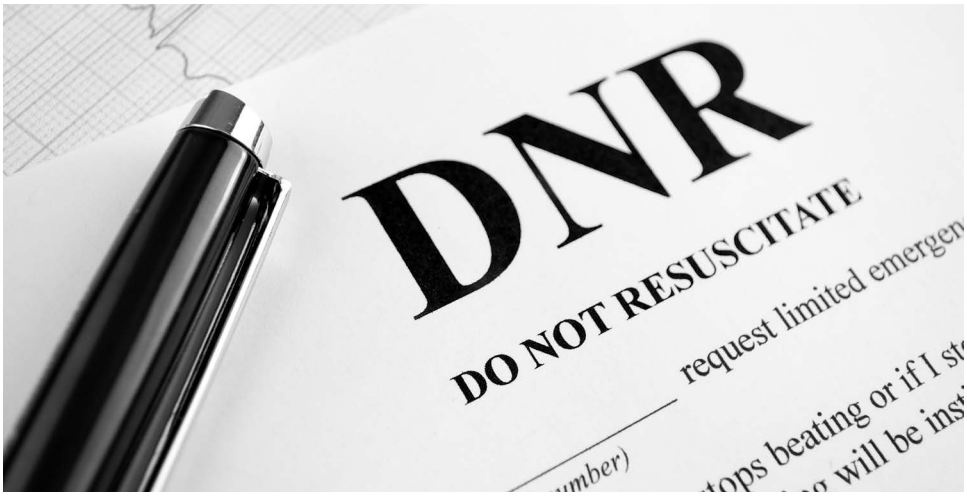
The Repeal of New York's Do Not Resuscitate Law: A Technical Clean-up Bill – And an Occasion for Reflection

By Robert Swidler



In the 2023 session, the New York State Legislature passed a bill to repeal New York's landmark 1987 Do-Not-Resuscitate (DNR) Law.[1] As of this writing, the bill is awaiting signature by the governor.

This is a noncontroversial and helpful technical clean-up bill and should promptly be signed into law. The 1987 DNR Law originally applied to DNR orders for any patients in any inpatient setting,[2] but its scope of applicability has all-but disappeared. Since 2011, DNR orders in most inpatient settings have been governed by the Family Health Care Decisions Act (FHCDA),[3] not the old DNR Law. Moreover, DNR orders for persons who receive services for developmental or intellectual disabilities are governed by a separate law, the Health Care Decisions Act (HCDA).[4] As a result, the old DNR Law, by default, now applies only in Office of Mental Health (OMH) operated or licensed psychiatric hospitals or hospital psychiatric units – where there are few DNR orders. This 2023 repealer provides that the FHCDA will now apply to DNR orders in such units.[5] The DNR principles in the 1987 DNR law and the 2010 FHCDA are so similar that psychiatric hospitals and units may not even notice the change.

So again, this is a technical clean-up bill. But the bill includes some details that health care providers and health lawyers should know about. Moreover, the repeal affords an occasion for a quick history of the DNR Law, and a mention of some unresolved DNR issues.

New York's 1987 DNR Law

A do-not-resuscitate order, or DNR order, is a medical order instructing clinical staff, in the event a patient's heartbeat and breathing stop, not to attempt to start them again by cardiopulmonary resuscitation (CPR) measures. Typically, a DNR order is considered appropriate when patient is dying and would prefer comfort care without extraordinary measures at the moment of death or when, due to the patient's diagnosis and prognosis, CPR is not likely to restore heartbeat or restore it for very long.

Until the mid-1980s the legality of DNR orders was uncertain.[6] Consequently, it was the practice of physicians at some New York City hospitals to write DNR orders secretly, without patient or family knowledge or consent. In some instances, the order was recorded in chalk on a blackboard, or by removable sticky colored dots on the patient's chart. These practices were widely reported in the media and became the subject of a Queens County grand jury investigation. In 1984 governor Mario M. Cuomo formed a multidisciplinary "Task Force on Life and the Law" to study policy issues relating to medical ethics, and he directed the Task Force to study DNR orders and make recommendations.[7] In 1986, the Task Force issued a report that advised that DNR orders are ethical, and should be recognized as lawful, under three circumstances:

1. If the patient has capacity, and consents to the DNR order.

2. If the patient lacks capacity, meets medical criteria,[8] and an appropriate surrogate decisionmaker consents to the order based on the patient's wishes if reasonably known or else the patient's best interests.

