

DEPARTMENT OF HEALTH

MEMORANDUM

HEALTH FACILITIES SERIES: H-27; RHCF-22; HHA-19; HOSPICE-10

SUBJECT: DNR Law Changes

Chapter 370 of the Laws of 1991, which amends Public Health Law, Article 29-B governing physician orders not to resuscitate (DNR), became effective in part on July 15, 1991. Certain provisions took effect on January 1, 1992. A copy of Chapter 370 is attached (Attachment A). The purpose of this memorandum is to:

- A. Clarify the requirements for issuance of non-hospital orders not to resuscitate.
- B. Explain the changes in hospital DNR orders affected by the law.
- C. Consolidate into one document CPR requirements applicable to pre-hospital emergency medical services personnel.

A separate Department of Health Memorandum will be issued dealing with medical futility.

I Background

Cardiopulmonary Resuscitation

Cardiopulmonary resuscitation (CPR) is the external support of circulation and respiration via external chest compression and artificial ventilation. The primary purpose of CPR is to sustain a constant blood flow of oxygenated blood to the brain cells, thereby maintaining brain viability until definitive medical treatment is available.

Do Not Resuscitate Orders

Prior to January 1, 1992, Article 29-B of the Public Health Law applied only in general hospitals, nursing homes and certain facilities and schools regulated under the Mental Hygiene Law. Under Chapter 370 the DNR Law also governs DNR orders in a non-hospital setting. This will enable adults living at home to have their wishes honored when emergency medical services personnel respond to calls. In addition, the DNR Law has been amended to permit certain procedural changes in hospitals. The requirements for physician reviews of DNR orders have been modified to recognize the different needs of different types of patients. Also, the possible confusion between applicability of the DNR Law and the Health Care Proxy Law has been addressed.

II Non-Hospital DNR Orders

A. General Rules on Non-Hospital DNR Orders

Issuing Non-Hospital Orders

A non-hospital order not to resuscitate may be issued while a patient is hospitalized, to take effect after hospitalization. It may also be issued for a person who is not in a hospital. In either case consent may be obtained:

1. from the patient, in writing, dated and signed in the presence of at least two witnesses eighteen years of age or older, who must also sign the decision;
2. from the patient, orally, to the attending physician alone;
3. from the patient during hospitalization, orally in the presence of at least two witnesses eighteen years of age or older, one of whom is a physician affiliated with the hospital in which the patient is being treated;
4. from a proxy-designated health care agent, orally, to the attending physician alone. For a patient not in a hospital, the attending physician is defined as the one who has primary responsibility for the care and treatment of the patient. If this responsibility is shared by more than one physician, any of the physicians can obtain the consent.

Effective September 1, 1992, non-hospital DNR orders based on surrogate consent or attending physician determination, may be issued prior to, during or after hospitalization. The attending physician must determine that the patient lacks capacity and that one or more of the following apply: 1) the patient has a terminal condition or is permanently unconscious, 2) resuscitation would be medically futile, or 3) resuscitation would impose an extraordinary burden for the patient under his/her medical circumstances. The law requires the attending physician's determination to be concurred in by another licensed physician.

Non-Hospital DNR orders must be issued on the attached Department of Health form. The Commissioner will also develop a standard bracelet that may be worn, but is not required to be worn, by a patient to identify that patient as having a non-hospital DNR order.

The attending physician must be the one to record the issuance a non-hospital DNR order in a patient's medical chart, and may not direct a registered nurse to do so. In a hospice, the medical director may serve as the attending physician for a hospice patient.

Dispute Mediation

Each hospital is required to establish a system for mediating disputes regarding the issuance of DNR orders. The mediation requirements in the DNR law, however, apply only during hospitalization.

Reviewing Non-hospital DNR Orders

The attending physician must review the order whenever examining the patient, or at least every ninety days, but need not do so more than once every seven days even if examinations occur more often. The attending physician must either record the review in the patient's chart or direct a registered nurse to record such review. The attending physician who directs a registered nurse must countersign that review in the patient's medical chart within fourteen days. However, failure to comply with review requirements will not render a non-hospital DNR order ineffective. Home care agencies must have reasonable written procedures in place that include, at a minimum, a written notification to the attending physician of the date by which an order needs review.

