

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.

New York State Public Health Law
Article 29-B Orders Not To Resuscitate (DNR)
Sections Important for EMS Personnel

§ 2960. Legislative findings and purpose.

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.

§ 2961. Definitions.

The following words or phrases, as used in this article, shall have the following meanings unless the context otherwise requires: 1. "Adult" means any person who is eighteen years of age or older, or is the parent of a child, or has married. 2. "Attending physician" means the physician selected by or assigned to a patient in a hospital or, for the purpose of provisions herein governing non-hospital orders not to resuscitate, a patient not in a hospital, who has primary responsibility for the treatment and care of the patient. Where more than one physician shares such responsibility, any such physician may act as the attending physician pursuant to this article. 3. "Capacity" means the ability to understand and appreciate the nature and consequences of an order not to resuscitate, including the benefits and disadvantages of such an order, and to reach an informed decision regarding the order. 4. "Cardiopulmonary resuscitation" means measures, as specified in regulations promulgated by the commissioner, to restore cardiac function or to support ventilation in the event of a cardiac or respiratory arrest. Cardiopulmonary resuscitation shall not include measures to improve ventilation and cardiac functions in the absence of an arrest. 5. "Close friend" means any person, eighteen years of age or older, who presents an affidavit to an attending physician stating that he is a close friend of the patient and that he has maintained such regular contact with the patient as to be familiar with the patient's activities, health, and religious or moral beliefs and stating the facts and circumstances that demonstrate such familiarity. 5-a. "Correctional facilities medical care personnel" means personnel engaged in providing health care at correctional facilities, as that term is defined in subdivision four of section two of the correction law. 6. "Developmental disability" means a developmental disability as defined in subdivision twenty-two of section 1.03 of the mental hygiene law. 7. "Emergency medical services personnel" means the personnel of a service engaged in providing initial emergency medical assistance, including but not limited to first responders, emergency medical technicians, and advanced emergency medical technicians. 8. "Health care agent" means a health care agent of the patient designated pursuant to article twenty-nine-C of this chapter. 9. "Hospital" means a general hospital as defined in subdivision ten of section twenty-eight hundred one of this chapter and a residential health care facility as defined in subdivision three of section twenty-eight hundred one of this chapter or a hospital as defined in subdivision ten of section 1.03 of the mental hygiene law or a school named in section 13.17 of the mental hygiene law. 10. "Hospital emergency service personnel" means the personnel of the emergency service of a general hospital, as defined in subdivision ten of section twenty-eight hundred one of this chapter, including but not limited to emergency services attending physicians, emergency services registered professional nurses, and registered professional nurses, nursing staff and registered physicians assistants assigned to the general hospital's emergency service. 11. "Hospitalization" means the period during which a person is a patient in, or a resident of, a hospital. 12. "Medically futile" means 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. 13. "Mental hygiene facility" means a residential facility operated or licensed by the office of mental health or the office of mental retardation and developmental disabilities. 14. "Mental illness" means a mental illness as defined in subdivision twenty of section 1.03 of the mental hygiene law, provided, however, that mental illness shall not include dementia, such as Alzheimer's disease or other disorders related to dementia. 15. "Minor" means any person who is not an adult. 16. "Non-hospital order not to resuscitate" means an order, issued in accordance with section twenty-nine hundred seventy-seven of this article, that directs emergency medical services personnel, hospital emergency service personnel or correctional facilities medical care personnel not to attempt cardiopulmonary resuscitation in the event a patient suffers cardiac or respiratory arrest. 17. "Order not to resuscitate" means an order not to attempt cardiopulmonary resuscitation in the event a patient suffers cardiac or respiratory arrest. 18. "Parent" means a parent who has custody of the minor. 19. "Patient" means a person admitted to a hospital or, for the purpose of provisions herein governing non-hospital orders not to resuscitate, a person who has or may be issued a non-hospital order not to resuscitate. 20. "Reasonably available" means that a person to be contacted can be contacted with diligent efforts by an attending physician or another person acting on behalf of the attending physician or the hospital. 21. "Surrogate" means the person selected to make a decision regarding resuscitation on behalf of another person pursuant to

section twenty- nine hundred sixty-five of this article. 22. "Surrogate list" means the list set forth in subdivision two of section twenty-nine hundred sixty-five of this article. 23. "Terminal condition" means an illness or injury from which there is no recovery, and which reasonably can be expected to cause death within one year.

