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Edward F. McArdle

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NEW YORK'S DO-NOT-RESUSCITATE LAW: GROUNDBREAKING PROTECTION OF PATIENT AUTONOMY OR A PHYSICIAN'S RIGHT TO MAKE MEDICAL FUTILITY DETERMINATIONS?

*Edward F. McArdle**

SUMMARY

New York's Do-Not-Resuscitate (DNR) law was groundbreaking when it was first enacted in 1987. Now, it is on the forefront of the medical futility debate, whose proponents seek to supplant patient autonomy with the medical ethical principles of beneficence and non-maleficence as the primary basis for medical decision making. Beneficence is a duty to promote the patient's interest, and non-maleficence (more commonly known by the adage "Do No Harm") is a duty to avoid harm to the patient.¹ Both are ethical principles derived from philosophical theory that guide health care providers to the clinical practice of medicine.² Since ancient times, they have been at the core of medical decision making.³ In the past half century, however, they have been

* Edward F. McArdle is an assistant attorney general on the staff of the New York Attorney General. He also serves as an adjunct lecturer at Upstate Medical University and an extern supervisor for the Syracuse University College of Law. He is admitted to the practice of law in New York and is a graduate of Albany Law School of Union University. This article expresses the author's views alone and is not intended to reflect the position of the New York Attorney General.

¹ See, e.g., BERNARD LO, RESOLVING ETHICAL DILEMMAS: A GUIDE FOR CLINICIANS 31-37 (Lipincott Press, 2nd Ed. 2000); RONALD MUNSON, INTERVENTION AND REFLECTION: BASIC ISSUES IN MEDICAL ETHICS 31-32 (Wadsworth/Thompson Learning, 6th Ed. 2000).

² *Id.*

³ See, e.g., Larry R. Churchill, Beneficence, ENCYCLOPEDIA OF BIOETHICS 243, 45-46 (Warren Thomas Reich ed., rev. ed. 1995) (citing duty of beneficence which has been "central to the health professions" since the Hippocratic Oath); Appendix, "Oath of Hippocrates, Fourth Century, B.C." *Id.* at 2632 (prescribes that physicians take beneficent action ("for the benefit of the sick") and refrain from maleficent action ("keep them from harm and injustice").

joined by the principle of patient autonomy to form the modern day cornerstone of the physician-patient relationship.⁴

Like DNR legislation enacted in other states, New York's DNR law sought to promote patient autonomy by providing a means for patients and families to make decisions to refuse cardiopulmonary resuscitation (CPR). However, it also empowered family members to consent to DNR orders when the patient's wishes about medical treatment were not known. As such, it served as a precursor to the current debate in New York and other states over surrogate decision making laws, which propose authorizing family members or other surrogates to make medical decisions in the absence of knowledge of the patient's wishes. This includes the power to consent to the withholding or withdrawal of life-sustaining treatment.

New York's DNR law was also more ambitious than conventional DNR laws because its theoretical framework incorporated other medical ethical principles in addition to patient autonomy, which in the last century has become the standard bearer for virtually all state laws and court decisions related to ending life-sustaining treatment. Going beyond laws in other states, New York's DNR law provided physicians with authority, based on medical futility, to make DNR orders for patients who lacked both decision making ability and a family member or proxy to make health care decisions.

In the context of the debate over withholding or withdrawing life-sustaining treatment for patients whose actual or likely wishes are not known, measuring the use of life-sustaining medical treatments on the yardstick of physician-determined medical futility remains controversial and hotly debated. New York's DNR law, however, which provides the same powers within the confines of CPR, has remained largely unquestioned. This may be because the law is limited to one type of life-sustaining treatment. Another reason may be that it is limited to patients who are terminally ill or permanently unconscious, which falls within societal normative values on when it is appropriate to withhold or withdraw life-sustaining treatment.

Currently, the New York State agency charged with overseeing New York's DNR law, the New York State Department of Health

⁴ See, e.g., Lo, *supra* note 1, at 3-41; THOMAS BEAUCHAMP, JAMES CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 12-13, 57-282 (5th ed., 2001). (The first edition published in 1979 is widely credited with founding the present-day bioethical approach to medical decision making and also advocated the wider principle of distributive justice in the provision of health care.)

(DOH), has thrown its weight behind an even broader application of medical futility that supports a physician's right to issue a DNR order based on medical futility over the objection of a patient or family member. Based on the work of the influential New York State Task Force on Life and the Law (Task Force), DOH and other important health care players in New York, this information can be found on the DOH official website. It has also been widely disseminated to New York physicians. Many, if not most, New York physicians believe that New York's DNR law supports a physician's determination to withhold CPR based on medical futility over the objection of the patient or a proxy decision maker.

The purpose of this article is to determine whether New York's DNR law supports the DOH's determination that a physician can override patient objection and issue a DNR order based on medical futility. The historical background and context for New York's DNR law and DNR legislation in general is examined, as well as the ethical conflict that results when patient autonomy clashes with the medical ethical principles of beneficence and non-maleficence. These principles are implicated when a physician seeks to override a patient or patient family refusal to consent to a DNR order.

The interpretation advanced by New York's DOH is unprecedented because it proposes balancing medical futility over patient autonomy. By doing so, a state agency, for what appears to be the first time, has recognized that autonomy can be overridden by ethical principles of beneficence and non-maleficence. Since at least the writing of the Hippocratic Oath, these principles have provided the underpinnings to the physician-patient relationship, which preceded the emergence of patient autonomy in the last century.

This article will argue that the New York state agency's interpretation is consistent with both the spirit and the intent of the DNR law, as well as with evolving ethical views on resolution of conflicts arising between patient autonomy and other medical ethical principles. It seeks to harmonize the DNR law's emphasis on patient self-determination against other, equally important medical ethical principles of beneficence and non-maleficence. It also contains necessary checks to insure that decisions to withhold CPR based on medical futility, as well as decisions by patients or family members to refuse to consent to a DNR order, comport with prevailing societal values on the use of life-sustaining treatments. The law must first be understood against the backdrop of ethical, medical and legal

principles, which support physician medical futility determinations to issue a DNR order when CPR will not sustain the patient's life. The statute's narrowly drawn definition of medical futility, and its requirement that proxy decisions not based on patient autonomy can only be made when the patient is terminally ill or permanently unconscious, supports the DOH's view and places it well within the mainstream of medical ethical thought.

The debate over New York's DNR law may herald a new recognition of the limits of health care decision making based on the principle of autonomy alone and revitalize other medical ethical principles, beneficence and non-maleficence, that historically have been important to the physician-patient relationship. The approach taken by New York could provide guidance to other states when they face the same unavoidable conflict between patient autonomy and health care providers relying on other medical ethical principles.

BACKGROUND

When enacted in 1987, New York's Do-Not-Resuscitate (DNR) Law was a leading edge legislative initiative which sought to provide patients with a clear means of declining cardio-pulmonary resuscitation.⁵ Cardio-pulmonary resuscitation (CPR) is the treatment for cardiac arrest.⁶ It refers to the various types of procedures available to physicians to "restore cardiac function or to support ventilation in the event of a cardiac or respiratory arrest."⁷ It is one of many lifesaving

⁵ N.Y. PUB. HEALTH LAW, Art. 29-B, §§ 2960-2979 (McKinney 1988); *See, e.g.*, § 2960, Legislative findings and purposes ("The legislature finds that, although cardiopulmonary resuscitation has proved invaluable in the prevention of sudden, unexpected death, it is appropriate for an attending physician, in certain circumstances, to issue an order not to attempt cardiopulmonary resuscitation of a patient where appropriate consent has been obtained. The legislature further finds that there is a need to clarify and establish the rights and obligations of patients, their families, and health care providers regarding cardiopulmonary resuscitation and the issuance of orders not to resuscitate."); *See, e.g.*, George P. Smith II, *Euphemistic Codes and Tell-Tale Hearts: Humane Assistance In End-Of-Life Cases*, 10 HEALTH MATRIX 175, 191 (2000) (As of 1994, New York one of only two states that had "enacted statutes that furnish formal procedures governing decisions not to resuscitate"); Elizabeth Shaver, *Do Not Resuscitate: The Failure to Protect the Incompetent Patient's Right of Self-Determination*, 75 CORNELL L. REV. 218, 239 - 243 (1989) (in criticizing the law, finds the law unique because it departs from substituted judgment standard for decision making for incompetent patients who have no surrogate).

