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LEGISLATIVE COMMENT

DO NOT RESUSCITATE ORDERS: A MATTER OF LIFE AND DEATH IN NEW YORK

*Science! true daughter of Old Time art!
Who alterest all things with thy peering eyes.
Why preyest thou thus upon the poet's heart,
Vulture, whose wings are dull realities?
How should he love thee? Or how deem thee wise?
Who would not leave him in his wanderings
To seek for treasure in the jewelled skies. . .*

*Sonnet—To Science
Edgar Allan Poe*

Cardiopulmonary resuscitation ("CPR") is the process of bringing a person back from the brink of death by restoring the person's heartbeat and breathing after "cardiac arrest" — the point at which a person's heart has stopped functioning.¹ CPR typically involves a number of medical procedures, including cardiac massage, insertion of endotracheal tubes to provide oxygen, injections of medication into the heart or veins, use of defibrillators to give electric shocks to induce heart contractions, and similar methods.² Cardiac arrest occurs at some point in the dying process of every person.³ Because a person will die within a very few minutes without a heartbeat, a decision whether or not to perform CPR must be made immediately upon cardiac arrest.⁴ A "do not resuscitate" ("DNR") order instructs the hospital staff that CPR is not to be administered on a patient if that patient suffers a respiratory or cardiac arrest.⁵

In the absence of legislative guidelines, there is a substantial question whether DNR orders are legal, and whether hospital personnel can be held

1. PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT, 231 (March 1983) [hereinafter PRESIDENT'S COMMISSION].

2. See J. Robertson, THE RIGHTS OF THE CRITICALLY ILL, 71 (1983). The President's Commission estimated that the cost of resuscitation is commonly over \$1,000, an estimate which does not include the derivative costs in caring for a surviving patient who suffers from side effects. PRESIDENT'S COMMISSION, *supra* note 1, at 244 n.44.

3. PRESIDENT'S COMMISSION, *supra* note 1, at 235.

4. *Id.*

5. See *infra* notes 18-20 and accompanying text.

liable for the issuance of a DNR order. For example, prior to the enactment of a DNR law in New York state, physicians, unsure of their potential liability, regularly opted not to issue DNR orders even when they believed such orders to be appropriate.⁶ One New York physician was quoted as saying:

Older physicians are afraid of putting "do not resuscitate" down because they are afraid of being sued for making a wrong decision. The younger physicians are anxious to put a "do not resuscitate" down because they are afraid of being sued for making a wrong decision. The nurses will not act without a "do not resuscitate" because they are afraid of being sued.⁷

In December 1984, New York Governor Mario Cuomo appointed a twenty-three member commission to review and propose legislation to help the state legislature respond to a range of issues pertaining to medicine and morality, including DNR orders.⁸ The New York State Task Force on Life and the Law published its detailed recommendations in April 1986.⁹

On August 7, 1987, the State of New York enacted a comprehensive law pertaining to the issuance of DNR orders.¹⁰ The law, which is based on the

6. See Letter from Stuart Showalter, Director, Division of Legal Services of the Catholic Health Association of the United States, quoted in a letter from John E. Curley, Jr., President of CHA, to the President's Commission (March 25, 1982), reprinted in PRESIDENT'S COMMISSION, *supra* note 1, at 239 n.31 ("[C]ommon sense is often subordinated to a hysterical reaction to the possibility of litigation."); Personal communication from Joel Glass, attorney with Ackerman, Salwen, and Glass, New York City, to Joanne Lynn (Jan. 10, 1983), reprinted in PRESIDENT'S COMMISSION, *supra* note 1, at 239 n.31 ("Few DNR orders are being written for incompetent patients in New York State at present, largely because district attorneys state that they consider such orders to be illegal and subject to criminal prosecution.").

7. Testimony of Dr. Albert Fine, transcript of 10th meeting of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (President's Commission) (June 4, 1981) at 95, reprinted in PRESIDENT'S COMMISSION, *supra* note 1, at 239.

8. Severo, *Cuomo Appoints 23 to Study Issues in Medical Technology*, N.Y. Times, Dec. 23, 1984, at A22, col. 1.

9. See NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, DO NOT RESUSCITATE ORDERS (1986) [hereinafter TASK FORCE].

10. N.Y. PUB. HEALTH LAW § 2960-2978. (McKinney 1987). The law is a result of the Task Force's report and a grand jury investigation conducted in New York state during 1983. The grand jury found that, rather than put DNR orders in any form of a writing that could incriminate them, physicians would use other, less obvious methods to convey that a DNR order had been issued. Sullivan, *New York State Drafts Right-To-Die Guidelines*, N.Y. Times, Aug. 13, 1987, at B4, col. 5. For example, physicians at La Guardia Hospital in Queens, N.Y. had ordered small purple dots attached to the medical charts of terminally ill patients to signify that a DNR order had been issued. *Id.* Physicians at the Memorial Sloan-Kettering Cancer Center wrote DNR orders on a blackboard which was erased after the order was carried out. *Id.* The grand jury also found that hospitals used "slow codes" to reach the same outcome. Under a "slow code", the physicians and nurses would use delaying tactics to make sure that any effort to utilize CPR would fail. By responding with a "slow code" the hospital could still tell the family of the patient that everything had been done to save the patient. *Id.*;

recommendations of the Task Force, establishes a presumption in favor of the patient's implied consent to CPR, but also establishes the lawfulness of a DNR order if the order is issued in compliance with the law.¹¹ The law allows an adult with capacity to authorize a DNR order in conjunction with his or her attending physician. Where an adult lacks capacity, or the patient is a minor, the law allows for the appointment of a surrogate who may decide, in concert with the patient's physician, to issue a DNR order. The law specifies that a DNR order does not constitute consent to the withholding or withdrawal of any medical treatment other than CPR.¹² Additionally, the law specifies that the issuance of a DNR order shall not legally impair, modify or invalidate any life insurance policy, and that a DNR order can neither be required nor prohibited by any insurance policy.¹³ The law also provides for a dispute mediation system and a judicial appeal process to help resolve disputes between interested parties. Finally, the law extends immunity both

see Report of the Special January Third Additional Grand Jury Concerning "Do Not Resuscitate" Procedures at a Certain Hospital in Queens County, (Sup. Ct., Queens Co., Feb. 8, 1984); see also Margolick, *Hospital is Investigated on Life-Support Policy*, N.Y. Times, June 20, 1982, at A34; Sullivan, *Hospitals Seek Rules on Withholding Life-Support*, N.Y. Times, Nov. 17, 1982, at B3; In re Grand Jury Proceedings: *People v. Doe*, No. 333 (N.Y. Ct. App. June 18, 1982).