Revoking Non-hospital DNR Orders

A patient or other person who has consented to a non-hospital DNR order can revoke consent to the order at any time. Such revocation need not be written. Any act evidencing the intent to revoke will suffice. If a health care worker is informed of the revocation of a non-hospital DNR order, the worker must notify the patient's attending physician. The attending physician must record the revocation in the patient's chart, cancel the order and make diligent efforts to retrieve the form and copies of the form on which the order was issued. If the patient has had a standard DNR bracelet, the attending physician must also make diligent efforts to retrieve it.

Honoring Non-hospital DNR Orders

Emergency medical services personnel and hospital emergency services personnel who are provided with a non-hospital DNR order or who identify a standard bracelet on a patient must comply with the order. Personnel who comply are not subject to any criminal or civil liability for actions taken reasonably and in good faith in conjunction with compliance. The order may be disregarded personnel if they believe in good faith that the order has been

cancelled or revoked. In addition, the order may be disregarded if objection by persons on the scene (other than EMS personnel) make a physical confrontation likely. Finally, a non-hospital DNR order may be disregarded at the direction of a hospital emergency service physician if significant and exceptional medical circumstances warrant doing so. Decisions made by physicians on this subject will not be disputed by the Department if reasonable and made in good faith.

Admitting Patient's with Non-hospital DNR Orders

If a patient with a non-hospital DNR order is admitted to a hospital, the order is treated the same as a hospital DNR order of a patient transferred from another hospital. The order remains effective and should be honored by hospital emergency personnel until the attending physician first examines the patient. The attending physician must then either issue a hospital DNR order or cancel the order. If the physician a hospital DNR order, it is not necessary to obtain an additional consent from the patient, agent or surrogate. If the physician cancels the order, the person who consented to the non-hospital order must be notified immediately. If the patient, agent or surrogate objects, the matter should be referred to the receiving hospital's dispute mediation system.

B. Requirements Applicable to Pre-hospital Personnel

Initiation of CPR

The first responsibilities of a certified first responder (CFR) or an emergency medical technician (EMT) (including advanced EMTs) when confronting a patient in possible cardiac arrest are to establish an open airway, then to determine whether the patient is breathing and has an adequate circulation. The steps followed by CFRs, EMTs and AEMTs to determine the need for CPR include assessing if a patient is unresponsive, breathless, and lacks a pulse. If the individual is breathing and has a pulse, CPR is unnecessary. CPR is to be commenced only for individuals who are non-responsive, non-breathing, and pulseless.

Since CPR is most effective when started immediately after cardiac arrest occurs, it is imperative that the CFR or EMT begin CPR as soon as possible in an effort to maintain the viability of the victim's central nervous system. The moment of collapse does not necessarily mark the onset of cardiac arrest. Cardiac activity may be sufficient following the individual's collapse to maintain the brain's viability up to the moment the cardiac arrest actually occurs. After the arrest occurs, brain death begins within four to six minutes. For this reason, when the CFR, EMT or AEMT arrives at the scene of a cardiac arrest, CPR should be initiated immediately if the individual is unresponsive, breathless and without a pulse. The only exceptions are 1) when the arrest occurs during an interfacility transfer and the sending facility has provided the EMTs with a written order not to resuscitate the patient, 2) when a non-hospital DNR order is presented on the standard Department of Health form, 3) when the standard DNR bracelet is found on the patient's body, or 4) in cases of obvious death such as decapitation or other similarly mortal injuries, or where rigor mortis, tissue decomposition, or extreme dependent lividity is present. Extreme dependent lividity is considered a contraindication for CPR only when there are extensive areas of reddish-purple discoloration of the skin which are present in dependent areas (those areas on which the body has been resting).