⁶ Paul C. Sorum, *Limiting Cardiopulmonary Resuscitation*, 57 ALB. L. REV. 617, 617-618 (1994) (provides detailed explanation of CPR).

⁷ N.Y. PUB. HEALTH LAW § 2961, subd. 4 (McKinney 1988).

techniques which became widely available in the second half of the 20th Century.⁸ Examples of CPR include mouth-to-mouth rescue breathing, direct cardiac injection, intravenous medications, electrical defibrillation and open chest cardiac massage.⁹ In order for it to be effective, CPR must be started within minutes of the arrest.¹⁰

However, as with other lifesaving techniques, the benefits of CPR may be limited for some patients, such as those who are chronically rather than acutely ill.¹¹ The effectiveness of CPR can be limited because of the patient's other medical conditions.¹² Further, it can be painful, with greater risk of pain for frail, elderly patients.¹³ CPR may not be able to prevent irreversible damage to body organs, including brain damage.¹⁴ Many seriously ill patients informed of the risks may wish to avoid CPR.¹⁵ Further, many doctors consider it to be medically

⁸ "Life-prolonging treatment" has been defined by the British Medical Association (BMA) as "all treatment which has the potential to postpone the patient's death and includes cardiopulmonary resuscitation, artificial ventilation, specialized treatments for particular conditions such as chemotherapy or dialysis, antibiotics when given for a potentially life-threatening infection and artificial nutrition and hydration." BMA, *Withholding and Withdrawing Life-Prolonging Medical Treatment -- Guidance for Decision Making*, Part 1, § 3.2.

⁹ See NYS Health Dept. Regs, 10 N.Y.C.R.R. § 405.43 (b)(4) (1988); DO NOT RESUSCITATE ORDERS: THE PROPOSED LEGISLATION AND REPORT OF THE NEW YORK STATE TASK FORCE ON LIFE AND THE LAW 3 (New York: New York State Task Force on Life and Law, 2nd ed. 1988) ("Basic resuscitation involves the initiation and maintenance of respiration and heartbeat through simple techniques such as mouth-to-mouth resuscitation and external chest compression which can be administered without equipment by any person trained in CPR. Advanced resuscitation requires more sophisticated techniques and is performed by trained medical personnel.").

¹⁰ See New York Task Force on Life and the Law, *supra* note 9, at 3 ("In order for CPR to be effective, basic techniques must be initiated within minutes of the arrest (ordinarily within 4-5 minutes), and must be followed immediately by advanced life support (within 10-12 minutes of the arrest).").

¹¹ See, e.g., Sorum, *supra* note 6, at 617-618.

¹² See New York State Task Force on Life and the Law, *supra* note 9, at 4.

¹³ *Id.*

¹⁴ See, e.g., *In re Dinnerstein*, 380 N.E.2d 134-136 (1978) ("many of these procedure are ... highly intrusive, and some are violent in nature. The defibrillator, for example, causes violent (and painful) muscle contractions which, in a patient suffering (as this patient is) from osteoporosis, may cause fracture of vertebrae or other bones. Such fractures, in turn, cause pain, which may be extreme."). See, e.g., Smith, *supra* note 5, at 176 ("Because many resuscitated patients were critically ill, extremely ill, extremely elderly, or severely and irreversible demented, resuscitation oftentimes served only to prolong suffering or to sustain patients in a persistent vegetative state.").

¹⁵ See, e.g., Sorum *supra* note 6, at 628-635; Smith *supra* note 5, at 176 ("[P]hysicians, patients and patients' families became increasingly concerned that resuscitation was not always in the best interests of the patient.").

futile for some patients and not always in the patient's best interests to attempt resuscitation.¹⁶

DNR legislation in New York and other states was enacted against a backdrop of expanding use of CPR for all patients, even for patients that physicians believed would experience little or no benefit from the procedures, and against court decisions in the 1970s and 1980s in which a right of competent patients to decline life-sustaining treatment became firmly established.¹⁷

The use of CPR was originally limited to patients suffering acute heart or respiratory arrest.¹⁸ However, it was soon expanded to all patients, including those suffering from underlying terminal illnesses.¹⁹ Its required use on all patients who suffer a heart arrest was institutionalized by hospitals and regulating authorities as an emergency procedure unless an order to the contrary, a DNR order, was written by a physician.²⁰

Many physicians have objected to the required use of CPR where it will likely fail as "a cruel and fruitless assault on severely ill and demented patients."²¹ In one documented case, CPR was administered fifty-two times over a six week period before the patient's death.²² Because it was believed that many patients, if given a choice, would refuse CPR, DNR legislation was enacted in order to provide patients

¹⁶ See, e.g., Smith, *supra* note 5. See also Thomas Finucane, Symposium Article, Thinking About Life-Sustaining Treatment Late In the Life Of A Demented Person, 35 GA. L. REV. 691 (2001).

¹⁷ See, e.g., ALAN MEISEL, THE RIGHT TO DIE 37 (Wiley Law Publications, 1995).

¹⁸ See, e.g., Sorum, *supra* note 6, at 618 ("But quickly it was used, even by its inventors, on patients without ventricular fibrillation as well, that is, on types of patients for whom it was not originally intended.").

¹⁹ See, e.g., Smith, *supra* note 5, at 178 ("[CPR] is a desperate invasive procedure that was not intended to delay the impending death of patients who are suffering from terminal illnesses.").

²⁰ See, e.g., Smith, *supra* note 5 at 178 ("This classification [of CPR as an emergency procedure] led to the expanded use of CPR, well beyond the select group of patients for which it was intended, and therefore a pervasive, indiscriminate, and often contraindicated use of CPR by health-care workers.").

²¹ See, e.g., Sorum, *supra* note 6 at 618. See also M. SCOTT PECK, DENIAL OF THE SOUL – SPIRITUAL AND MEDICAL PERSPECTIVES ON EUTHANASIA AND MORTALITY 10-12 (Harmony Books, 1997) (author recounts experience as a psychiatric resident involved in the care of a permanently unconscious patient who had been placed on life support and was being maximally treated over author's objection, author intentionally twisted IV that was providing medication that was maintaining patient's blood pressure).

²² See New York Task Force on Life and the Law, *supra* note 9, at 8.

with an advance means to reject CPR.²³ It was also hoped that patient choice would end the use of "slow" or "show" codes²⁴ by some physicians, who would make delayed or half-hearted attempts to revive patients for whom they believed CPR would provide little or no benefit.²⁵

NEW YORK'S DO-NOT-RESUSCITATE LAW

In New York, the need for DNR legislation was especially compelling because of a decision by its highest court in 1981, in *Matter of Storar* and *Matter of Eichner*, that hinged termination of lifesaving treatment on knowledge of the actual intent of the patient.²⁶ Expanding on earlier cases in other states that based decisions to terminate life-sustaining treatment on patient autonomy, New York's Court of Appeals held that life-sustaining treatment could not be terminated for a patient who had never been competent to express an intention.²⁷ In *Eichner*, the Court authorized removal of a respirator from a Catholic cleric, who had suffered a stroke which rendered him permanently comatose, because he had made his wishes known about life-sustaining treatment when he was competent.²⁸ In the companion *Storar* case, however, the Court held that lifesaving blood transfusions required by a developmentally disabled, never-competent man suffering from cancer could not be

²³ See N.Y. PUB. HEALTH LAW § 2960 (McKinney 1988) ("it is appropriate for an attending physician, in certain circumstances, to issue an order not to attempt cardiopulmonary resuscitation of a patient where appropriate consent has been obtained.").

²⁴ A "slow code" is a delayed response to a patient's cardiac or respiratory arrest that the health care provider knows is likely to be ineffective in reviving the patient. The goal is to "shield [physicians] from litigation that could arise from an outward or written order calling for the inaction of hospital personnel." See Smith, *supra* note 5, at 180. A "show code" is sometimes also referred to as a "short code" and refers to a prompt but less than maximal response by a health care provider to a patient's arrest "taken largely as a symbolic gesture designed to reassure or placate the family of a patient- or the health care personnel, themselves- that 'everything was done.'" See Smith, *supra* note 5, at 184.