3. If the patient lacks capacity, there is no surrogate, and the attending physician and a concurring physician find that resuscitation would be medically futile – that is, will not be successful in starting the heart or that resuscitation would be needed repeatedly.

The Task Force proposal was unique in several respects, first and foremost for recognizing the legality of DNR orders

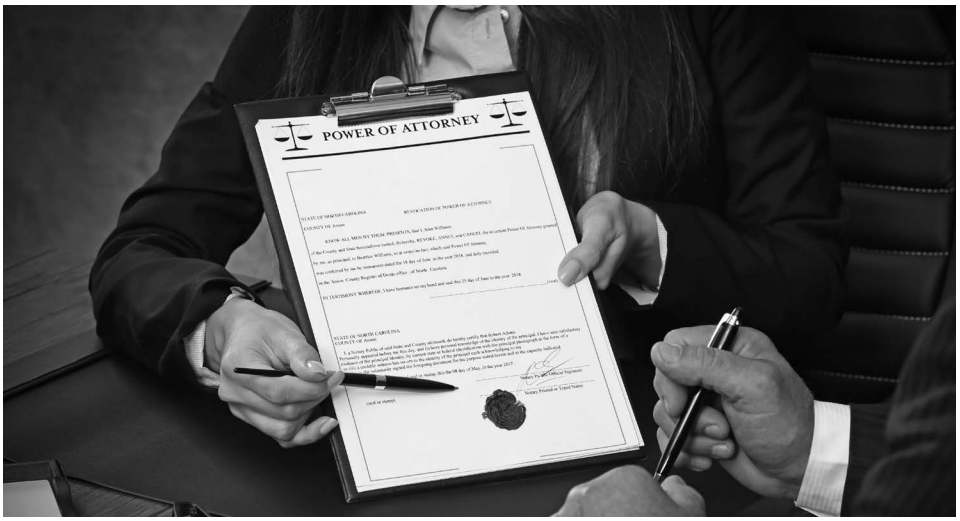
when issued in accordance with the principles above. But it was also unique for (i) crafting a bedside process to determine incapacity; (ii) listing a clear hierarchy of surrogate decisionmakers; and (iii) articulating a surrogate decision making standard based on bioethical principles.

The New York State Legislature, wary about DNR orders, added several additional constraints and requirements, but passed the proposal in in 1987.[9] It became Public Health Law (PHL) Article 29-B – Orders Not to Resuscitate.

The 1987 DNR Law was quite controversial, with criticisms from opposite perspectives: A widespread view in both the public and Legislature was that physicians should never be allowed to "give up" on a patient by writing a DNR order, even if asked to do so or consented to by the patient or family. Meanwhile, physician groups and others criticized the law from a different standpoint by arguing that a physician should have the authority to write a DNR when the physician determines, as a medical matter, that resuscitation would not be medically indicated.[10] Over time, it is fair to say that the public and the medical profession have come to accept the core principle of the DNR Law – that a DNR order can be acceptable but generally should be based on patient or surrogate consent. Thus, the 1987 DNR Law brought an end to the era of legal uncertainty and to secret DNR orders.

The 2010 Family Health Care Decisions Act

The DNR Law was a treatment-specific law: it authorized surrogate decision-making only for DNR decisions. It did not authorize an incapable patient's closest family member or friend to make other life-sustaining treatment decisions such as whether to withhold or withdraw a ventilator, tube feeding, dialysis, antibiotics, chemotherapy, or surgery. In fact, in most cases family members did not even have clear authority under New York law to consent to beneficial treatment, like surgery, for an incapable patient, although that was common practice.[11] Accordingly, in 1991, the Task Force issued a proposal for general surrogate decision making.[12] It was promptly introduced in the Legislature and became known as "The Family Health Care Decisions Act."[13]



The FHCDA addressed decisions for incapable patients and offered an approach to end of life decisions that was structurally similar to the DNR law. That is, it allowed the withdrawal or withholding of any life-sustaining treatment, including resuscitation:

1. If the incapable patient meets medical criteria similar to but more general than that in the DNR Law, and an appropriate surrogate decisionmaker consents to the order based on the patient's wishes if reasonably known or else the patient's best interests; or

2. If there is no surrogate, the attending physician and a concurring physician find that the treatment would – in effect – be medically futile.