11. After approximately one year of study, the Task Force concluded that legislation regarding DNR orders was essential to "create uniform practices and to clarify the rights, authority and protections afforded patients, family members, and health care professionals in the issuance of [DNR] orders." TASK FORCE, *supra* note 9, at 15. See also Note, *To Die or Not to Die: The New York Legislature Ponders A Natural Death Act*, 13 FORDHAM URB. L.J. 630 (1985). Another study which reviewed DNR orders was published by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. See PRESIDENT'S COMMISSION, *supra* note 1.

12. Under the law, CPR does not include measures to improve ventilation and cardiac functions in the absence of an arrest. N.Y. PUB. HEALTH LAW § 2961(4). In this way, the law requires that routine care be provided to patients who have requested a DNR order. The law explicitly does not require a hospital to expand its existing equipment or facilities to provide CPR. N.Y. PUB. HEALTH LAW § 2962(4). This decision is in accord with the report of the President's Commission, which stated that "an order not to resuscitate holds no necessary implications for any other therapeutic decisions." PRESIDENT'S COMMISSION, *supra* note 1, at 9. The Task Force report not only states that the issuance of a DNR order should have no effect on the provision of ordinary care, but adds that a DNR order can never justify discharging a patient from the hospital since presumably the patient for whom a DNR order is issued is terminally ill, and needs special care during the dying process. TASK FORCE, *supra* note 9, at 22.

13. N.Y. PUB. HEALTH LAW § 2975(1),(2). Indeed, the Task Force believed that the decision to perform CPR should be completely divorced from concerns regarding insurance coverage. TASK FORCE, *supra* note 9, at 46. The President's Commission took the insurance issue one step further; "the level or extent of health care that will be reimbursed under public or private insurance programs should never be linked to [DNR] orders." PRESIDENT'S COMMISSION, *supra* note 1, at 9.

to hospital personnel and to those individuals who participate in the mediation process.

Although enacted on August 7, 1987, the law became effective on April 1, 1988, with any additions, amendments or repeal of any necessary rule or regulation as authorized and directed to be made and completed prior to the effective date.¹⁴ In the interim period, the law authorized the New York State Commissioner of Health, after consultation with the Commissioners of Mental Health and Mental Retardation and Developmental Disabilities, to prepare a statement summarizing the rights, duties and requirements of the law. The statement was to be distributed by hospitals to their patients and to individuals authorized by the law to act as a patient's surrogate in making a decision regarding CPR (if those individuals are known to the hospital at or prior to the time of the patient's admission). The statement was then to be distributed to all members of the hospital staff who were involved in providing medical care. The statement was also to be posted in a public place in each hospital.

On February 4, 1988, the Commissioner promulgated regulations to implement the statute. The regulation makes an almost verbatim statement of the law applicable to medical facilities.¹⁵ The regulation also makes the law applicable to residential health care facilities.¹⁶ Additionally, the Commissioner has required all hospitals to ensure that each member of the hospital's staff involved in providing medical care is trained in the requirements of the law. Each hospital is also required to post in a public place the hospital's policy governing the rights, duties and requirements of the DNR orders.¹⁷

This legislative comment will first analyze the New York DNR law as it pertains to an adult with capacity, an adult who lacks capacity, and a minor. It will then review the process for revoking a DNR order, the requirements of mandatory physician review of DNR orders, the policy on institutional transfers, the workings of the dispute mediation process, and the immunity granted by the law. Throughout the paper's description of these aspects of the New York statute, it will compare the New York law to the recommendations in the Governors' Task Force report, to a similar study conducted by the President's Commission for the Study of Ethical Problems in Medicine

14. The law became effective April 1, 1988 and it appeared that during the interim the medical industry continued on as it had before legislation: under self-regulation. For an example of self-regulated guidelines relating to DNR orders, see MEDICAL SOCIETY OF THE STATE OF NEW YORK, DO NOT RESUSCITATE GUIDELINES FOR HOSPITALS, PHYSICIANS AND NURSING HOMES (Sept. 9, 1982, as amended Nov. 11, 1985).

15. See N.Y. COMP. CODES R. & REGS. tit. 10, § 405.42 (1988). Differences between the law and the Commissioner's rule will be noted throughout this text.

16. See N.Y. COMP. CODES R. & REGS. tit. 10, § 414.23 (1988).

17. See N.Y. COMP. CODES R. & REGS. tit. 10 § 405.42 (1988).

and Biomedical and Behavioral Research, and to the existing common law relating to DNR orders.

1. WHETHER A DNR ORDER SHOULD BE ISSUED

A. *A Competent Adult's Right To Decide Whether A DNR Order Should Be Issued*

Under the New York law, every person admitted to a hospital is presumed to consent to the administration of CPR in the case of cardiac or respiratory arrest.¹⁸ The law also provides, however, that an adult with capacity may request that his or her attending physician issue a DNR order.¹⁹ This was one of the central recommendations of the Task Force, and the central provision of the new statute.²⁰

18. The law defines cardiopulmonary resuscitation as "measures, as specified in regulations promulgated by the commissioner, to restore cardiac function or to support ventilation in the event of cardiac or respiratory arrest." N.Y. PUB. HEALTH LAW § 2961(4). The Commissioner defined cardiopulmonary resuscitation as "measures to restore cardiac function or to support ventilation in the event of cardiac or respiratory arrest." N.Y. COMP. CODES R. & REGS. tit. 10 § 405.42 (1988). The Task Force concluded that the regulations should define CPR, as opposed to the legislation, in order to permit the flexibility needed to adjust the definition to changing medical technology and practices. TASK FORCE, *supra* note 9, at 20. The law defines hospitalized as "the period during which a person is a patient in, or a resident of, a hospital." N.Y. PUB. HEALTH LAW § 2961(8).