²⁵ See, e.g., Smith *supra* note 5, at 180-184; DO NOT RESUSCITATE ORDERS: THE PROPOSED LEGISLATION AND REPORT OF THE NEW YORK STATE TASK FORCE ON LIFE AND THE LAW 6-7 (New York: New York State Task Force on Life and Law, 2nd ed. 1988).

²⁶ See, e.g., *Matter of Storar* and *Matter of Eichner*, 420 N.E.2d 64 (1981), cert. denied, 454 US 858 (1981).

²⁷ *Matter of Storar* and *Eichner*, *supra* note 26. (In the *Storar* case, in which application was made by parent to discontinue blood transfusion for a never-competent, terminally ill patient, Court rejected use of substituted judgment standard (i.e. determination of probable wishes by a surrogate), finding that "it would be unrealistic to attempt to determine whether he would want to continue potentially life prolonging treatment if he were competent.").

²⁸ *Id.*

ended, even with the consent and at the behest of the patient's parent, because there was and could be no competent evidence of the patient's wishes about his health care treatment.²⁹

The purpose of New York's DNR law was not limited to giving a voice to patients who had made their wishes clear about resuscitation while competent. The law also spells out a list of surrogates to make decisions for incompetent patients and empowers these surrogates to make decisions based on the best interests of the patient if the patient's actual wishes are not known and cannot be ascertained.³⁰ The surrogate list is so comprehensive that any patient with a spouse, child over eighteen, parent, sibling over eighteen or even a "close friend" has someone who could act for the patient.³¹ A precondition to the surrogate's authority to consent to a DNR order is a determination by the attending physician and a second physician that the patient suffers from a qualifying medical condition, either that the patient suffered from a terminal condition or was permanently unconsciousness, that resuscitation would be medically futile, or that "resuscitation would impose an extraordinary burden on the patient."³²

New York's DNR law represents one of the first state laws to authorize the withholding of a life-sustaining treatment for patients who had not made an intention known.³³ Likewise, it may have been the first law to acknowledge that the withholding of a life-sustaining treatment could be in the best interests of the patient.³⁴ By authorizing decisions to withhold CPR when patient autonomy is absent, it gave life to longstanding, but neglected, medical ethical principles of beneficence and non-maleficence, which along with patient autonomy,

²⁹ *Id.*

³⁰ *See, e.g.*, N.Y. PUB. HEALTH LAW § 2965 subd. 2(a) (McKinney 1988) (sets forth a surrogate list to be chosen in order of priority, beginning with a guardian, spouse, child over eighteen, parent, sibling over 18, and ending with a close friend); *See also* § 2965 subd. 3 (requires that surrogates make decisions based on the "the adult patient's wishes, including a consideration of the patient's religious and moral beliefs, or, if the patient's wishes are unknown and cannot be ascertained, on the basis of the patient's best interests.) (Note that subd. 3 requires that before a DNR can be issued that the attending physician with the concurrence of another physician determine that the patient have a terminal condition, be permanently unconscious, that resuscitation be medically futile or that resuscitation would place "an extraordinary burden" on the patient).

³¹ *See* § 2965 subd. 2.

³² *See, e.g.*, § 2965 subd. 3(c).

³³ *See, e.g.*, Smith, *supra* note 5.

³⁴ *See, e.g.*, § 2965 subd. 3 (a).

form the key ethical principles guiding medical decision making.³⁵ Equally important, New York's DNR law, by primarily limiting its application to patients who were terminally ill or permanently unconscious, comports with prevailing societal normative values on when it is ethically appropriate to terminate life-sustaining treatment.³⁶

Even more far reaching, New York's DNR law authorizes unilateral physician determinations to issue a DNR order based on medical futility when the patient is incompetent and has no known surrogates to make decisions.³⁷ This was groundbreaking because it went beyond the autonomy base recognized in court cases and legislation in other states. It was heralded because it allowed physicians to withhold CPR, a life-sustaining procedure, based on medical futility grounds.³⁸ It was also criticized as failing to protect the rights of incompetent patients from decisions made by physicians to issue a DNR order which would lead to the death of the patient.³⁹ Given the reach of the law, it has generated surprisingly little litigation.⁴⁰

³⁵ See, e.g., LO, *supra* note 1, at 30 et seq. (Lippincott Press, 2nd ed. 2000) (this chapter which provides guidance for physicians in how to balance patient autonomy, beneficence, and doing no harm, author "discusses how physicians can protect the well-being of patient, while avoiding the pitfalls of paternalism." When patients "reject the recommendations of their physicians ... physicians are torn between respecting autonomy and acting in the patient's best interests. If physicians simply accept unwise patient decisions in the name of respecting patient autonomy, their role seems morally constricted.").

³⁶ See N.Y. PUB. HEALTH LAW § 2965 subd. 3(c) (McKinney 1988).

³⁷ § 2966 ("If no surrogate is reasonably available ... regarding issuance of an order not to resuscitate on behalf of an adult patient who lacks capacity and who has not previously expressed a decision regarding cardiopulmonary resuscitation, an attending physician may issue an order not to resuscitate the patient, provided that the attending physician determines in writing that, to a reasonable degree of medical certainty, resuscitation would be medically futile, and another physician concurs in writing with such determination ...").

³⁸ See, e.g., Daniel Robert Mordarski, *Medical Futility: Has Ending Life Support Become the Next "Pro-Choice/Right to Life" Debate?*, 41 CLEV. ST. L. REV. 751, 784-786 (1993) (relies on New York's DNR statute as basis for proposed legislation that would authorize physicians to make decisions to withhold CPR or other life-sustaining treatment based on medical futility grounds if, after a dispute mediation process, it was determined that the surrogate's refusal to consent to a DNR order or to the withdrawal or withholding of other life-sustaining treatment constituted one of the "few extreme and outrageous situations in which the surrogate was clearly not making a decision in the best interest of the patient."). *Id.*

³⁹ See Shaver, *supra* note 5.

⁴⁰ See MEISEL, *supra* note 17, § 9.4 at 544.

Although New York's DNR legislation reached beyond patient self-determination, it is firmly rooted in autonomy.⁴¹ Consent is necessary from the patient or surrogate before issuance of a DNR order.⁴² Indeed, because CPR is considered an emergency procedure, New York's law presumes consent to its administration.⁴³ It is only when the patient does not make an intention known and there is no surrogate who can exercise the patient's autonomy that the DNR law permits physicians to unilaterally issue a DNR order for patients who are terminally ill, permanently unconscious or for whom resuscitation would be medically futile.⁴⁴

The law also provides for a mediation system for disputes about the use of CPR.⁴⁵ Each hospital is required to establish a mediation system.⁴⁶ Unless patient capacity is at issue, the law imposes few requirements on the process employed other than that it be documented in writing, and even authorizes the hospital to make use of existing resources, such as a patient advocate or chaplain's office.⁴⁷ A hospital ethics committee would be well suited to hear such disputes.

"Any dispute" about CPR can be heard under the system and submission of a dispute stays the entry of a DNR order for up to 72 hours.⁴⁸ However, although the law planned for disputes between physicians and patients or their proxies over the use of CPR, it contemplated that these disputes would be based on patient refusal of

⁴¹ See, e.g., N.Y. PUB. HEALTH LAW § 2960 (McKinney 1988) ("legislature finds" that "is appropriate for an attending physician, in certain circumstances, to issue an order not to attempt cardiopulmonary resuscitation of a patient where an appropriate consent has been obtained).

⁴² See § 2964 subd. 1(a); § 2965 subd. 3 (The consent of an adult with capacity must be obtained prior to issuing an order not to resuscitate, except as provided in [§2964 subd 3]); N.Y. PUB. HEALTH LAW § 2965 subd. 3 requires that the physician obtain the consent of a health care agent or, if none, then from the surrogate list set forth in N.Y. PUB. HEALTH LAW § 2965 subd. 2(a)).

⁴³ See, e.g., § 2962 subd. 1. ("Every person admitted to a hospital shall be presumed to consent to the administration of cardiopulmonary resuscitation in the event of cardiac or respiratory distress, unless there is consent to the issuance of an order not to resuscitate as provided in this article."); See Sorum, *supra* note 6, at 633 ("CPR is, like other emergency life-saving treatments, a procedure to which the patient is automatically presumed to consent in the absence of an explicit prior decision to withhold it. This principle, which in New York State is given legal force in the 1988 DNR legislation, follows from the preciousness of life, the incapacity of the unconscious patient who has suffered the arrest, and the need to start CPR immediately if it is to have any chance of success.").