Termination of CPR

Once CPR is initiated by a CFR, EMT or AEMT it must be continued until one of the following occurs: effective spontaneous circulations has been restored; resuscitative efforts have been transferred to another appropriately trained individual who continues CPR and other basic life support measures; a physician assumes the responsibility for the care of the patient; a physician (on scene, or by radio, telephone, or other means) orders termination of CPR; care of the patient is transferred to hospital staff assigned responsibilities for emergency care; a valid non-hospital DNR form is present; or, the CFR, EMT or AEMT is exhausted and physically unable to continue resuscitation.

Hospital DNR Orders During Patient Transfer

Article 29-B requires pre-hospital personnel to comply with a hospital order not to resuscitate issued by a patient's attending physician whenever the patient is being transferred from one institution to another. Such institutions

include acute care hospitals, nursing homes, inpatient hospice units, and psychiatric hospitals. The transferring institution must provide the EMS personnel with a written DNR order, which may be incorporated into the transfer orders and need not be a separate order. EMS personnel should not accept a verbal DNR order. The EMS personnel must provide the receiving facility with a copy of the DNR order, unless the patient expires during the transfer. In that case the ambulance service should retain the order (attached the pre-hospital care report). The sending facility should accept the expired patient back, unless the receiving facility is willing to accept the patient.

When the patient is being transferred from a health care institution to home, EMS personnel are obliged to honor a non-hospital DNR or bracelet.

Patients enrolled in certified hospice programs must also have formal DNR orders. Hospice programs are designed as home care programs, although each has a back-up support agreement with an acute care hospital. Hospices should provide pre-hospital personnel with a non-hospital DNR order.

Health Care Proxy

If a person signs a health care proxy he or she designates another person, called an agent, to make decisions on his or her behalf. The authority of an agent to make decisions begins only after a physician has determined that the patient lacks capacity. Also, a health care agent must consult with qualified professionals to ensure informed decision-making.

In an out-of-hospital emergency situation, it would be unusual for a physician to be present to make the capacity decision, an agent to be present, and licensed professionals to be present to provide advice to the agent. Therefore, it is very unlikely that an agent will be authorized to make immediate resuscitation decisions.

Accordingly, in the absence of a written DNR order or bracelet, pre-hospital personnel should follow their normal treatment protocols when a proxy is presented or an agent is present. The destination hospital should be notified of the existence of the proxy, and it should be brought with the patient. The agent should be advised of the hospital to which the patient will be taken, and the agent should be advised that emergency department personnel can make capacity decisions and provide advice to the agent. (EMS providers should note that this supercedes EMS Policy Statement 92-01.)

Living Wills

A living will is a statement of the patient's desires or intentions regarding treatment or resuscitation. New York State courts have ruled that if a living will provides clear and convincing evidence of the patient's intentions, it may be followed. There is no standard living will form. Pre-hospital EMS personnel should not attempt to determine whether a living will provides clear and convincing evidence, but rather should notify medical control of its existence and bring it to the hospital.

Transportation of Patients From the Community to Hospitals

All acutely ill patients should be transported to a hospital unless one or more of the following exceptions apply:

- The patient gives informed consent to refuse transportation.
- The patient has suffered a cardiac arrest and a non-hospital DNR order exists.

There is no need to transport a dead body to the hospital for a declaration of death. If the death is unexpected, it must be investigated by the county coroner or medical examiner, who should be notified. If the coroner or medical examiner has not been notified by the police, then a member of the ambulance service should do so. If the death is expected, the law requires that a physician sign the death certificate stating the cause of the death. If the patient is enrolled in a hospice or has been receiving home care, that provider should be contacted. Otherwise the family should be assisted in contacting a funeral director of their choice, who can arrange with the physician for the death certificate to be signed.

C. Responsibilities of Home Care Providers Including Hospices

Home care providers should discuss non-hospital DNR orders, along with other forms of advance directives, when discussing patient rights and the admission process. See department of Health Memorandum 92-3. Providers should take steps to ensure that non-hospital DNR orders are reviewed on a timely basis by attending physicians. It is appropriate for a home care agency to request a review of the non-hospital DNR order when all other M.D. orders are reviewed (at least every 62 days). This will ensure that the statutory 90 day review requirement for DNR orders is met.