19. The law defines a DNR order as "an order not to attempt cardiopulmonary resuscitation in the event a patient suffers cardiac or respiratory arrest." N.Y. PUB. HEALTH LAW § 2961(3). For a historical review of DNR orders see Note, *No-Code Orders vs. Resuscitation: The Decision to Withhold Life-Prolonging Treatment From the Terminally Ill*, 26 WAYNE L. REV. 139 (1979).

The law defines an adult as "any person who is eighteen years of age or older, or is the parent of a child, or has married." N.Y. PUB. HEALTH LAW § 2961(1).

The law defines capacity as "the ability to understand and appreciate the nature and consequences of an order not to resuscitate, including the benefits and disadvantages of such an order, and to reach an informed decision regarding the order." N.Y. PUB. HEALTH LAW § 2961(3).

20. The Task Force recognized that "[t]he right to decline CPR is an expression of the person's common law right, well-recognized in this State, to direct the course of one's own medical treatment, and not be treated without consent." TASK FORCE, *supra* note 9, at 22, (cites omitted). This position is consistent with New York state case law which recognizes the right of an adult with sound mind to determine what should be done to his or her own body. *In re Eichner*, 52 N.Y.2d 363, 420 N.E.2d 64, 70, 438 N.Y.S.2d 266, *cert. denied sub nom. Storar v. Storar*, 454 U.S. 858 (1981). The only common law exception to this rule is in the case of an emergency where the person is unconscious and it is necessary to operate before consent can be obtained. *Id.* Treatment without consent would therefore be considered either a battery (see *Zimmerman v. N.Y.C. Health & Hospital Corp.*, 91 A.D.2d 290, 458 N.Y.S.2d 552, 555 (App. Div. 1983)), or negligence (see *Dries v. Gregor*, 72 A.D.2d 231, 424 N.Y.S.2d 561 (App. Div. 1980)).

For background on *In re Eichner* and its companion case *In re Storar* see Comment, *Medico-Legal Implications of "Orders Not to Resuscitate,"* 31 CATH. U.L. REV. 515 (1982);

There are two ways in which a patient can request a DNR order. First, an adult with capacity, while in the hospital, may request orally that a DNR order be issued.²¹ The patient's oral request must be witnessed by two persons who are at least eighteen years of age, one of which must be a physician affiliated with the hospital.²² Second, prior to or during hospitalization, an adult with capacity can make a written decision not to accept CPR.²³ The written decision must be dated and signed by the patient and two witnesses at least eighteen years of age; it is not required that a physician be one of the witnesses.

Issuance of a DNR order is not automatic upon a patient's request. Rather, before an order will be issued, the attending physician must fulfill a number of duties and obligations.²⁴ The attending physician must first, in

Live or Let Die: Who Decides an Incompetent's Fate? In re Storar and In re Eichner, 1982 B.Y.U. L. REV. 387 (1982).

21. The law defines a hospital as "a general hospital as defined in subdivision ten of section twenty-eight hundred one of this chapter and a residential care facility as defined in subdivision three of section twenty-eight hundred one of this chapter or a hospital as defined in subdivision ten of section 1.03 of the mental hygiene law or a school named in section 13.17 of the mental hygiene law." N.Y. PUB. HEALTH LAW § 2961(7). The Commissioner's rules removed the word "general" from the definition of a hospital. N.Y. COMP. CODES R. & REGS. tit. 10, § 405.42 (1988). See also N.Y. PUB. HEALTH LAW § 2801, 2801(3) (McKinney 1985); N.Y. MENTAL HYG. LAW § 1.03(10), 13.17 (McKinney 1978 & Supp. 1987).

22. N.Y. PUB. HEALTH LAW § 2964(2)(a). The Task Force recommended that one of the witnesses to the oral statement made during hospitalization be a physician affiliated with the hospital so that the physician could make certain required determinations concerning the decision. "Since the authenticity and meaning of the oral statement must be evaluated by the attending physician, the fact that the statement was made in the presence of a hospital physician will greatly assist that evaluation and the attending physician's willingness to rely on the statement." TASK FORCE, *supra* note 9, at 20.

The Task Force did not include prior oral statements which are not made in the required context because it did not believe there was any reliable way to test the veracity and content of such statements. *Id.* at 26.

23. N.Y. PUB. HEALTH LAW § 2964(2)(b). The law does not make any reference to the rationale and procedures for adopting prior statements by the patient as to a CPR decision. *But see* TASK FORCE, *supra* note 9, at 25. ("Reliance on written statements must be limited, however, to those circumstances where there is little doubt about the authenticity and applicability of the instructions and no better alternative *e.g.*, a contemporaneous statement by the person." The Task Force would have authorized the Commissioner of Health to provide a form to be used for this purpose.) See also *id.* at 25; PRESIDENT'S COMMISSION, *supra* note 1, at 245, n.47 ("If a patient, while competent anticipated a later incompetence and medical condition, understood what should be entailed in a decision for or against resuscitation, and made firm and explicit statements regarding the decision, then those directives should be honored provided there is no reason to think that the patient's choice had changed or would have changed."). The President's Commission leaves the physician responsible for assessing whether "the patient adequately understood the ramifications of the choice and clearly stated his or her decision." *Id.*

24. The law defines an attending physician as "the physician selected by or assigned to a patient in a hospital, who has primary responsibility for the treatment and care of the patient."

concert with a hospital-appointed physician, decide whether or not the patient is an adult as defined by the law and whether the patient has the requisite capacity to make such a decision.²⁵ If the attending physician decides that the patient is an adult with capacity under the law, the physician must provide the patient with information about the patient's diagnosis and prognosis, the reasonably foreseeable risks and benefits of CPR as they pertain to that patient, and a description of the consequences of a DNR order.²⁶ The attending physician must also include the patient's written statement in the patient's medical chart, or note on the chart the patient's oral decision.

Once the attending physician has made a determination regarding adulthood and capacity, the physician then has the option of either issuing the DNR order or voicing his or her opposition to the order.²⁷ If the physician decides that the order should be issued, the order can either be issued immediately or upon the occurrence of any prerequisite medical condition specified by the patient. Upon issuance, the hospital staff responsible for the patient's care must be notified.