⁴⁴ See, e.g., § 2965 subd. 3(c).

⁴⁵ § 2972.

⁴⁶ § 2972 subd. 1(a).

⁴⁷ § 2972 subd. 1(b).

⁴⁸ § 2972 subd. 2-3.

CPR and not on physician refusal based on medical futility.⁴⁹ As a result, the application of the dispute process is arguably limited to disputes between patients "rejecting cardiopulmonary resuscitation and an attending physician or the hospital that is caring for the patient" opposing the request.⁵⁰ The law does not expressly provide a process for handling the flip side of these disputes when the physician seeks to withhold CPR based on medical futility and the patient or proxy objects.

THEORETICAL UNDERPINNINGS OF DNR LAWS: THE ETHICAL ISSUES AND THE LAW WHEN A PHYSICIAN SEEKS TO ISSUE A DNR ORDER OVER PATIENT OR SURROGATE OBJECTION BASED ON MEDICAL FUTILITY

New York's DNR law, which promotes patient autonomy and surrogate decision making where it exists as the final word on decisions to withhold CPR, has been both praised and criticized by medical ethicists. It has been touted for providing patients with a means for making their wishes known and for allowing family members and others who best knew the patient to make decisions for the patient in accordance with the patient's intent or best interests. It also served to end unwritten physician practices to withhold CPR without informing patients.⁵¹ Criticism has come from both ends of the ethical spectrum, however. There are those who are dismayed that it provides physicians with unilateral authority to issue a DNR without inquiring about the patient's likely wishes about treatment.⁵² Others have argued that it hamstring physicians when patients or surrogates refuse to consent to the entry of a DNR Order when CPR would be medically futile.⁵³

⁴⁹ § 2972 subd. 4.

⁵⁰ N.Y. PUB. HEALTH LAW § 2972 subd. 4.

⁵¹ See Smith, *supra* note 5, at 180-184; DO NOT RESUSCITATE ORDERS: THE PROPOSED LEGISLATION AND REPORT OF THE NEW YORK STATE TASK FORCE ON LIFE AND THE LAW 6-7 (New York: New York State Task Force on Life and the Law, 2nd ed. 1988).

⁵² See, e.g., Shaver, *supra* note 5 (argues that New York's DNR law violates patient's right of self-determination because it allows doctors to make decisions to issue a DNR for incompetent patients based on medical futility without knowing or attempting to know the likely wishes (substituted judgment) of the patient).

⁵³ See, e.g., Finucane, *supra* note 16, at 189 (argues that physicians should have authority to issue a DNR based on medical futility even if the patient objects).

Ethical Debate When Patient Autonomy and Medical Futility Collide

The earlier view, embraced by the courts in the 1970s and 1980s, based decisions to withhold or withdraw various forms of life-sustaining treatment, including CPR, on patient autonomy. Originally grounded in the common law right of competent patients to refuse medical treatment, the United States Supreme Court determined in 1990 in *Cruzan v. Director, Missouri Department of Health* that the right to refuse lifesaving treatment was a constitutionally protected liberty interest under the Due Process Clause of the United States Constitution.⁵⁴ If the patient's actual or likely wishes were unknown and could not be determined, courts have consistently found that life-sustaining treatment cannot be discontinued.⁵⁵ Moreover, under the patient autonomy model, courts have consistently upheld the right of patients or proxies to refuse to consent to the termination of medical treatments which, if not provided, would lead to the patient's death.⁵⁶

More recently, a competing ethical theory has been advanced that proposes that decisions to withhold or withdraw life-sustaining treatment be based on medical futility even over the objection of the patient or surrogate.⁵⁷ This theory seeks to give equal weight to the medical ethical principles of beneficence and non-maleficence, which, along with autonomy, form the ethical basis of modern medical decision making.⁵⁸ Because it is not based on autonomy, its application

⁵⁴ *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990).

⁵⁵ See MEISEL, *supra* note 17, § 7.12, at 397.

⁵⁶ See *In re Conservatorship of Wanglic*, No. PX-91-283 (Minn. Dist. Ct. Hennepin Co. July, 1991); *Wendland v. Spark*, 574 N.W.2d 327 (Iowa 1998); *Causey v. St. Francis Med. Cntr.*, 719 So. 2d 1072 (La. Ct. App. 2 Cir. 1998).

⁵⁷ See, e.g., Smith, *supra* note 5 (argues that New York's DNR law is flawed because it presumes consent to CPR by patients who have not made an intention known about CPR); James F. Drane and John L. Coulehan, *The Concept of Futility: Patients Do Not Have the Right to Demand Medically Useless Treatment*, 74 HEALTH PROGRESS 28, 30 (1993) (argues that patients do not have a right to "futile treatments," defined as "fruitless because they do not achieve 'worth' in the sense of meeting a patient's medical goal or providing a true personal benefit...A futile treatment is not ineffective, but it is worthless, either because the medical action itself is futile (no matter what the patient's condition) or the condition of the patient makes it futile."). This article also argues that patient consent is not necessary for a DNR order when CPR is "deemed futile," referring to the AMA's Council on Ethical and Judicial Affairs.

⁵⁸ See, e.g., Smith, *supra* note 5, 186, 187 (a physician's refusal based on medical futility to issue a DNR which is not medically indicated but without consent of patient or surrogate is based on ethical principle of beneficence that will usually "trump autonomy.") (further argues that beneficence should "trump autonomy" when a patient makes a request that "does not comport with sound medical judgment."); Barney Sneiderman, *A Do Not Resuscitate Order for an Infant Against Parental Wishes: A Comment on the Case of Child and Family Services v.*

is not limited to competent or once competent patients who expressed an intention about medical treatment.

Followed to its logical end, some commentators have argued that an informed consent from patients or surrogates is not needed before a physician issues a DNR because it is not a treatment being recommended by the physician.⁵⁹

Proponents also argue that medical futility should be the primary basis for overriding objections of patients or surrogates when the treating physician determines that providing a life-sustaining treatment would be medically futile.⁶⁰ This view is embodied in the Uniform Health-Care Decisions Act, which is the basis for advance directive legislation in several states.⁶¹ Specifically, it states that "a health-care provider or institution may decline to comply with an individual instruction or health-care decision that requires medically ineffective health care or health care contrary to generally accepted health-care standards."⁶²

The Continuing Controversy over the Meaning of Medical Futility and Whether It Should Override an Autonomous Patient Decision to Withhold or Withdraw Life-Sustaining Treatment

The line between patient's rights and physician's rights has been clearly drawn in the context of DNR orders when patient autonomy conflicts with medical futility. The patient autonomy model for health care decision making has not ended the use of CPR that the attending physician believes to be medically futile. Patients or their families, when suddenly faced with the issue whether to agree to a DNR order, are often inclined to say that everything should be done even when the patient is suffering from the end stage of a terminal disease and the likelihood that CPR will help the patient is near nil.⁶³ On the other side

R.L. and S.L.H., 7 HEALTH L. J. 205, 211, 223 (1997) (argues further that physician unilateral decision to issue DNR under same circumstances can be based on either beneficence or do-no-harm ethical principle).

⁵⁹ *Id.*

⁶⁰ *Id.*

⁶¹ Unif. Health-Care Decisions Act (1993, National Conference of Commissioners on State Laws), 2000 Supplement, *Table of Jurisdictions Where Act Has Been Adopted*, (Lists California, Delaware, Hawaii, Maine, Mississippi, and New Mexico).

⁶² See Unif. Health-Care Decisions Act, § 7(f) (in "Comments" defines "medically ineffective health care" as "treatment which would not offer the patient any significant benefit.").