Notably, the FHCDA was designed to apply to any type of life-sustaining treatment decision for an incapable patient, including but not limited to the DNR decision. The Task Force and drafters therefore recognized that the basic policies of the DNR Law should be merged with the FHCDA.[14]

The FHCDA was introduced and tabled repeatedly for 17 years.[15] But by 2009, the two houses appeared ready to update, finalize and pass the bill. One of the final outstanding issues was whether the FHCDA should apply to persons in or from facilities for persons with developmental disabilities and patients in or from OMH licensed hospitals or hospital units.

With respect to persons with developmental disabilities, the Office of Mental Retardation and Developmental Disabilities or OMRDD (later renamed the Office for People with Developmental Disabilities or OPWDD) and some allied advocacy groups contended that this population was better served by the principles in the HCDA and by OMRDD regulations governing treatment decisions. Accordingly, the drafters "carved out" this population from the bill to the extent the HCDA or OMRDD regulations already addressed the treatment issue.[16] Accordingly, going forward the HCDA governed DNR orders for this population.

Meanwhile, OMH contended that it needed to consider further the implications of extending the FHCDA to patients in OMH licensed or operated hospitals and hospital units. So the drafters

similarly "carved out" that population from the FHCDA to the extent OMH regulations governed the treatment issue.[17] More specifically, the bill renamed PHL Article 29-B from "Orders Not to Resuscitate" to "Orders Not to Resuscitate for Residents of Mental Hygiene Facilities."[18]

At the same time, the FHCDA bill directed the Task Force to study both the OPWDD and OMH carve-outs and make recommendations as to whether the FHCDA should be extended to those patients.[19]

The FHCDA was enacted in 2010 and became effective in 2011.[20] As of the FHCDA effective date, the 1987 DNR Law was reduced to applying only to patients in or from psychiatric hospitals and general hospital psychiatric units.

The 1987 DNR Law Since 2011

As explained above, since 2011 the 1987 DNR Law has applied only to patients in or from psychiatric hospitals or hospital psychiatric units. Over time, it has become increasingly clear that: (1) the principles in the FHCDA regarding DNR orders are substantially similar to those in the old DNR Law; (2) that the minor differences in the DNR Law cannot be considered special safeguards for psychiatric patients but are vestigial historical features; (3) that those differences simply cause confusion and noncompliance; and finally (4) that there is no rationale for preserving the DNR Law in such settings.

In 2016 the Task Force issued the report that the Legislature had called for on whether the FHCDA should be extended to previously "carved out" populations.[21] Most of the report focused on the extending the FHCDA to end of life decisions for persons with developmental or intellectual disabilities. But it also spoke about extending the FHCDA to cover DNR orders for persons in psychiatric hospitals or units. It wrote:

> [I]t has become apparent that there is no need for a separate law for DNR orders in psychiatric hospitals and units, and its existence is a source of complexity and confusion. Bills to repeal this vestige of the original DNR law and apply the FHCDA to DNR orders in those settings have been introduced in the state Legislature.[22]

For over a decade, bills have been introduced to "repeal this vestige of the original DNR law." Year after year they died in one committee or another – probably because there was no great grassroots advocacy for a technical clean-up bill. Finally in the 2023, the Legislature took this action.

DNR Law v. the FHCDA

The provisions in the DNR law differ in some respects from those in the FHCDA. First, the DNR Law includes several provisions that uniquely relate to DNR orders. For example:

- The DNR law includes a presumption that patient consents to CPR unless there is a DNR order.[23] The FHCDA, which addresses a broad range of emergency and non-emergency treatments, has no similar presumption.
- The DNR law includes a definition of medical futility that relates specifically to CPR. When an incapable patient does not have a surrogate, the attending practitioner may write a DNR order when he or she finds 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.[24]

  The FHCDA does not use the term "medical futility" but includes the same concept. It provides that the attending practitioner does not need to provide a treatment (including CPR) in cases where the incapable patient does not have a surrogate, and the practitioner finds that:

  > life-sustaining treatment offers the patient no medical benefit because the patient will die imminently, even if the treatment is provided; and (ii) the provision of life-sustaining treatment would violate accepted medical standards.[25]

- The DNR Law specifies periods for the review of a DNR order;[26] the FHCDA leaves the review of DNR and other treatment orders up to hospital policies.[27]
- The DNR law also addresses DNR decisions for capable patients;[28] the FHCDA does not because it governs only decisions for patients who lack capacity.
- The DNR Law is missing several provisions that appear in the later FHCDA. For example:
  - The FHCDA allows a broader range of providers to make the concurring determination of incapacity.[29]
  - The FHCDA surrogate decision making standard offered more detailed guidance. [30]