If, however, the attending physician objects to the issuance of a DNR order, the physician should immediately inform the patient of his or her objection and the reasons underlying it.²⁸ If the discussion between the physician and the patient does not resolve their difference of opinion, the physi-

N.Y. PUB. HEALTH LAW § 2961(2). In addition, the law provides that "where more than one physician shares such responsibility, any such physician may act as the attending physician." *Id.*

25. As used in this article, a hospital-appointed physician is a physician other than the attending physician who is selected by a person authorized by the hospital to make such a selection. *See* N.Y. PUB. HEALTH LAW § 2963(3)(a).

26. N.Y. PUB. HEALTH LAW § 2962(3). The President's Commission noted that health care professionals would require training in order to help their patients make a decision regarding CPR. "The education of health care professionals should ensure that they know how to help patients and family make ethically justified decisions for or against resuscitation; those responsible for professional licensure and certification may want to assess knowledge in these areas." PRESIDENT'S COMMISSION, *supra* note 1, at 9. The Commission determined that there are three values at stake in a decision regarding CPR: self-determination (the value of extending life for whatever period of time and under whatever conditions vs. an earlier death); well-being (whether CPR will promote a patient's welfare); and equity (society's obligation to provide an adequate level of care to all without excessive burdens). *Id.* at 240-44.

The Task Force, like the President's Commission, also recognized the balancing of values which must go into a decision regarding CPR. The Task Force determined that "[t]he benefit of extending life, often only for brief periods marked by suffering and disability, must be weighed against an earlier, more peaceful, death." TASK FORCE, *supra* note 9, at 7.

27. The DNR order must be effective immediately. N.Y. PUB. HEALTH LAW § 2964(2). Therefore, if the patient has determined that a DNR order should be issued only when a specified medical condition exists, the physician must determine that the specified condition exists before issuing the order. This determination must be reflected in the patient's chart.

28. The Task Force hoped that this discussion would bring about a reconciliation of the patient's and physician's views. TASK FORCE, *supra* note 9, at 19.

cian has two options. The physician must either make all reasonable efforts to arrange for the transfer of the patient to another physician,²⁹ or promptly submit the matter to the dispute mediation system established by the law.³⁰

There is an additional level of review involved if the patient is in or was transferred from a mental hygiene facility.³¹ In such a case, the facility director must be notified that the patient has consented to a DNR order before the order can be issued.³² If the facility director concludes that the patient lacks capacity or that the order is not in the best interests of the patient, the facility director must submit the matter to the dispute mediation system.

The law also contains a "therapeutic exception" to the requirement that the patient be involved in a CPR decision. In the event that the attending physician determines that, to a reasonable degree of medical certainty, an adult with capacity would suffer severe and immediate physical or mental injury from a discussion of CPR, the physician may issue a DNR order without first obtaining the patient's consent.³³ The law does not specify what potential "injury" is sufficient to invoke this exception, but the Task Force report provided some examples: a patient with arrhythmia for whom the discussion might trigger a cardiac arrest, and a patient with severe paranoia, depression, or suicidal tendencies who might inflict harm on himself or herself.³⁴

In order to take advantage of this exception, the physician must follow a number of steps: 1) consult with and obtain the written concurrence of a hospital-appointed physician after the appointed physician has personally

29. The Task Force reiterated the fact that while the physician is attempting to transfer the patient, he or she still has a professional obligation not to abandon care of the patient. TASK FORCE, *supra* note 9, at 21.

30. This result is contrary to the recommendation of the President's Commission. According to the Commission, if the patient and physician disagree, "further discussion and consultation are appropriate; [but] ultimately the physician must follow the patient's decision or transfer responsibility for the patient to another physician." PRESIDENT'S COMMISSION, *supra* note 1, at 8.

31. The law defines a mental hygiene facility as "a residential facility operated or licensed by the office of mental health or the office of mental retardation and developmental disabilities. N.Y. PUB. HEALTH LAW § 2961(10).

32. Notification of the facility director should not delay issuance of the order. N.Y. PUB. HEALTH LAW § 2965(6)(c).

33. N.Y. PUB. HEALTH LAW § 2964(3).

34. TASK FORCE, *supra* note 9, at 23. The Task Force makes clear that the therapeutic exception is only to be used to avoid harming the patient and not to be used to avoid talking to the patient about the dying process. *Id.* at 22. There is a minority report included in the Task Force's report which was written by two members of the Task Force who disagreed with the other members of the Task Force only on this point. The minority report argues that the therapeutic exception articulated by the majority is too narrow. See *Do Not Resuscitate Orders, Minority Report of the New York State Task Force* (May 1986).

examined the patient and decided that the patient would be immediately and severely injured by a discussion of CPR; 2) ascertain the wishes of the patient to the extent possible without causing injury; 3) include the reasons the patient was not consulted in the patient's medical chart; and 4) if the patient has not previously consented to a DNR order, obtain the consent of a surrogate.³⁵ The attending physician is also required to reevaluate, on a regular basis, the potential harm to the patient which might result from a discussion of CPR. If upon reassessment the physician determines that a risk no longer exists, the physician must consult with the patient regarding CPR.

B. Determination That An Adult Lacks Capacity

As set forth above, once an adult patient requests a DNR order, the attending physician has the principal responsibility to decide, to a reasonable degree of medical certainty, whether the patient has capacity to decide whether the order should be issued.³⁶ If the attending physician decides that the patient lacks capacity, the physician must include in the patient's chart the cause and nature of the patient's incapacity as well as the extent and probable duration of the incapacity.³⁷ A hospital-appointed physician must also examine the patient and concur in the attending physician's assess-

35. The Task Force states that the purpose of the consultation between the physician and the patient is not to gain consent, but to solicit the patient's wishes. TASK FORCE, *supra* note 9, at 23.

36. A lack of capacity shall not be presumed from the fact that a committee or a conservator has been appointed for the adult under article seventy-two or seventy-eight of the New York mental hygiene law, or that a guardian has been appointed under article seventeen-A of the surrogate's court procedures act. N.Y. PUB. HEALTH LAW § 2963(1).