⁶³ See, e.g., Finucane, *supra* note 16, at 692, n. 6 (argues that very ill patients are more willing to do whatever it takes to stay alive, and cites to several studies in support).

are physicians, experienced in the relative lack of success of CPR for patients suffering from serious underlying pathologies, who balk at repeated resuscitations of such patients. Many health care providers argue that there is no right to CPR or other life-sustaining treatment that is medically futile.⁶⁴

An understanding of the debate requires an analysis and understanding of the meaning of medical futility. There are circumstances when there is a near or absolute certainty that CPR will not be effective, such as when the patient is already undergoing maximal treatment when the arrest occurs or where CPR has been tried repeatedly and failed.⁶⁵ In those cases, there is near consensus that it is medically and ethically appropriate for physicians to unilaterally discontinue CPR.⁶⁶

There are other instances, however, where some physicians find a medical treatment to be futile because the likelihood of success is small, the patient's quality of life is deemed unacceptable or the benefit to the patient is considered disproportionate to the burdens to the patient or the resources required.⁶⁷ It is in this latter category that the meaning of medical futility comes into question and there is disagreement about the ethical basis for unilaterally discontinuing CPR. This is because there is some possibility of therapeutic benefit from CPR, where survival is rare but not unprecedented, and the patient or surrogate has not consented to its withdrawal.⁶⁸

⁶⁴ See *supra* pp. 65-66.

⁶⁵ See LO, *supra* note 1 (refers to these examples as fitting squarely within the meaning of medical futility); See Sorum, *supra*, note 6, at 621-622 (refers to the official guidelines of the American Heart Association, and finds that the patients who have already undergone full resuscitation for a period of time without success and patients "whose cardiac arrest is the culmination of a relentlessly deteriorating and terminal condition – for example, a patient in an intensive care unit who is receiving maximal therapy but whose blood pressure or oxygen level is nevertheless progressively falling" as fitting within the medically futile category); See also, New York State Task Force Report, *supra* note 9, at 6 (defines "medically inappropriate resuscitation" as "resuscitation which will probably fail or succeed only to the extent that the patient is repeatedly resuscitated in a short period of time before death.").

⁶⁶ See, e.g., N.Y. PUB. HEALTH LAW § 2961 subd. 12 (narrowly defines "medical futility" as meaning that "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 occurs.").

⁶⁷ See LO, *supra* note 1, at 74-75.

⁶⁸ See LO, *supra* note 1, at 75-76 (notes that physicians are often mistaken about the likelihood of success of CPR and, further, that situations where the use of CPR can be reliably predicted to be futile are rare, citing to studies); See Sorum, *supra* note 6, at 619-624 (argues that lack of effectiveness of CPR and cost are not adequate ethical grounds for denying CPR and that the only valid limitation of its use must be based on patient autonomy).

Ethicists advocating medical futility as the primary basis for medical decision making argue that physicians should be entitled to override the decisions of patients or their surrogates who refuse to consent to a DNR order when the physician believes that CPR is medically futile.⁶⁹ Their argument is that DNR laws are flawed because they legislate clinical ethics, putting the law out-of-step with evolving medical ethics practices. They base their argument on the concept that a patient's negative right to refuse treatment is larger than and not synonymous with a positive right to demand treatment not recommended by the patient's physician.⁷⁰ Under this line of reasoning, the physician has no duty to provide a life-sustaining treatment that the physician does not recommend even if the patient or surrogate demands the treatment.⁷¹

Others have argued even further that a physician is under no obligation to discuss a treatment that is not recommended.⁷² Accordingly, there is no need to obtain consent from the patient or right to refuse it. As a result, physicians would be empowered to override autonomous decisions by patients and surrogates to refuse to consent to a DNR when the physician believes that it would be medically futile to provide CPR.⁷³ Further, if physicians have no legal obligation to even discuss with the patient the treatment they deem to have no benefit, it stands to reason that patients will be less likely to demand it or to object if it is not provided.

Aligned against this view are physicians and ethicists who subscribe to a limited definition of medical futility. As declared in at least one authoritative medical textbook on clinical decision making, physicians are justified in unilaterally withholding or withdrawing a lifesaving treatment if it has no physiologic rationale, if cardiac arrest continues to occur despite maximal treatment or if the intervention has already been tried and failed with the patient.⁷⁴ Any more expansive

⁶⁹ See, e.g., Smith, *supra* note 5.

⁷⁰ See, e.g., Sneiderman, *supra* note 58 (citing W. PRIP and A. MORETTI, *Medical Futility: A Legal Perspective*, in M.B. ZUCKER & H.D. ZUCKER (eds.), *MEDICAL FUTILITY AND THE EVALUATION OF LIFE-SUSTAINING TREATMENT* (Cambridge University Press, 1997), 136, 139 ("The difference between the demands "don't touch me" and "you must touch me" is dramatic. The law has almost uniformly conceded the former but only hesitantly recognized the latter, and only in situations related to public health and safety.").

⁷¹ See MEISEL, *supra* note 17, §9.5 at 547.

⁷² See MEISEL, *supra* note 17, § 9.5, at 547-48; LO, *supra* note 35, at 77.

⁷³ See, e.g., Smith, *supra* note 5, at 201 (argues that physicians should have the unilateral authority to issue a DNR for incompetent or terminally ill patients).

⁷⁴ LO, *supra* note 1, at 73-74.

definition of medical futility, based on low likelihood of success, patient's quality of life or measurement of benefit against resources required, is a value judgment, not a medical decision, and is not the physician's decision to make.⁷⁵ The definition of medical futility contained in New York's DNR law is narrowly drawn along these lines.⁷⁶

Put differently by another commentator, a "provider cannot unilaterally terminate life support for a deteriorated, but preservable patient."⁷⁷ The surrogate's refusal to consent to a termination of treatment must be "abusive," where "...the patient is subjected to pointless suffering" or "... the surrogate's course is inexplicably aberrant from what the vast majority of people would want."⁷⁸

**The Legal Debate When Medical Futility and Patient Autonomy
Collide: Courts Have Not Supported Physician-Initiated
Termination of Life-Sustaining Treatment over Patient Objection
When the Patient Has Any Chance of Survival**

When the withholding or withdrawal of medical treatment will not result in the death of the patient, physicians have historically had the ethical and legal right to refuse to treat based on medical futility or for other reasons.⁷⁹ However, a broad physician's right to refuse to treat has not been recognized in the end-of-life context.⁸⁰ Courts have required that decisions to terminate life-sustaining treatment for once competent patients be based on autonomy, as expressed prospectively in an advance directive or other writing executed by the patient when competent. However, where the patient or surrogate objects, courts have tacitly aligned with ethicists advocating a limited meaning for

⁷⁵ LO, *supra* note 35, at 74-75.

⁷⁶ See N.Y. PUB. HEALTH LAW § 2961 subd. 12 (defines "medically futile" to mean that "cardiopulmonary resuscitation will be unsuccessful in restoring cardiac and respiratory function or that the patient will experience repeated arrest in a short period of time).

⁷⁷ Norman L. Cantor, *Twenty-Five Years After Quinlan: A Review of the Jurisprudence of Death and Dying*, 29 J. OF LAW, MED. AND ETHICS 182, 185 (2001).

⁷⁸ *Id.* at 186.

⁷⁹ See, e.g., *Vacco v. Quill*, 521 U.S. 793 (1997) (United States Supreme Court refused to find patient constitutional right to compel physician to assist in patient's suicide); LO, *supra* note 1, at 72 ("Physicians do not need to provide futile interventions, even if patients or surrogates request them."); *id.* at 197 ("Physicians may refuse to care for persons because they believe the threat to their personal safety or economic security is unacceptable. In other situations, physicians may seek to terminate a counterproductive or adversarial doctor-patient relationship.").

⁸⁰ *Id.*

medical futility. In other words, if there is any chance that the treatment will keep the patient alive, it is likely that a court will order that treatment be continued.⁸¹

Courts have provided little support for physicians who seek to override the objection of a patient or proxy to termination of life-sustaining treatment. Outside of the context of cases involving infants who were abused or neglected by their parents and near death, courts have not been receptive to the argument that physicians can override a surrogate's refusal to consent to the termination of treatment which, if not provided, will lead to the death of the patient.⁸²

In the vast majority of such cases in which there is no question about the surrogate's good intentions, however, courts have come close to declaring that CPR or other life-sustaining treatments cannot be withdrawn when there is an objection. Numerous articles have warned physicians of the serious legal risk in unilaterally writing a DNR order without informing or obtaining consent from the patient or surrogate.⁸³ One commentator has argued that medical futility can only be the basis for physician decision making when the surrogate's refusal to consent is abusive.⁸⁴

One well known court decision is the *Wanglie* case, decided by a Minnesota court in 1991.⁸⁵ In *Wanglie*, the 86 years old patient was sustained by a mechanical respirator, and had been determined by her physicians to be in a permanent vegetative state.⁸⁶ The patient's family refused to consent to removal of the respirator. The court refused the application of one of the patient's physicians to be appointed the patient's guardian in order to terminate life support, finding that the patient's husband was satisfactorily performing as the patient's guardian.