§ 2964. Decision-making by an adult with capacity.

1. (a) The consent of an adult with capacity must be obtained prior to issuing an order not to resuscitate, except as provided in subdivision three of this section. (b) If the adult has capacity at the time the order is to be issued, the consent must be obtained at or about such time, notwithstanding any prior oral or written consent. 2. (a) During hospitalization, an adult with capacity may express a decision consenting to an order not to resuscitate 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. Any such decision shall be recorded in the patient's medical chart. (b) Prior to or during hospitalization, an adult with capacity may express a decision consenting to an order not to resuscitate in writing, dated and signed in the presence of at least two witnesses eighteen years of age or older who shall sign the decision. (c) An attending physician who is provided with or informed of a decision pursuant to this subdivision shall record or include the decision in the patient's medical chart if the decision has not been recorded or included, and either: (i) promptly issue an order not to resuscitate the patient or issue an order at such time as the conditions, if any, specified in the decision are met, and inform the hospital staff responsible for the patient's care of the order; or (ii) promptly make his or her objection to the issuance of such an order and the reasons therefor known to the patient and either make all reasonable efforts to arrange for the transfer of the patient to another physician, if necessary, or promptly submit the matter to the dispute mediation system. (d) Prior to issuing an order not to resuscitate a patient who has expressed a decision consenting to an order not to resuscitate under specified medical conditions, the attending physician must make a determination, to a reasonable degree of medical certainty, that such conditions exist, and include the determination in the patient's medical chart. 3. (a) In the event that the attending physician determines, in writing, that, to a reasonable degree of medical certainty, an adult patient who has capacity would suffer immediate and severe injury from a discussion of cardiopulmonary resuscitation, the attending physician may issue an order not to resuscitate without obtaining the patient's consent, but only after: (i) consulting with and obtaining the written concurrence of another physician selected by a person authorized by the hospital to make such selection, given after personal examination of the patient, concerning the assessment of immediate and severe injury to the patient from a discussion of cardiopulmonary resuscitation; (ii) ascertaining the wishes of the patient to the extent possible without subjecting the patient to a risk of immediate and severe injury; (iii) including the reasons for not consulting the patient in the patient's chart; and (iv) obtaining the consent of a health care agent who is available and would be authorized to make a decision regarding cardiopulmonary resuscitation if the patient lacked capacity or, if there is no such agent, a surrogate pursuant to section twenty-nine hundred sixty-five of this article, provided, however, that the consent of an agent or surrogate shall not be required if the patient has previously consented to an order not to resuscitate pursuant to subdivision two of this section. (b) Where the provisions of this subdivision have been invoked, the attending physician shall reassess the patient's risk of injury from a discussion of cardiopulmonary resuscitation on a regular basis and shall consult the patient regarding resuscitation as soon as the medical basis for not consulting the patient no longer exists. 4. If the patient is in or is transferred from a mental hygiene facility, notice of the patient's consent to an order not to resuscitate shall be given to the facility director prior to the issuance pursuant to this section of an order not to resuscitate. Notification to the facility director shall not delay issuance of an order not to resuscitate. If the facility director concludes that the patient lacks capacity or that issuance of an order not to resuscitate may be inconsistent with the patient's wishes, the facility director shall submit the matter to the dispute mediation system of this article. 5. If the patient is in or is transferred from a correctional facility, notice of the patient's consent to an order not to resuscitate shall be given to the facility director and reasonable efforts shall be made to provide notice to an individual designated by the patient to receive such notification prior to the issuance of the order not to resuscitate. Notification to the facility director or the individual designated by the patient shall not unreasonably delay issuance of an order not to resuscitate.

§ 2965. Surrogate decision-making.

1. (a) The consent of a surrogate or health care agent acting on behalf of an adult patient who lacks capacity or on behalf of an adult patient for whom consent by a surrogate or health care agent is authorized by subdivision three of section twenty-nine hundred sixty-four of this article must be obtained prior to issuing an order not to resuscitate the patient, except as provided in paragraph (b) of this subdivision or section twenty-nine hundred sixty- six of this article. (b) The consent of a surrogate or health care agent shall not be required where the adult had, prior to losing capacity, consented to an order not to resuscitate pursuant to subdivision two of section twenty- nine hundred sixty-four of this article. (c) A decision regarding cardiopulmonary resuscitation by a health care agent on a principal's behalf is governed by article twenty-nine-C of this chapter and shall have priority over decisions by any other person, except the patient or as otherwise provided in the health care proxy. 2. (a) One person from the following list, to be chosen in order of priority listed, when persons in the