As the Task Force points out, lack of capacity can include a broad spectrum of conditions. TASK FORCE, *supra* note 9, at 27. For example, a patient who is unconscious and cannot make or communicate any decision lacks capacity. *Id.* at 27. More difficult judgements must be made where, for example, the patient suffers from mild retardation, or the patient is elderly and senile with intermittent lapses of lucidity. *Id.* at 27. The Task Force proposed that capacity include cognitive and conceptual skills to recognize the importance of the decision, and emotional development. *Id.* at 28.

37. If the attending physician in a general hospital determines that a patient lacks capacity because of mental illness, the concurring opinion must be provided by a physician certified or eligible to be certified by the American Board of Psychiatry and Neurology. N.Y. PUB. HEALTH LAW § 2963(3)(b). If the attending physician determines that the patient lacks capacity because of a developmental disability, the concurring opinion must be provided by a physician or psychologist who is employed by a school named in section 13.17 of the mental hygiene law, or who has been employed a minimum of two years to render care and service in a facility operated or licensed by the Office of Mental Retardation and Developmental Disabilities, or who has been approved by the Commissioner of Mental Retardation and Developmental Disabilities in accordance with regulations promulgated by such Commissioner. N.Y. PUB. HEALTH LAW § 2963(3)(c). Such regulations must require that a physician or psychologist possess special training or three years experience in treating developmental disabilities. *Id.*

A determination by the attending physician that the patient lacks capacity to make a deci-

ment.³⁸ The hospital-appointed physician is required to note in the patient's chart the cause and nature of the patient's incapacity, its extent and possible duration.

When the attending and hospital-appointed physicians make a determination that the patient lacks capacity, notice, including a copy of the summary statement to be prepared by the Commissioner of Health,³⁹ must be given promptly to the patient (when there is any indication that the patient will comprehend the notice). Notice also must be given to the person highest on the patient's surrogate list⁴⁰ and, if the patient is in or was transferred from a mental hygiene facility, to the facility director.⁴¹

C. Surrogate Decision Where The Adult Patient Lacks Capacity

Where an adult who lacks capacity had, prior to losing capacity, consented to a DNR order, no further approval is needed; the adult's prior decision rules.⁴² Conversely, where an adult lacks capacity to make a decision regarding a DNR order and no prior decision was made by the patient regarding CPR, a surrogate may authorize a DNR order on behalf of the adult.⁴³ An adult with capacity has the right to designate a surrogate to

sion regarding CPR cannot be construed as a determination that the patient lacks capacity for any other purpose. N.Y. PUB. HEALTH LAW § 2963(5).

38. The Task Force specifies that the physicians' decisions be made independently. TASK FORCE, *supra* note 9, at 29. The Task Force discouraged the use of the judiciary to determine capacity because "it does not always guarantee a better decision since the courts must ultimately rely on the judgement of medical professionals." *Id.* at 29.

39. *See supra* note 14 and accompanying text.

40. The surrogate list includes the person appointed by the patient, a court appointed surrogate, the spouse, a child at least eighteen years of age, a parent, a sibling at least eighteen years of age or a close friend. N.Y. PUB. HEALTH LAW § 2965(4). The surrogate will be chosen from this list in the order listed. *Id.*

41. The Task Force determined that these procedures would safeguard the patient's right to due process. *See* TASK FORCE, *supra* note 9, at 30-31. For a discussion of other constitutional considerations *see id.* at 38-39.

42. This same result would most likely have been reached prior to enactment of the law. *See Saunders v. New York*, 129 Misc.2d 45, 492 N.Y.S.2d 510 (Sup. Ct. 1985).

43. The law defines a surrogate as "the person selected to make a decision regarding resuscitation on behalf of another person." N.Y. PUB. HEALTH LAW § 2961(17).

Allowing a surrogate to make a life or death decision for an incompetent appears to be contrary to the prior common law in New York. *See In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied sub nom. Storar v. Storar* 454 U.S. 858 (1981); *see also New York v. Eulo*, 63 N.Y.2d 341, 472 N.E.2d 286, 296, 482 N.Y.S.2d 436 (N.Y. 1984) (citing *In re Storar*) ("[i]n the absence of such evidence of personal intent [there, due to the patient's incompetence]) a third party has no recognized right to decide that the patient's quality of life has declined to a point where treatment should be withheld and the patient should be allowed to die."); *In re Kerr*, 517 N.Y.S.2d 346, 348 (N.Y. Sup. Ct. 1986) (citing *In re Storar*) ("When a person is not competent to make such a life or death decision, the court must intervene in favor of life prolonging treatment, despite the feelings and desires of those closest to the patient.").

make a decision regarding CPR in the event that the patient loses capacity. An adult with capacity may choose a surrogate in a dated, signed, writing which is witnessed and signed by two persons who are at least eighteen years of age. Alternatively, while in the hospital, the adult with capacity may select a surrogate orally in the presence of two witnesses eighteen years of age or older. In the event that no surrogate has been designated (or the appointed surrogate is not reasonably available, willing and competent to make a decision regarding a DNR order), the law provides a selection system and authority for appointment of a surrogate.⁴⁴ The surrogate is to be selected from the following list of persons in order of priority: 1) a person designated by the adult patient having capacity; 2) a committee made up of the person or guardian appointed by the court; 3) the patient's spouse; 4) a child of the patient who is eighteen years of age or older; 5) a parent of the patient; 6) a sibling of the patient who is eighteen years of age or older; and 7) a close friend of the patient.⁴⁵ Once the surrogate has been identified, the name of the surrogate must be written into the patient's medical chart.

The surrogate is authorized to make a decision on behalf of the patient regarding a DNR order. The surrogate's decision may be based on the patient's religious and moral beliefs or, if that information is not known, on the basis of the patient's "best interests." The surrogate is also granted the same rights as the patient to receive medical records and information.