In another well-known case, *In re Baby K*, a hospital treating a newborn anencephalic patient sought to remove a ventilator which was

⁸¹ See, e.g., *Wendland v. Sparks*, 574 N.W.2d 321, 332 (Iowa 1998) (In wrongful death action based on physicians unilateral determination to issue DNR without obtaining family member consent, Court refused to dismiss lawsuit -- "In the present case, in which the chances of successful resuscitation were questionable and any recovery for wrongful death would be severely limited because of the patient's preexisting condition, even a small chance of survival is worth something.").

⁸² See, e.g., *Cantor*, *supra* note 77, at 186.

⁸³ See MEISEL, *supra* note 17 at §9.6 at 554.

⁸⁴ *Cantor*, *supra* note 77, at 188.

⁸⁵ *In re Conservatorship of Wanglie*, No. PX-91-283 (Minn. Dist. Ct. Hennepin Co. July, 1991) (this case is discussed in *Sneiderman*, *supra* note 58, at 217-218).

⁸⁶ *Id.*

necessary for the infant's continued survival.⁸⁷ Anencephaly ordinarily results in a newborn's death within days or weeks of birth because of resulting complications. The mother of the infant opposed the withdrawal, and the court agreed. Rejecting the argument made by the hospital that the ventilator was futile because it did not treat the patient's underlying anencephaly, a terminal condition, the court found that the treatment was not futile because it resolved the patient's respiratory distress. Further, the court found that the hospital's failure or refusal to provide a life-sustaining ventilator for the patient, without family or surrogate consent to its termination, constituted a violation of a federal statute, the Emergency Medical Treatment and Active Labor Act (EMTALA), which requires that patents with emergency conditions be provided stabilizing treatment.⁸⁸

On the other hand, the Fourth Circuit in *Bryan v. Rectors* rejected an affirmative use of the EMTALA statute by a plaintiff seeking to find a physician civilly liable for issuing a DNR Order over the patient's wishes.⁸⁹ This can be explained, if not justified, by the tendency of courts to resist placing civil or criminal liability on physicians who act upon reasonable medical judgment and withhold or withdraw life-sustaining treatment in particular cases.⁹⁰

There is a risk that civil litigation could be commenced when a physician takes unilateral action over the objection of a patient's family. Although a physician would appear to be well insulated in withholding CPR when there is no likelihood that the treatment will be effective, courts have not been as charitable when there is any possibility that CPR could have revived the patient.⁹¹ Regardless of the likelihood of

⁸⁷ *In re Baby "K"*, 16 F.3d 590 (4th Cir. 1994); cert. denied 115 S. Ct. 91 (1994); *In re Doe*, 418 S.E.2d 3 (Ga. 1992). The Baby "K" case is discussed in Sneiderman, *supra* note 58, at 218.

⁸⁸ *Id.*

⁸⁹ *Bryan v. Rectors & Visitors of the University of Virginia*, 95 F.3d 349 (4th Cir. 1996).

⁹⁰ *See, e.g.*, Sneiderman, *supra* note 58, at 220; *Barber and Nejdil v. Superior Court*, 195 Cal. Rptr. 484 (1983) (criminal charges dropped against physician who, with support of family, discontinued artificial life support. "A physician has no duty to continue treatment once it has proved to be ineffective. Although there may be a duty to provide life-sustaining machinery in the immediate aftermath of a cardio-respiratory arrest, there is no duty to continue its use once it has become futile in the opinion of qualified medical personnel. A physician is authorized under the standards of medical practice to discontinue a form of therapy which in his medical judgment is useless ... without fear of civil or criminal liability. By useless is meant that the continued use of the therapy cannot and does not improve the prognosis for recovery" *id.* at 491-92).

⁹¹ *See, e.g.*, *Wendland v. Sparks*, 574 N.W.2d 321, 327 (Iowa 1998); *Causey v. St. Francis Med. Ctr.*, 719 So.2d 1072 (La. App. 2 Cir. 1998).

the patient's quality of life after being revived, some Courts have found that patients are entitled to that chance.⁹² In any situation where the withholding of CPR is contemplated over patient or family objection, even where the physician deems it physiologically futile, preemptive application for a court order would immunize the physician from liability.

**NEW YORK'S DNR LAW: DOES IT SUPPORT AN
INTERPRETATION THAT PHYSICIANS CAN TERMINATE
CPR OVER PATIENT OR SURROGATE OBJECTION? IF IT'S
LEGAL, IS IT ETHICAL?**

As with other life-sustaining treatment, there is little doubt that laws in other states require consent from the patient or surrogate before CPR can be withheld or withdrawn.⁹³ Further, institutional mandate and customary hospital practice has been to resuscitate patients when the patient or surrogate is unable or refuses to consent.⁹⁴ CPR has historically been determined to be an emergency procedure that must be provided unless the patient has expressed an intent to reject it. It is only when the patient is incapacitated, the physician has no knowledge of the patient's wishes about treatment and there is no family member surrogate available, that some DNR laws, such as New York's law, have delegated to doctors the right to make such decisions based on medical futility. New York's DNR law is progressive and changes the common law which would otherwise prohibit the cessation of CPR for patients where no consent could be obtained.⁹⁵

New York's Department of Health (DOH) has embraced a seemingly broader interpretation of New York's DNR law, which would empower physicians to override patient or surrogate refusal to

⁹² *Id.*

⁹³ *See, e.g.,* Sorum, *supra* note 6 at 633 ("CPR is, like other emergency life-saving treatments, a procedure to which the patient is automatically presumed to consent in the absence of an explicit prior decision to withhold it. This principle ... in New York State is given legal force in the 1988 DNR legislation, follows from the preciousness of life, the incapacity of the unconscious patient who has suffered the arrest, and the need to start CPR immediately if it is to have any chance of success.").

⁹⁴ *See, e.g.,* Finucane, *supra* note 16, at 699 ("In most facilities in the United States, the rule is that CPR must be initiated unless a clear order to the contrary has been written."); *See, e.g.,* Smith, *supra* note 5, at 184 ("When there are no orders written which specify what resuscitative measures should be taken with particular patients, hospital policies may well dictate that a full code should be called for, in other words, resuscitation is initiated.").

⁹⁵ *See, e.g.,* Smith, *supra* note 5, at 195.

consent and unilaterally enter a DNR order. A pamphlet containing answers to common questions by health care providers about New York's DNR law, prepared by the Department of Health, the New York State Task Force on Life and the Law, and other health care groups, has been placed on the official Department of Health website.⁹⁶ The New York State Task Force on Life and the Law, comprised of noted physicians, medical ethicists and other professionals, was an early seminal influence on evolving medical ethical issues. Among other credits, the Task Force drafted New York's DNR law.

The following question and answer is posed on the Department of Health website:

"Q[uestion]: What if the health care agent or surrogate refuses to consent to a DNR order and the physician believes that CPR would be futile for the patient?

[Answer]: The attending physician must seek a second opinion. If the second physician concurs that CPR would be futile, as futility is defined by the law, and the concurrence is written in the chart, the attending physician may enter the order on grounds of futility, but must inform the agent."⁹⁷

This information is well known to New York physicians, who likely rely upon it when making decisions to issue DNR orders over the refusal of patients or their families.

Courts in New York, as in other jurisdictions, perform a deferential review of governmental agency decisions, which presumes the agency's competence in its field of expertise. Under this limited review, a court will only overturn an agency interpretation if it is arbitrary and capricious.⁹⁸ In other words, the court will not disturb an

⁹⁶ DO NOT RESUSCITATE ORDERS – QUESTIONS AND ANSWERS FOR HEALTH CARE PROFESSIONALS (New York: New York State Task Force on Life and Law, Medical Society of the State of New York, and Hospital Association of New York State, 2nd ed. 1992), at 28; can be found at www.health.state.ny.us/nysdoh/consumer/patient/dnrmain.htm (last visited Dec. 20, 2002).