D. Issuance of Orders by Hospices

The medical director of a hospice may serve as the attending physician for its patients. Non-hospital DNR orders may be issued or received by the director for hospice patients. It is appropriate for the medical director of the hospice to review the order every 90 days to meet the statutory requirement. Hospice programs are encouraged to provide adequate patient and family education about the role of pre-hospital personnel in performing CPR in the absence of a valid non-hospital DNR order.

III. Clarification of DNR Law's Relationship to Health Care Proxy Law

In a hospital as defined by Article 29-B, the provisions of the health care proxy law take precedence over conflicting provisions of the DNR law. As a result, a proxy-designated health care agent makes resuscitation decisions where a patient lacks the capacity to do so, and when the agent can be reasonably presumed to have information necessary to make an informed decision. The only exception would be if the health care proxy provides that the agent may not make resuscitation decisions. Where there is no health care agent, a surrogate under the DNR law may make such decisions.

IV. Hospital DNR Orders in the Operating Room

Sometimes patients with DNR orders undergo surgery. For example, palliative surgery may improve the quality of life of a terminally ill patient. Although surgery and the anesthesia required increase the risk of cardiac or respiratory arrest, CPR has a more successful outcome in the operating room than in other settings.

As a result of the distinct circumstances involved in administering CPR in the operating room, some physicians and hospitals have taken the position that DNR orders should always be suspended during surgery. However, Section 2975 of the DNR Law provides that no person may prohibit issuance of a DNR order as a condition for receiving health care services.

Non-hospitals and physicians cannot suspend a DNR order or require suspension of all orders prior to surgery without the permission of the patient, agent, or surrogate. Physicians must inform the patient, agent, or surrogate of the circumstances involved in administering CPR in the operating room, and the likely outcome for the patient of providing CPR in that setting. Hospitals should inform surgeons of the need to seek advance decisions about existing DNR orders.

If a patient, agent, or surrogate does not agree to suspend the order during surgery, a physician who objects to this decision must promptly inform the person who consented to the DNR order and the hospital of his or her objection. The physician must make all reasonable efforts to arrange to transfer the patient to another physician, if necessary, or promptly submit the matter to the hospital's dispute mediation system. In an emergency situation, the patient's wishes must take precedence.

V. Technical Amendments to the DNR Law

Patient Designated Surrogate

As of January 1, 1992, a surrogate cannot be appointed to make CPR decisions for a hospitalized patient without capacity. Anyone who wishes to designate an individual to make such decisions can do so by signing a health care proxy form appointing a health care agent. An agent can then make decisions concerning a DNR order. A surrogate prior to January 1, 1992 retains surrogate authority and responsibility subsequent to January 1, 1992.

Oral Consent to DNR Order

The DNR law no longer requires that the consent of a surrogate or parent to a DNR order be in writing. Such a consent may now be given orally to two adult witnesses, one of whom must be a physician affiliated with the treating hospital. The decision must be recorded in the medical chart.

Notification of Non-custodial Parent

The DNR law no longer requires a physician to notify a non-custodial parent about consent to a DNR order for a minor patient in all cases. Such notification is now required only if the non-custodial parent has maintained substantial and continuous contact with the minor. The attending physician, or someone acting on his/her behalf, must make reasonable efforts to determine if the non-custodial parent has maintained such contact with the minor. If so, diligent efforts must be made to notify such parent prior to issuing the order. In determining whether there has been substantial and continuous contact, an attending physician or someone acting on his/her behalf may rely in good faith on the statements made by a custodial parent.

Definition of Mental Illness

Dementias, such as Alzheimer's disease, as well as other disorders related to dementia, are excluded from the definition of "mental illness". The definition is the same as the definition of "mental illness" in the health care proxy law. As a result, the concurring physician on questions of incapacity for patients who have dementia does not have to be a psychiatrist or neurologist.