The surrogate may authorize a DNR order only after the attending and hospital-appointed physicians find, after personal examinations of the patient and to a reasonable degree of medical certainty, that the patient has a terminal condition,⁴⁶ is permanently unconscious,⁴⁷ that resuscitation would

44. The Task Force did not suggest requiring judicial appointment of the surrogate because "[w]hile court appointment of a guardian provides additional safeguards, including judicial assessment of the surrogate's character and good faith, the judicial process is often ill-suited for urgent medical decisions: it is too slow, too cumbersome and too costly." TASK FORCE, *supra* note 9, at 32.

45. Even though the Task Force did not require appointment of the surrogate by the judiciary, the surrogate list reflects the fact that sometimes a court will grant a conservator authority to make health care decisions. *Id.* at 33.

The Task Force did not determine a selection process where there are more than one qualified candidates within a surrogate class (for example, where there are three children over the age of eighteen); it is up to the family or the dispute mediation system to resolve such disputes. *Id.* at 34.

The law defines a close friend as "any person eighteen years of age or older, who presents an affidavit to an attending physician stating that he is a close friend of the patient and that he has maintained such regular contact with the patient as to be familiar with the patient's activities, health, and religious or moral beliefs and stating the facts and circumstances that demonstrate such familiarity." N.Y. PUB. HEALTH LAW § 2961(5).

46. The law defines terminal condition as "an illness or injury from which there is no recovery, and which reasonably can be expected to cause death within one year." N.Y. PUB.

be medically futile,⁴⁸ or that resuscitation would impose an extraordinary burden on the patient in light of the patient's medical condition and the expected outcome of resuscitation. The physicians' findings must be included in the patient's medical chart.

A surrogate's consent to a DNR order must be set forth in a dated writing that is signed by the surrogate and one witness who is at least eighteen years of age.⁴⁹ Once notified, the attending physician must enter the surrogate's decision in the patient's medical chart and either issue the DNR order and inform the hospital staff attending the patient of the order, or make the physician's objections to the order known to the surrogate and attempt to transfer the patient to another physician or submit the matter to the dispute mediation system. If the patient is in or was transferred from a mental hygiene facility, the facility director must be given notice. Like the attending physician, the facility director may submit the matter to the dispute mediation system if he or she determines that the patient has capacity or that the DNR order is otherwise improper. Notice to the facility director must not delay the issuance of the DNR order.

If the attending physician has actual notice that anyone on the surrogate list or the facility director opposes the DNR order, the physician must submit the matter to the dispute mediation system and not issue the order. Notice of the DNR order must be given to the patient if there is any indication that the patient will comprehend the order, unless a decision has been made that such notice would harm the patient.⁵⁰ If the patient objects, the DNR

HEALTH LAW § 2961(19). The Task Force emphasized that "the one year period is only a guideline and does not require a degree of medical certainty not afforded by medical prognosis." TASK FORCE, *supra* note 9, at 36.

47. The Task Force used the term "irreversibly comatose" to include all patients who have permanently lost consciousness, including the loss of all thought, sensation and awareness of self or environment. TASK FORCE, *supra* note 9, at 36 n.41. The Task Force found irreversibly comatose to include patients in a persistent vegetative state, patients who are completely unresponsive after brain injury or hypoxia and fail to stabilize in a vegetative state, patients in the end stages of degenerative neurological conditions such as Alzheimer's disease, patients with intracranial mass lesions and patients with congenital hypoplasia of the central nervous system. *Id.* at 36.

48. The law defines medically futile as a situation where "cardiopulmonary resuscitation will be unsuccessful in restoring cardiac and respiratory function or that the patient will experience repeated arrest in a short time period before death." N.Y. PUB. HEALTH LAW § 2961(9). The Task Force explained that decisions regarding whether CPR would be medically futile can be made to a reasonable degree of certainty based on statistical experiences with CPR. TASK FORCE, *supra* note 9, at 36.

49. Under the law, the physician cannot also act as a surrogate for his or her patient. N.Y. PUB. HEALTH LAW § 2965(5)(d). The Task Force specifies that the physician and surrogate must act independently to provide greater protection for the patient. TASK FORCE, *supra* note 9, at 38.

50. *See supra* notes 33-34 and accompanying text.

order must be revoked.

D. Issuance Of A DNR Order When The Adult Patient Lacks Capacity And No Surrogate Is Available

If no surrogate is reasonably available, willing, or competent to make a decision regarding a DNR order, and the adult patient who lacks capacity has not previously expressed a decision regarding CPR, the attending physician may issue a DNR order if the physician determines in writing that, to a reasonable degree of medical certainty, resuscitation would be medically futile.⁵¹ A concurring decision must be made by a hospital-appointed physician, in writing, after a personal examination of the patient. A DNR order may also be issued pursuant to a court order.⁵² The patient must be given notice of the decision to issue a DNR order if there is any indication that the patient will be able to comprehend the decision.⁵³

E. Decision-Making On Behalf Of A Minor

The attending physician, in concert with the minor's parent or legal guardian, must determine whether or not the minor has the capacity to make a determination regarding CPR.⁵⁴ Even if the minor has capacity to decide in favor of a DNR order, the minor's parent or legal guardian must concur in the decision before a DNR order can be issued.⁵⁵

If the attending physician determines that the minor lacks capacity, the parent or legal guardian of the patient must make the decision whether or not to issue a DNR order based on the beliefs of the minor, including the minor's religious and moral beliefs.⁵⁶ The parent or legal guardian may consent to the issuance of a DNR order only after the attending physician and the hospital-appointed physician concur in writing, after a personal examination of the patient, that to a reasonable degree of medical certainty one of

51. N.Y. PUB. HEALTH LAW § 2966(1)(a). This decision must be entered on the patient's chart.

52. N.Y. PUB. HEALTH LAW § 2966(1)(b). See *infra* notes 85-93 and accompanying text.

53. As in other contexts, if the patient is in or was transferred from a mental hygiene facility, the facility director must be given notice and is allowed to submit the matter to the dispute mediation system for cause. See *supra* notes 31-32 and accompanying text.

54. The law defines a minor as "any person who is not an adult." N.Y. PUB. HEALTH LAW § 2961(12).

55. The Task Force report emphasized that, unlike an adult, a minor should not be presumed to have capacity because the minor's capacity may still be developing. TASK FORCE, *supra* note 9, at 40. Unlike the law, the Task Force would only have allowed the minor to "assent" as opposed to "consent." *Id.* at 41. The Task Force believed that assent was appropriate because it connotes an authority less than full consent. *Id.* at 41.