⁹⁷ *Id.*

⁹⁸ See, e.g., *Marzec v. DeBuono*, 95 N.Y.2d 262, 266 (2000); *Matter of Howard v. Wyman*, 28 N.Y.2d 434, 438 (1971); *Matter of N.Y. Health Plan Ass'n, Inc. v. Levin*, 723 N.Y.S.2d 819 (2001) (state insurance department "circular letter" interpreting state's Prompt Payment Law as holding HMOs and health insurers liable for late payment even if have contractually delegated claims payment process found not to be arbitrary and capricious); *Matter of Taher v. Novello*, 718 N.Y.S.2d 520 (2000) (department's interpretation of its

agency's interpretation if it has a rational basis.⁹⁹ An absence of agency authority to decide an issue can be the basis for a court reversal of an agency decision.¹⁰⁰ Further, the court will not defer to an agency guideline that "runs counter to the clear wording of a statutory provision."¹⁰¹

The position taken by the DOH is novel because it weighs a physician's right to withhold a life-sustaining treatment over an autonomous objection by a patient or surrogate. It is supported by a broad ethical consensus because the DOH begins with the premise that the two-physician authority to override based on medical futility requires that "CPR would be futile, *as futility is defined by the law.*" (emphasis added)¹⁰² New York's DNR statute narrowly defines "medically futile" to mean that "cardiopulmonary resuscitation will be unsuccessful in restoring cardiac and respiratory function or that the patient will experience repeated arrest in a short period of time."¹⁰³ This meaning goes little beyond physiologic futility, in which CPR by definition would have no chance of keeping the patient alive after CPR was completed, and is accepted across the ethical spectrum as an appropriate basis for withholding CPR. When medical futility is defined narrowly, virtually all medical ethicists agree that beneficence and non-maleficence, other guiding principles in medicine, supercede patient autonomy.¹⁰⁴

regulations denying request that cost of equipment include in skilled nursing facility's reimbursement rate was not irrational, unreasonable, or contrary to state law).

⁹⁹ *Matter of Crater Club v. Adirondack Park Agency*, 86 A.D.2d 714, *aff'd* 57 N.Y.2d 990; *Sigety v. Ingraham*, 29 N.Y.2d 110 (1971); *Cortlandt Nursing Care Center v. Whalen*, 46 N.Y.2d 979 (1979).

¹⁰⁰ *See, e.g., N.Y. State Ass'n of Nurse Anesthetists v. Novello*, 734 N.Y.S.2d 420 (2001) (Court found that Department of Health lacked the statutory authority to issue standards for physician use of certified registered nurse anesthetists rather than anesthesiologist physicians in office-based surgeries).

¹⁰¹ *Matter of N.Y. Public Interest Group, Inc., v. Dept. of Insurance*, 66 N.Y.2d 444, 448 (1985); *See also Kurcsics v. Merchants Mutual Ins. Co.*, 49 N.Y.2d 451, 459 (1980) ("if the regulation runs counter to the clear wording of a statutory provision, it should not be entitled to any weight.").

¹⁰² *See* QUESTIONS AND ANSWERS FOR HEALTH CARE PROFESSIONALS, *supra* note 96, at 28.

¹⁰³ N.Y. PUB. HEALTH LAW § 2961 subd. 12.

¹⁰⁴ *See, e.g., Edmund D. Pellegrino, Patient and Physician Autonomy: Conflicting Rights and Obligations In The Physician-Patient Relationship*, 10 J. CONTEMP. HEALTH L. & POL'Y 47 (1993) ("For centuries, physician beneficence went unchallenged as the first principle of medical ethics.... [N]o creditable ethical opposition was mounted until a quarter of a century ago when patient autonomy was asserted as a prima facie moral principle of equal or greater weight than beneficence.").

If the DOH's interpretation is clearly within ethical norms, is it legal? New York's DNR law provides no explicit authority for physicians to withhold CPR under any circumstances when the patient or surrogate refuses consent. The law in New York and other states clearly treats CPR as an emergency procedure that must be provided if it stands some chance of keeping the patient alive. Although a physician will likely be able to avoid criminal liability if CPR is withheld for a terminally ill or permanently unconscious patient, the physician could face a malpractice lawsuit. Consent is not required to perform CPR or provide other emergency treatment, but New York's DNR law at first glance would appear to require that the patient or surrogate agree if it is not to be provided.

However, a statute does not stand alone and should be interpreted against a backdrop of public policy and normative values. In the case of New York's DNR law, it would follow, based on established principles of jurisprudence, that the legislature did not intend to provide patients with unfettered authority to demand CPR even when the attending physician has determined that it would provide no therapeutic value to the patient and that with certainty CPR would not keep the patient alive after the treatment was completed. In the context of the provision of non-lifesaving treatment, patients do not have the authority to demand medical treatment that the treating physician believes holds no therapeutic value. Likewise, it would be nonsensical, in the absence of explicit instruction in the law to the contrary, to believe that the legislature intended by its enactment of New York's DNR law to create a patient right to demand CPR that provided no physiologic value to the patient. Indeed, a prime purpose of the law was to end physician and hospital slow and show codes by providing a means for patients to prospectively exercise autonomy to consent to a DNR order, the theory being that patients or surrogates would consent to a DNR order when CPR was medically futile. To allow patients or surrogates absolute authority to demand CPR, including medically futile CPR, would result in more clashes with physicians and more DNR issues than before the law's enactment. Unfortunately, the law did not envision that patients or their families might demand CPR that under any definition was medically futile.

Further, the DOH's view is supported by court cases in which medical futility issues have been raised. Courts have measured the use or withholding of life-sustaining treatment on whether the treatment, if provided, would keep the patient alive. Courts have rejected expansive

definitions of medical futility based on low likelihood of success, patient's quality of life or an allocation of limited resources analysis. Further, courts have clearly aligned with the narrow definition of medical futility espoused by some ethicists and by the DOH, in which there cannot be even a small chance of survival, including a compromised survival, in order for the treatment to be deemed medically futile.

It is submitted that a patient right to demand CPR that provides no chance of continued life, or that goes against ethical consensus and legal precedent on the meaning of medical futility, cannot be read into New York's DNR law. Accordingly, the DOH's position that physicians can act unilaterally to withhold CPR that will provide no benefit to the patient is on firm legal and ethical footing. It would likely withstand challenge under the deferential standard applied by New York courts when reviewing governmental agency decisions. A medical malpractice suit would likely also be unsuccessful under this narrow definition of medical futility.¹⁰⁵

At the same time, the DOH does not authorize physicians to make unilateral medical futility determinations that are based on low likelihood of success, patient quality of life, or other reasons that are in effect value judgments and not medical decisions. Further, the DOH interpretation protects patients by requiring that all decisions related to CPR, whether to provide CPR or to unilaterally issue a DNR order, be discussed with the patient or surrogate.¹⁰⁶ This comports with legal analysis on informed consent and the ethical position that is most protective of patient autonomy, which holds that patients must be informed of all decisions related to their medical care, including decisions to not provide a life-sustaining treatment.

Arguably, the interpretation by the DOH conflicts with the law's goal to promote patient self-determination and family decision making. However, it also promotes what appears to be the primary, unstated goal of the law: to limit the use of CPR to those cases in which the

¹⁰⁵ See *supra*, note 90 and associated text.

¹⁰⁶ See QUESTIONS AND ANSWERS FOR HEALTH CARE PROFESSIONALS, *supra* note 96, at 28. ("If the physician determines that CPR would be medically futile ... the physician must discuss the DNR order with the patient, agent, or surrogate, if possible...").

patient could benefit, thereby ending the hidden use of slow or show codes.¹⁰⁷

The position taken by New York's Department of Health could herald a recognition of the limits of health care decision making based on the principle of autonomy alone and revitalize other medical ethical principles, primarily beneficence and non-maleficence. The theory, if not the practice of medicine, in the past several decades has been to promote autonomy.¹⁰⁸ However, autonomy has never stood alone: the law has balanced autonomy against state interests. Further, in medical ethics, autonomy is a relative latecomer. Historically, beneficence was the key guiding principle in medicine, existing for as long as the Hippocratic Oath and well before autonomy.¹⁰⁹ Providing physicians with authority to issue DNR orders when CPR provides no benefit to the patient, even over patient objection, is an attempt to strike a balance between beneficence and autonomy when they conflict.¹¹⁰

Moreover, the Do-No-Harm principle is a well known provision of the Hippocratic Oath. It is reinvigorated under the interpretation embraced by Department of Health because it provides support for physicians who object to providing an ineffective treatment that causes the patient suffering.