prior sub-paragraphs are not reasonably available, willing to make a decision regarding issuance of an order not to resuscitate, and competent to make a decision regarding issuance of an order not to resuscitate, shall have the authority to act as surrogate on behalf of the patient: (i) a committee of the person or a guardian appointed pursuant to article seventeen-A of the surrogate's court procedure act, provided that this paragraph shall not be construed to require the appointment of a committee of the person or guardian for the purpose of making the resuscitation decision; (ii) the spouse; (iii) a son or daughter eighteen years of age or older; (iv) a parent; (v) a brother or sister eighteen years of age or older; and (vi) a close friend. (b) After the surrogate has been identified, the name of such person shall be included in the patient's medical chart.

3. (a) The surrogate shall make a decision regarding cardiopulmonary resuscitation on the basis of 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. (b) Notwithstanding any law to the contrary, the surrogate shall have the same right as the patient to receive medical information and medical records. (c) A surrogate may consent to an order not to resuscitate on behalf of an adult patient only if there has been a determination by an attending physician with the concurrence of another physician selected by a person authorized by the hospital to make such selection, given after personal examination of the patient that, to a reasonable degree of medical certainty: (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. Each determination shall be included in the patient's medical chart.

4. (a) A surrogate shall express a decision consenting to an order not to resuscitate either (i) in writing, dated, and signed in the presence of one witness eighteen years of age or older who shall sign the decision, or (ii) orally, to two persons eighteen years of age or older, one of whom is a physician affiliated with the hospital in which the patient is being treated. Any such decision shall be recorded in the patient's medical chart. (b) The attending physician who is provided with the decision of a surrogate shall include the decision in the patient's medical chart and, if the surrogate has consented to the issuance of an order not to resuscitate, shall either: (i) promptly issue an order not to resuscitate the patient and inform the hospital staff responsible for the patient's care of the order; or (ii) promptly make the attending physician's objection to the issuance of such an order known to the surrogate and either make all reasonable efforts to arrange for the transfer of the patient to another physician, if necessary, or promptly refer the matter to the dispute mediation system. (c) If the patient is in or is transferred from a mental hygiene facility, notice of a surrogate's consent to an order not to resuscitate shall be given to the facility director prior to the issuance pursuant to this section of an order not to resuscitate. Notification to the facility director shall not delay issuance of an order not to resuscitate. If the facility director concludes that the patient has capacity or that issuance of an order not to resuscitate is otherwise inconsistent with this article, the facility director shall submit the matter to the dispute mediation system of this article. (d) If the attending physician has actual notice of opposition to a surrogate's consent to an order not to resuscitate by any person on the surrogate list, or, if the patient is in or is transferred from a mental hygiene facility, by the facility director, the physician shall submit the matter to the dispute mediation system and such order shall not be issued or shall be revoked in accordance with the provisions of subdivision three of section twenty-nine hundred seventy-two of this article.

5. If a surrogate has consented to an order not to resuscitate, notice of the surrogate's decision shall be given to the patient where there is any indication of the patient's ability to comprehend such notice, except if a determination has been made pursuant to subdivision three of section twenty-nine hundred sixty-four of this article. If the patient objects, an order not to resuscitate shall not be issued.

§ 2966. Decision-making on behalf of an adult patient without capacity for whom no surrogate is available.

1. If no surrogate is reasonably available, willing to make a decision regarding issuance of an order not to resuscitate, and competent to make a decision regarding issuance of an order not to resuscitate on behalf of an adult patient who lacks capacity and who had not previously expressed a decision regarding cardiopulmonary resuscitation, an attending physician (a) 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 selected by a person authorized by the hospital to make such selection, after personal examination of the patient, reviews and concurs in writing with such determination, or, (b) shall issue an order not to resuscitate the patient, provided that, pursuant to subdivision one of section twenty-nine hundred seventy-six of this article, a court has granted a judgment directing the issuance of such an order.

2. If the patient is in or is transferred from a mental hygiene facility, prior to issuance of an order not to resuscitate pursuant to subdivision one of this section, notice of such order shall be given to the facility director. Notification to the facility director shall not delay issuance of an order not to resuscitate. If the facility director concludes that the patient has capacity or that issuance of an order not to resuscitate is otherwise inconsistent with this article, the facility director shall submit the matter to the dispute mediation system of this article.