56. N.Y. PUB. HEALTH LAW § 2967(4)(a).

the four specified conditions exists.⁵⁷ The parent or legal guardian's decision must be made in a dated writing signed by the deciding parent or guardian and one witness at least eighteen years of age.⁵⁸ Upon notice of the written consent of the parent or legal guardian (and minor, if appropriate), the attending physician must issue the DNR order or, if the physician disagrees with the order, make known the reasons for the disagreement and transfer the patient to another physician.⁵⁹

Where the attending physician has reason to believe that another parent or non-custodial parent exists who has not been informed of a DNR order, the attending physician must make a diligent effort to locate the parent and notify the parent of the issuance of a DNR order.⁶⁰ If the newly-advised parent does not consent to the DNR order, the physician must revoke any order which has been issued and submit the matter to the dispute mediation system.⁶¹

2. REVOCATION OF A DNR ORDER

An adult with capacity who authorized a DNR order may revoke the order at any time by making either a written or oral statement to a physician or member of the hospital nursing staff, or by any act evidencing specific intent to revoke the order.⁶²

A surrogate, parent, or legal guardian may revoke a DNR order by notifying a physician or member of the hospital nursing staff in a dated, signed writing, or by orally notifying the attending physician in the presence of one witness who is at least eighteen years of age.⁶³

Once a physician is informed of a revocation of consent, the physician must immediately place notice of the revocation in the patient's chart, cancel the order and notify the hospital staff responsible for the patient's care of the rescission of the order.⁶⁴

3. PHYSICIAN'S CONTINUING REVIEW

Once a DNR order has been issued, the attending physician must con-

57. *Id.* at § 2967(3).

58. *Id.* at 2967(4)(a).

59. *Id.* at § 2967(4)(b).

60. *Id.* at § 2967(2)(b).

61. *Id.* at § 2967(4)(c).

62. *Id.* at § 2969(1).

63. *Id.* at § 2969(2).

64. *Id.* at § 2969(3). The Task Force's recommendation differs from the law in that the Task Force would have required that "[a]ny medical staff member informed of revocation of the order [would be] required to record the revocation in the patient's chart and to cancel the order immediately." TASK FORCE, *supra* note 9, at 20.

tinue to review the patient's chart to determine whether the order is still appropriate in light of the patient's condition.⁶⁵ If the patient is in a hospital other than a residential health care facility, the physician must review the patient's chart every three days.⁶⁶ For a patient in a residential care facility, the physician must review the patient's chart each time the physician sees the patient but not less than once every sixty days.⁶⁷ Failure to follow this procedure would not render the DNR order moot.

If the attending physician determines that the DNR order is no longer appropriate, the physician must immediately notify the person who consented to the order.⁶⁸ If that person does not revoke their consent to the order, the physician must attempt to transfer the patient to another physician or submit the matter to the dispute mediation system.⁶⁹ If the order was consented to by a surrogate, parent, or legal guardian, and an attending physician determines that one of the four specified conditions no longer exists,⁷⁰ the physician must include such determination in the patient's chart, cancel the order, and notify the person who gave consent and the hospital staff of the rescission of the order.⁷¹

Additionally, if the consent was given by a surrogate and the adult patient regains capacity at any time, the attending physician must immediately cancel the order and notify both the person who consented to the order and the hospital staff,⁷² thereby allowing the patient to make his or her own decision.

4. INSTITUTIONAL TRANSFERS

If the patient for whom a valid DNR order has been issued is transferred to a different hospital, the order remains in effect until a physician at the new hospital cancels the order or until twenty-four hours have elapsed.⁷³ The physician at the new hospital who receives a DNR order may assume that the order is valid and may issue a new order based on the previous order.⁷⁴

65. N.Y. PUB. HEALTH LAW § 2970(1).

66. *Id.* at § 2970(1)(a).

67. N.Y. PUB. HEALTH LAW § 2970(1)(b). The Task Force recommended that the order be reviewed every thirty days, a schedule that it felt was consistent with the existing requirements for physicians to visit patients in nursing homes every thirty days. TASK FORCE, *supra* note 9, at 22. The Task Force also recommended that if more frequent visits by a physician are medically indicated, that the physician also review the order during those visits. *Id.* at 22.

68. *Id.* at § 2970(2)(a).

69. *Id.* at § 2970(2)(b).

70. *See supra* notes 43-45 and accompanying text.

71. N.Y. PUB. HEALTH LAW § 2970(b).

72. *Id.* at § 2970(c).

73. *Id.* at § 2971.

74. *Id.* at § 2971(2).

5. THE DISPUTE MEDIATION SYSTEM

Each hospital must establish its own dispute mediation system.⁷⁵ The system must be set forth in writing and adopted by the hospital's governing authority.⁷⁶ Under the law, the system may utilize any existing hospital resources or it may create a new body to handle DNR orders.⁷⁷ In addition, with respect to disputes involving a patient who is found to lack capacity, the system must have available to it either: 1) a physician or psychologist, or 2) a family member or legal guardian of a person having the same mental illness (or developmental disability) as the patient, to assist in making a concurring determination regarding the patient's capacity.⁷⁸

The dispute mediation system must be authorized to mediate any dispute challenging consent to the issuance of a DNR order, including disputes regarding a patient's capacity and disputes between any combination of the hospital, the attending physician, the patient, a surrogate, any individual on the surrogate list, a minor, the minor patient's parent or legal guardian, a non-custodial parent, and a facility director (if the patient is in or was transferred from a mental institution).⁷⁹ The dispute mediation system is advisory only; dispute mediation personnel do not have authority to decide whether or not a DNR order should be issued.⁸⁰

Once a dispute has been submitted to the dispute mediation system, no DNR order shall be issued.⁸¹ If an order has already been issued, it must be revoked.⁸² An order may not be issued, or reissued, until: 1) the dispute has been resolved, 2) the mediation system has concluded its effort to resolve the dispute, or 3) seventy-two hours have passed from the submission of the dispute to mediation, whichever comes first.⁸³ Thus, if it is to be effective, the dispute mediation system must make a decision regarding the dispute within seventy-two hours. When the dispute mediation system is unable to come to a decision, whether because no conclusion can be reached or be-

75. *Id.* at § 2972(1)(a).