Recognition of the importance of the principles of beneficence and non-maleficence can be found in the terms "medical futility" and "treatment." These terms, carefully defined, form the ethical basis for physician decisions to withhold medical treatment that could prolong the patient's life. If there is a near certainty that CPR will not revive the patient, such as when it has been tried and failed or cardiac arrest occurs while the patient is receiving maximal treatment, then it would be ethically appropriate to issue a DNR. The key is whether CPR will return the patient from cardiac or respiratory distress, not whether the patient will or may lose brain functioning or already exist in a low quality state. To make such a decision based on a likelihood of a successful return to a "quality life" is to make a value judgment, which

¹⁰⁷ See, e.g., N.Y. PUB. HEALTH LAW § 2960 (purpose of law was "to clarify and establish the rights and obligations of patients, their families, and health care providers regarding cardiopulmonary resuscitation and the issuance of orders not to resuscitate.").

¹⁰⁸ See, e.g., Sorum, *supra* note 6, at 629.

¹⁰⁹ See, e.g., Pellegrino, *supra* note 104, at 47.

¹¹⁰ See, e.g., Smith, *supra* note 5, at 187 (in the context of patient requests for a partial DNR code, states that "[s]imply because a competent patient makes a request of this nature, does not mean it must be respected; if it does not comport with sound medical judgment by a health care provider, it will not be executed. Beneficence will usually trump autonomy.").

is beyond the limited meaning of medical futility and beyond the physician's competence, as compared to that of the patient, to make medical decisions.

A further basis for recognition of beneficence and non-maleficence, which may provide a basis for trumping patient autonomy, may be found in the meaning of treatment - it is axiomatic that an intervention which will not provide a benefit to the patient and in fact may harm the patient is not a treatment and, accordingly, could be the basis for unilaterally issuing a DNR order. Again, determining benefit must be assessed strictly on whether the treatment will resolve the patient's breathing or cardiac crisis, not on its effect on the patient's underlying pathology.¹¹¹

CONCLUSION

Once again, New York's DNR law is on the leading edge of medical ethics. This time it is on the forefront of the medical futility debate and whether a physician's determination that a lifesaving treatment holds no therapeutic value, based on medical ethical principles of beneficence and Do No Harm, overrides patient autonomy. Although the legal and ethical debate has been framed as a battle of competing medical principles and as an attack on patient autonomy, ultimately it comes down to how we choose to define medical futility and treatment.

Ethically, there is consensus that there are times when CPR does not provide a benefit or would be harmful to the patient because it would be disproportionately painful to the patient as compared to the benefit.¹¹² If the patient's underlying condition is such that with physiologic certainty CPR will not keep the patient alive (e.g. that even with CPR effective circulation cannot be sustained or the type of CPR intervention has already been tried and failed), by any ethical meaning this would constitute a medically futile treatment. Under these circumstances, a physician's decision to issue a DNR order over the objection of the patient or surrogate is ethically moored, provided the physician discusses the DNR order with the patient, agent, or surrogate.

Finding ethical consensus on the medical futility of CPR or other life-sustaining treatment, however, requires that medical futility be defined narrowly to the question whether it will resolve the patient's

¹¹¹ See, *supra*, pp. 70-73.

¹¹² See, *supra*, p. 68.

cardiac or respiratory distress. If it can be said to a reasonable degree of medical certainty that CPR will not, physicians ethically can, with disclosure to the patient or proxy, unilaterally issue a DNR order.

The interpretation advanced by the New York State Department of Health of New York's DNR law, which is aligned with this more restrictive definition of medical futility and which requires disclosure to the patient or surrogate, meets ethical standards under any view. It can and should be read into New York's DNR law that physicians, with patient disclosure, can unilaterally issue a DNR under this limited definition of medical futility.

Many physicians and ethicists, however, advocate a broader definition of futility based on whether CPR will resolve the patient's underlying pathology or whether resuscitation will result in an unacceptably low quality of life. This view has been criticized because it effectively imbues physicians with authority to make decisions about whether the patient's life is worth saving, and goes beyond the competence of physicians to make medical decisions. These are value judgments that belong to patients and their families.

Alternatively, the argument that the likelihood of success is low must be rejected because of the inability of physicians to accurately predict the effectiveness of CPR. Where the patient has any chance, the courts have uniformly found, in support of ethicists who favor a narrow definition of medical futility, that physicians owe a duty to their patients to take those actions necessary to save the patient.¹¹³ It is not the physician's prerogative to make unilateral decisions to withhold a life-sustaining intervention because of the physician's determination that resuscitation would result in a low likelihood of success or that the patient would likely be revived to a life "not worth living."

The guidelines promulgated by New York's Department of Health, because they are tied to a legal definition of medical futility embodied in the DNR statute, do not support a broader, qualitative definition of medical futility advanced by some ethicists. Further, the DOH rejects the argument that disclosure need not be made to patients or families of a physician's determination to withhold CPR.

Sometimes, end-of-life issues come down to the need of families and patients for more time in order to come to grips with the patient's dire medical prognosis. It is a matter of human dignity, of providing patients with the opportunity for a "good death," that physicians should

¹¹³ See, *supra*, pp. 70-73.

only as a last resort, when CPR holds no therapeutic value and only after fully communicating with the patient or family, unilaterally issue a DNR order.

Under all circumstances, including situations where CPR can with certainty be deemed medically futile, fairness and respect for patients requires that physicians inform patients and their families when they recommend the issuance of a DNR order. The DOH's position, which requires that patients and surrogates be informed when a physician decides that CPR be withheld, is well within these ethical, legal and moral standards.

Further, New York's DNR law recognizes the value of a cooling-off period before a DNR order is issued and provides for a review process that includes a non-adversarial forum for resolution of disputes over CPR. Hospital ethics committees, which contain physicians but also non-medical professionals and lay people, can adequately fill this function. It is crucial that ethics committees hearing these issues include people from outside the health care profession, so that a non-clinical perspective on issues can be considered. For instance, a layperson committee member may be better able to share the concerns of the patient's family and to effectively communicate with them. Ethics committees which contain people from many backgrounds would also make it possible that decisions will be grounded in societal normative values.

Should we as a society give doctors the right to override a patient's request for a treatment that represents a chance to live? And should we give doctors the right to make qualitative assessments of futility or to perform bedside rationing of care based on the value of the life left to be lived? Neither the publication co-authored by the New York State Department of Health, New York's DNR law, nor court cases, support these views. There is no morally valid reason why doctors should be accorded such absolute authority. Arguments that physicians will withhold CPR anyway and that it is better that this be done openly, or that financial reasons require that triage decisions based on utilitarian principles be made about who should receive treatment, are both ethically and morally troubling. Decisions based on financial considerations or bedside rationing are value judgments, and are beyond the competence of physicians to make. Patients and their families should retain the right to make determinations about CPR where there is hope, however small, that the patient's life can be continued, however compromised.

Giving physicians broad authority to unilaterally issue DNR orders hearkens back to the days of paternalistic beneficence, which was rejected by the past century's emphasis on patient autonomy. However, the position advanced by New York's Department of Health, which is based on the New York DNR law's restrictive definition of medical futility which requires a determination that CPR holds no value to sustaining the patient's life before it can be withheld, regardless of the patient's underlying pathology or the likelihood that the patient will have a poor quality of life if resuscitated, strikes a balance between autonomy and beneficence that is supported by the vast majority of jurists and ethicists.

The debate over New York's DNR law could herald a valid recognition of the limits of health care decision making based on the principle of autonomy alone, and revitalize medical ethical principles of beneficence and non-maleficence which have historically guided patient autonomy before the advent of patient autonomy in the last century. It could also provide guidance to other states similarly seeking to balance the interests of patients and health care providers when these other medical ethical principles are at odds with patient autonomy and when the use of a life-sustaining treatment is at issue.

Clearly, decisions related to withholding CPR must always be handled with care and dignity. To die because your doctor refuses to provide a treatment as basic as CPR, without seeking patient consent or over patient objection, is not a dignified death. We as a society can afford and ought to give our citizens the right to be informed about physician decisions to treat or not treat, and to be provided life-sustaining treatment that offers a chance, however minimal, of continued life. Further, even in cases in which CPR by any definition is medically futile, patients and their families should be provided a review forum that includes lay people as well as medical professionals in order to have their say and make their peace.