- The FCHDA definition of terminal illness is narrower than the DNR definition: the patient must be expected to die within 6 months not one year.[31]
- The FHCDA authorizes the attending practitioner to enter a DNR order for a patient without a surrogate not only on the basis of futility but also as part of a hospice admission and plan of care.[32]
- The FHCDA addresses provider conscience objections.[33]

Again, none of these differences were crafted to meet needs of patients in psychiatric hospitals or units; they are just holdovers from the 1987 law. In practice, these differences cause confusion and noncompliance.

The Repealer Bill

Section 1 of the Repealer Bill repeals the old DNR Law, PHL Article 29-B. Bill §§ 2 – 4 take care of related housekeeping:

- Section 2 amends the FHCDA to make it apply to DNR decisions for persons in a psychiatric hospital or unit (that is, to eliminate the former carve-out).
- Section 3 amends the PHL article that governs non-hospital orders not to resuscitation to provide that consent by patient or surrogate for a patient in a psychiatric hospital or unit to a nonhospital DNR order is governed by the FHCDA, while consent to such order for a person who is intellectually or developmentally disabled is governed by the HCDA.
- Section 3 amends the FHCDA to provide that the FHCDA section on interinstitutional transfers applies to a patient with a non-hospital DNR order who is admitted to a hospital, as well as to a patient with a hospital DNR who is transferred to another hospital.

Unsettled Issues

This repealer is a helpful clean-up bill. But it also draws attention to longstanding unresolved legal, professional, ethical and policy issues regarding DNR orders. Here are two issues that stand out:

1. **Futility or No Benefit DNR Orders.** Surprisingly, neither the DNR Law nor the FHCDA clearly resolve a fundamental question – Does a practitioner need patient or surrogate consent for a DNR order if the practitioner determines that, in the event of cardiac arrest, CPR would not provide any medical benefit? To be sure the DNR Law and FHCDA both provide that a DNR is lawful if written with patient or surrogate consent. And both laws provide that a practitioner may write a DNR for in capable patient based on medical futility (or its equivalent) if there is no surrogate. Both laws confer immunity on the provider who writes a DNR in compliance with these principles. But it does not necessarily follow from those principles that it is unlawful to write a DNR order without consent when CPR would be medically futile. Indeed, there may be no other example in medicine where consent is required to ***not*** provide a futile, useless, medically unnecessary treatment. At various times, the Department of Health and or health commissioner expressed support for the view that consent is not required for a DNR order based on medical futility.[34]

The key policy counterargument is that the physician may never be completely certain that CPR would be useless. A second counterargument is that futility DNR orders, if permitted, would become the rule rather than the exception and undermine efforts to urge providers to seek consent from, or even tell, the patient or surrogate. There is also a concern that unconsented futility DNR orders will disproportionately be written for poor or minority patients.

There are legitimate weighty legal, policy, ethical, professional arguments on both sides of this question, and a great deal of literature on the question.[35] It remains the greatest unsettled DNR issue.

2. **Extending the FHCDA to Persons With Intellectual Disabilities.** After this repealer becomes law, the FHCDA will govern end of life decisions for everyone except persons with Intellectual/Developmental Disabilities. Decisions for this population are governed by the HCDA. This disparate treatment is problematic for many reasons, described at length in the Task Force's 2016 report. The Task Force recommended extending the FHCDA to include this population, with some additional safeguards derived from the HCDA.[36] That is a second great unsettled DNR issue.

Robert Swidler recently retired as general counsel to St. Peter's Health Partners and St. Joseph's Health, not-for-profit health care systems in New York's capital region and central region. He plans to remain active in the NYSBA Health Law Section and the Empire State Bioethics Consortium, and to continue to teach in the Alden March Bioethics Center at Albany Medical College.