3. Notwithstanding any other provision of this section, where a decision to consent to an order not to resuscitate has been made, notice of the decision shall be given to the patient where there is any indication of the patient's ability to comprehend such notice, except where a determination has been made pursuant to subdivision three of section twenty-nine hundred sixty-four of this article. If the patient objects, an order not to resuscitate shall not be issued.

§ 2967. Decision-making on behalf of a minor patient.

1. An attending physician, in consultation with a minor's parent or legal guardian, shall determine whether a minor has the capacity to make a decision regarding resuscitation. 2. (a) The consent of a minor's parent or legal guardian and the consent of the minor, if the minor has capacity, must be obtained prior to issuing an order not to resuscitate the minor. (b) Where the attending physician has reason to believe that there is another parent or a non-custodial parent who has not been informed of a decision to issue an order not to resuscitate the minor, the attending physician, or someone acting on behalf of the attending physician, shall make reasonable efforts to determine if the uninformed parent or non-custodial parent has maintained substantial and continuous contact with the minor and, if so, shall make diligent efforts to notify that parent or non-custodial parent of the decision prior to issuing the order. (c) If the minor is in or is transferred from a mental hygiene facility, notice of a decision to issue an order not to resuscitate the minor shall be given to the facility director prior to issuance of an order not to resuscitate. Notification to the facility director shall not delay issuance of an order not to resuscitate. If the facility director concludes that issuance of an order not to resuscitate is inconsistent with this article, the facility director shall submit the matter to the dispute mediation system of this article. 3. A parent or legal guardian may consent to an order not to resuscitate on behalf of a minor only if there has been a written determination by the attending physician, with the written concurrence of another physician selected by a person authorized by the hospital to make such selections given after personal examination of the patient, that, to a reasonable degree of medical certainty, the minor suffers from one of the medical conditions set forth in paragraph (c) of subdivision three of section twenty-nine hundred sixty-five of this article. Each determination shall be included in the patient's medical chart. 4. (a) A parent or legal guardian of a minor, in making a decision regarding cardiopulmonary resuscitation, shall consider the minor patient's wishes, including a consideration of the minor patient's religious and moral beliefs, and shall express a decision consenting to issuance of an order not to resuscitate either (i) in writing, dated and signed in the presence of one witness eighteen years of age or older who shall sign the decision, or (ii) orally, to two persons eighteen years of age or older, one of whom is a physician affiliated with the hospital in which the patient is being treated. Any such decision shall be recorded in the patient's medical chart. (b) The attending physician who is provided with the decision of a minor's parent or legal guardian, expressed pursuant to this subdivision, and of the minor if the minor has capacity, shall include such decision or decisions in the minor's medical chart and shall comply with the provisions of paragraph (b) of subdivision four of section twenty-nine hundred sixty-five of this article. (c) If the attending physician has actual notice of the opposition of a parent or non-custodial parent to consent by another parent to an order not to resuscitate a minor, the physician shall submit the matter to the dispute mediation system and such order shall not be issued or shall be revoked in accordance with the provisions of subdivision three of section twenty-nine hundred seventy-two of this article.

§ 2968. Effect of order not to resuscitate on other treatment.

Consent to the issuance of an order not to resuscitate shall not constitute consent to withhold or withdraw medical treatment other than cardiopulmonary resuscitation.

§ 2971. Inter-institutional transfers.

If a patient for whom an order not to resuscitate has been issued is transferred from a hospital to a different hospital the order shall remain effective, unless revoked pursuant to this article, until the attending physician first examines the transferred patient, whereupon the attending physician must either: 1. Issue an order continuing the prior order not to resuscitate. Such order may be issued without obtaining further consent from the patient, surrogate or parent pursuant to this article; or 2. Cancel the order not to resuscitate, provided the attending physician immediately notifies the person who consented to the order and the hospital staff directly responsible for the patient's care of the cancellation. Such cancellation does not preclude the entry of a new order pursuant to this article.

§ 2977. Non-hospital orders not to resuscitate.

