hospice Program (if any) _____

Name and telephone number of patient's physician_____

_____
___

(side two)

I have explained this form and its consequences to the signer and obtained assurance that the signer understands that death may result from any refused care listed above (on reverse side).

_____ Date

_____

(Licensed health care provider)

I was present when this was signed (or marked). The patient then appeared to be of sound mind and free from duress.

_____ Date

_____

(Witness)

Do Not Resuscitate Examination

Select the ***best*** answer to each of the following items. Mark your responses on the Answer form.

1. A DNR order means that a physician's order for a patient indicating that no Basic or Advanced cardiac life support efforts will be initiated in the event of cardiac and/or respiratory arrest.

a. True
b. False

2. A DNR order may be revoked at any time by the patient or another in his/her presence at his/her direction by the cancellation or destruction of the DNR Form and bracelet; or, by a(n) _____by the patient of intent to revoke; or, by the patient's attending physician or at the direction of the surrogate decision-maker.

a. court order
b. oral expression
c. 911 call
d. None of the above

3. In considering the appropriateness for a patient/surrogate request for an out-of-hospital DNR order, factors such as the following warrant discussion with the patient/surrogate_____.

a. The life-sustaining treatment is likely to be ineffective or futile, or is likely to merely prolong an imminent dying process
b. The patient is in a terminal condition
c. There is a chronic debilitating disorder or the burdens of resuscitation significantly outweigh the benefits.
d. All of the above

4. A durable power of attorney (DPA) for health care is another kind of advance directive. A DPA states whom you have chosen to make health care decisions for you. It becomes active any time you are unconscious or unable to make medical decisions. A DPA is generally more useful than a living will. But a DPA may not be a good choice if you don't have another person you trust to make these decisions for you.

a. True
b. False

5. A do not resuscitate (DNR) order is another kind of advance directive. A DNR is a request not to have cardiopulmonary resuscitation (CPR) if your heart stops or if you stop breathing. (Unless given other instructions, hospital staff will try to help all patients whose heart has stopped or who have stopped breathing.) You can use an advance directive form or tell your doctor that you don't want to be resuscitated. In this case, a DNR order is put in your medical chart by your doctor. DNR orders are accepted by doctors and hospitals in all states.

a. True
b. False

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How to Complete Your Test and Print Your Certificate Online

If you chose to receive your order by postal mail, you have been mailed the printed course material(s) and the printed test(s). To take a test, simply complete the mailed test and send it back. Upon successful completion of a test, a certificate will be mailed or faxed to you. If you don't wish to mail the test back, customers who chose to have the course material(s) mailed may also follow the steps below to complete a test and print a certificate online.

INSTRUCTIONS

1. Go to www.mededsys.com
2. Login and go to "My Account".
3. On the page that opens, select an option from the "My Courses" menu.
4. Select the test you wish to complete.
5. After completion of test, print your certificate online by clicking on the "Continue" button. Alternatively, you may return to the "My Courses" section and select the option to print a certificate.