76. *Id.* at § 2972(1)(b).

77. *Id.* at § 2972(1)(b).

78. *Id.* at § 2972(1)(b). The Task Force reviewed the types of committees which hospitals have been developing to deal with new medical problems and moral issues as they arise. TASK FORCE, *supra* note 9, at 43. For example, most committees maintain diverse memberships including, *inter alia*, physicians, nurses, clergy, lawyers, philosophers, social workers and community representatives. *Id.* at 43.

79. N.Y. PUB. HEALTH LAW § 2972(2).

80. *Id.* at § 2972(5). Like the law, the Task Force report specified that the dispute mediation system should mediate but not adjudicate disputes. TASK FORCE, *supra* note 9, at 44. Accordingly, the decision of the system could never be binding. *Id.*

81. N.Y. PUB. HEALTH LAW § 2972(3).

82. *Id.*

83. *Id.*

cause the seventy-two hours have expired, the attending physician must promptly issue the DNR order if the appropriate conditions precedent still exist and inform the hospital staff of the issuance of the order, or promptly arrange the transfer of the patient to another physician or hospital.⁸⁴

6. JUDICIAL REVIEW

The law authorizes certain persons, by petition to a court of competent jurisdiction, to commence a special proceeding with respect to any dispute arising out of the law.⁸⁵ A decision by a patient not to consent to a DNR order cannot be challenged, however.⁸⁶ Any challenge to a decision regarding the issuance of a DNR order on the grounds that it is contrary to the patient's wishes or best interest must be proved by clear and convincing evidence.⁸⁷

The law grants the courts authority to issue an order, pursuant to the standards applicable to the issuance of a temporary restraining order, which shall suspend the DNR order to permit the court's review.⁸⁸ No dispute can be brought before the court without first being brought before the dispute mediation system unless brought by the patient or by the Department of Health or any other authorized state agency to enjoin a violation of the law.⁸⁹

The court may also review a proposed DNR order where the patient lacks capacity and had not previously expressed a decision regarding CPR, and there is no surrogate reasonably available, willing and competent to make a decision on behalf of the patient.⁹⁰ In this instance, the attending physician or the hospital may commence a special proceeding, in a court of competent jurisdiction, for a judgment directing the physician to issue a DNR order

84. *Id.* at § 2972(4).

85. *Id.* at § 2973(1).

86. *Id.*

87. *Id.* The Task Force believed that, under its proposed legislation, resort to the courts would be rare because the dispute mediation system would "enhance the quality of decisions made by patients and physicians and minimize conflict." TASK FORCE, *supra* note 9, at 19. The Task Force believed that "[o]nly the highly improbable case of the otherwise healthy patient who might fully recover from resuscitation presents the kind of conflict which is likely to require judicial intervention." *Id.* at 43.

The President's Commission also clearly expressed its view that decisions regarding CPR should not end up in court unless necessary. "[D]ecisionmaking about life-sustaining care is rarely improved by resort to the courts." PRESIDENT'S COMMISSION, *supra* note 1, at 247. The Commission did admit that a court is probably the "appropriate forum for serious, intractable disagreements between a patient's surrogate and physician." *Id.* at 248.

88. N.Y. PUB. HEALTH LAW § 2973(2).

89. *Id.* at § 2973(3).

90. *Id.* at § 2976(1).

where the patient has a terminal condition, is permanently unconscious, or resuscitation would impose an extraordinary burden on the patient in light of the patient's medical condition and the expected outcome of the resuscitation.⁹¹ The court's decision must be consistent with the patient's wishes and must be based on an examination of the patient's religious and moral beliefs or, if not known, the best interest of the patient.⁹² The law does not preclude a court of competent jurisdiction from approving the issuance of a DNR order under circumstances other than those described in the law.⁹³

7. IMMUNITY

The law provides immunity from criminal prosecution, civil liability or from charges of unprofessional conduct for all hospital personnel where the personnel acted in good faith under the law.⁹⁴ Additionally, hospital personnel cannot be held liable for criminal prosecution, civil liability or charges of unprofessional conduct where the individual provided CPR and there was a DNR order in effect if the person was reasonably and in good faith unaware of the DNR order or reasonably and in good faith thought that the consent to a DNR order had been revoked.⁹⁵ Additionally, no individual can be subjected to criminal prosecution or civil liability for consenting or declining to consent to the issuance of a DNR order where the decision was made in good faith.⁹⁶ Mediators are also protected from criminal prosecution, civil liability or charges of unprofessional conduct for acts performed in good faith as a dispute mediator.⁹⁷

CONCLUSION

The New York State law implements practices which are very close to those recommended by both the New York State Task Force on Life and Law and the President's Commission for the Study of Ethical Problems in

91. *Id.*

92. *Id.*

93. *Id.* at § 2976(2).

94. *Id.* at § 2974(1). Accordingly, the physician would not be granted immunity if he or she failed to meet the applicable standards of skill and care in making the medical diagnosis required by the law. TASK FORCE, *supra* note 9, at 52. Hospital personnel granted immunity include any physician, health care professional, nurse's aide, hospital, or person employed by or under contract to a hospital. See N.Y. PUB. HEALTH LAW § 2974.

95. N.Y. PUB. HEALTH LAW § 2974(2)(a),(b). Under New York state case law, the physician would have been held liable in damages for any treatment performed without the competent patient's consent. See *In re Eichner*, 52 N.Y.2d 363, 420 N.E.2d 64, 70, 438 N.Y.S.2d 266, *cert. denied sub nom.* 454 U.S. 858 (1981).

96. N.Y. PUB. HEALTH LAW § 2974(3).

97. *Id.* at § 2974(4).

Medicine and Biomedical and Behavioral Research. It is a comprehensive, well thought out law which codifies in part and changes in part the common law. The law is designed to protect medical personnel and the dispute mediators, as well as the patient and the patient's family. Backers of the statute hope that by protecting all involved, the hysteria revolving around DNR orders will be alleviated and the orders will be used where appropriate.

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