1. Emergency medical services personnel, hospital emergency service personnel and correctional facilities medical care personnel shall honor non-hospital orders not to resuscitate, except as provided in subdivision ten of this section. 2. (a) A non-hospital order not to resuscitate shall be governed as an order not to resuscitate pursuant to this article, except as otherwise specifically provided in this section. (b) The requirements for dispute mediation established in this article shall only apply with respect to patients during hospitalization. 3. A non-hospital order not to resuscitate may be issued during hospitalization to take effect after hospitalization, or may be issued for a person who is not a patient in, or a resident of, a

hospital. 4. Consent to a non-hospital order not to resuscitate shall be governed by sections twenty-nine hundred sixty-four through twenty-nine hundred sixty-seven of this article, provided, however, (a) that an adult with capacity, whether or not hospitalized or a health care agent, may also consent to a non-hospital order not to resuscitate orally to the attending physician, and (b) when the concurrence of a second physician is sought to fulfill the requirements for the issuance of an order not to resuscitate for hospice and home care patients, such second physician shall be selected by the hospice medical director or hospice nurse coordinator designated by the medical director or by the home care services agency director of patient care services, as appropriate to the patient. 4. (a) Consent to a non-hospital order not to resuscitate shall be governed by sections twenty-nine hundred sixty-four through twenty-nine hundred sixty-seven of this article, provided, however, that an adult with capacity, whether or not hospitalized or a health care agent, may also consent to a non-hospital order not to resuscitate orally to the attending physician. (b) When the concurrence of a second physician is sought to fulfill the requirements for the issuance of an order not to resuscitate for patients in a correctional facility, such second physician shall be selected by the chief medical officer of the department of corrections or his or her designee. This paragraph shall not apply to the issuance of an order not to resuscitate pursuant to section two thousand nine hundred sixty-six of this article. 5. The attending physician shall record the issuance of a non-hospital order not to resuscitate in the patient's medical chart. 6. A non-hospital order not to resuscitate shall be issued upon a standard form prescribed by the commissioner. The commissioner shall also develop a standard bracelet that may be worn by a patient with a non-hospital order not to resuscitate to identify that status; provided, however, that no person may require a patient to wear such a bracelet and that no person may require a patient to wear such a bracelet as a condition for honoring a non-hospital order not to resuscitate or providing health care services. 7. An attending physician who has issued a non-hospital order not to resuscitate, and who transfers care of the patient to another physician, shall inform the physician of the order. 8. For each patient for whom a non-hospital order not to resuscitate has been issued, the attending physician shall review whether the order is still appropriate in light of the patient's condition each time he or she examines the patient, whether in the hospital or elsewhere, but at least every ninety days, provided that the review need not occur more than once every seven days. The attending physician shall record the review in the patient's medical chart record provided, however, that a registered nurse who provides direct care to the patient may record the review in the chart record at the direction of the physician. In such case, the attending physician shall include a confirmation of the review in the patient's medical chart within fourteen days of such review. Failure to comply with this subdivision shall not render a non-hospital order not to resuscitate ineffective. 9. A person who has consented to a non-hospital order not to resuscitate may at any time revoke his or her consent to the order by any act evidencing a specific intent to revoke such consent. Any health care professional informed of a revocation of consent to a non-hospital order not to resuscitate shall notify the attending physician of the revocation. An attending physician who is informed that a non-hospital order not to resuscitate has been revoked shall record the revocation in the patient's medical chart, cancel the order and make diligent efforts to retrieve the form issuing the order, and the standard bracelet, if any. 10. Emergency medical services personnel, hospital emergency service personnel or correctional facilities medical care personnel who are provided with a non-hospital order not to resuscitate, or who identify the standard bracelet on the patient's body, shall comply with the terms of such order; provided, however, that: (a) emergency medical services personnel, hospital emergency service personnel or correctional facilities medical care personnel may disregard the order if: (i) they believe in good faith that consent to the order has been revoked, or that the order has been cancelled; or (ii) family members or others on the scene, excluding such personnel, object to the order and physical confrontation appears likely; and (b) hospital emergency service physicians may direct that the order be disregarded if other significant and exceptional medical circumstances warrant disregarding the order. 11. If a patient with a non-hospital order not to resuscitate is admitted to a hospital, the order shall be treated as an order not to resuscitate for a patient transferred from another hospital, and shall be governed by section twenty-nine hundred seventy-one of this article. 12. No person shall be subjected to criminal prosecution or civil liability, or be deemed to have engaged in unprofessional conduct, for honoring reasonably and in good faith pursuant to this section a non-hospital order not to resuscitate, for disregarding a non-hospital order pursuant to subdivision ten of this section, or for other actions taken reasonably and in good faith pursuant to this section.