Endnotes

1. A.4332 (Gunther) (passed by Assembly March 27, 2023) / S.2930 (Rivera)(passed by Senate June 1, 2023). The bill repeals NY Public Health Law Article 29-B (Orders Not to Resuscitate for Residents of Mental Hygiene Facilities).
2. A separate statute, PHL Article 29-CC, governs non-hospital DNR orders.
3. NY Public Health Law Article 29-DD.
4. NYS Surrogate Court Act § 1750-B "Health Care Decisions for Persons who are Intellectually Disabled."
5. A.4332 § 2.
6. *See* NYS Task Force on Life and the Law, DNR Orders: Report and Recommendations.
7. *See* Governor Mario M. Cuomo, Executive Order No. 56, Dec. 21, 1984, https://www.governor.ny.gov/sites/default/files/2022-02/13__new_york_regulations_section_456_executive_order_n.pdf. *See also*, https://www.health.ny.gov/regulations/task_force/about.htm.
8. The medical criteria set forth in the DNR Law as a predicate for a surrogate decision are: (i) the patient has a terminal condition; or (ii) the patient is permanently unconscious; or (iii) resuscitation would be medically futile; or (iv) resuscitation would impose an extraordinary burden on the patient in light of the patient's medical condition and the expected outcome of resuscitation for the patient. PHL § 2995.3(c).
9. NY Laws of 1987, Chapter 818, creating NY PHL Article 29-B Orders Not to Resuscitate.
10. *See, e.g.,* R. Baker, The Legitimation and Regulation of DNR Orders, in R. Baker & M.A. Strosberg (eds.), Legislating Medical Ethics: A Study of the New York Do-Nat-Resuscitate Law, 33-101.
11. NY Task Force on Life and the Law, *When Others Must Choose: Deciding for Patients Without Capacity* (March 1992), pp 75, 93.
12. *When Others Must Choose, supra*. https://www.health.ny.gov/regulations/task_force/reports_publications/docs/when_others_must_choose.pdf.
13. *See* R. Swidler, *New York's Family Health Care Decisions Act – The Legal and Political Background, Key Provisions and Emerging Issues, NYSBA Journal,* June 2010, p.18.
14. *When Others Must Choose,* p. 269.
15. *See* R. Swidler, *supra* note 13.
16. PHL § 2994-b.3.
17. PHL § 2994-b.3.
18. NY Laws of 2010, Chapter 8 § 4.
19. *Id.* § 28.
20. Chapter 8, Laws of 2010.
21. NYS Task Force on Life and the Law, *Recommendations for Amending the Family Health Care Decisions Act to Include Health Care Decisions for Persons with Developmental Disabilities and Patients in or Transferred from Mental Health Facilities*, June 21, 2016, https://www.health.ny.gov/regulations/task_force/reports_publications/docs/2016-06_recommendations_for_amending_fhcda.pdf.
22. *Id.*, p. 26.
23. PHL § 2962. This provision has sometimes been misread to impose a duty to commence CPR unless there is a DNR order. It does not say that or mean that. It simply reflects the longstanding caselaw principle that in an emergency, consent is presumed. *See, e.g.*, PHL § 2805-d.2, and 4(c). So when a patient has a cardiac arrest, CPR can be provided without the patient's consent, unless there is a DNR order. The presumption of consent does not address a duty to provide CPR.
24. PHL § 2961.12.
25. PHL § 2994-g.5.
26. PHL § 2970.
27. PHL § 2994-k.
28. PHL § 2964.
29. *Compare* PHL § 2963 *with* PHL § 2994-c.
30. *Compare* PHL § 2965 *with* PHL § 2994-d.4. and d.5.
31. *Compare* PHL § 2961 *with* PHL §2994-a.
32. PHL § 2994-g.5-a.
33. PHL § 2994-n.
34. *See, e.g.*, NYS Health Facilities Memorandum Series 88-24, March 18, 1988; NYS Task Force on Life and the Law, *When Others Must Choose*, p. 274.
35. *E.g.,* M. Cantor, C. Braddock, A. Derse, *Do-Not-Resuscitate Orders and Medical Futility*, Arch Internal Medicine 2003; 163(22); L. Vivas, T Carpenter, *Meaningful Futility: requests for resuscitation against medical recommendation*, J Med Ethics 2021;47:654–656 (2020); Bailey S., The concept of futility in health care decision making, Nurs. Ethics 2004;11(1):77–83; Youngner SJ, *Who defines futility?,* JAMA 1988; 260(14):2094–5; Pellegrino E., *Decisions at the end of life – an abuse of the concept of futility*, Practical Bioethics 2015;1(3):4–6; Schneiderman LJ., *Defining medical futility and improving medical care*, J Bioeth Inq. 2011;8(2):123.
36. *See* note 17, *supra.*