

## **DNR, DNI, MOLST – THE FORMS FOR THE END OF LIFE**

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Resulting from the legal obligations of the medical community, as well as established standard procedures within medicine, documentation of end-of-life decisions regarding treatment has become critical to the process of being treated in the later parts of life. Sometimes, the purposes of these forms used for documentation are misunderstood and can cause confusion for patients and families in difficult times of health, but recent changes in the NYS Public Health Law offer a more streamlined, organized and advantageous method for keeping end-of-life treatment decisions in order.

### **DO NOT RESUSCITATE ORDER**

A Do-Not-Resuscitate Order (“DNR”) is an order generally written within a hospital to instruct that the patient shall not undergo CPR or advanced cardiac life support in the event that the patient’s heart or breathing stops. A DNR does not pertain to treatment other than that requiring intubation or CPR. This decision may be made by a patient with capacity, legal surrogate decision-makers, or two physicians if the patient is lacking capacity and there are no individuals that fulfill the allowed for roles. A patient may make oral request for a DNR order in front of two witnesses, one of which must be a physician, or the request may be in writing.

Article §29-B of the New York State Public Health Law delineates the procedure required to obtain a DNR. Recent updates to the law through the Family Health Care Decisions Act appoints family members to make decisions for incapacitated patients.

Orders to withhold/withdraw life sustaining treatments and DNR orders shall be reviewed when medically appropriate. Hospital orders do not need routine renewal. Non-hospital DNR orders require renewal every 90 days.

### **DO NOT INTUBATE ORDER**

A Do-Not-Intubate Order (“DNI”) is similar to a DNR, though it specifies that only chest compressions or cardiac drugs may be used to resuscitate, not intubation.

### **MOLST FORM**

The MOLST form was revised by the changes to the Public Health Law brought about by the Family Health Care Decisions to keep end-of-life decisions organized once patients or their respective guardians make them. The Department of Health has created checklists to assist practitioners and caretakers in completing MOLST forms with patients, and there are several categories of patients that have different checklists. These categories include:

- Adult with capacity, any setting
- Adult with health care proxy, any setting
- Adult with FHCDA surrogate
- Adult without FHCDA surrogate
- Adult without capacity in the community

The MOLST form is organized to ensure that health care proxies, living wills, organ donation wishes, and oral advance directive documentation are addressed with patients (or surrogates) to ensure effective communication during treatment. They are intended to

ensure transparency in treatment choices in various levels of health care, such as for physicians in hospitals, EMS responders, and those offering health care in non-hospital settings. They are printed on pink paper to put health care practitioners on alert that the patient has a MOLST form.

## **REAL LIFE IMPLICATIONS FOR FIRST RESPONDERS**

The NYS Department of Health has issued several memos regarding the interpretation, application and implications of a Non-Hospital DNR. These memos clarify the responsibilities of EMS responders in the event there is a known DNR and the steps taken by the DOH to ensure that EMS personnel are on notice of the existence of these forms. The Commissioner of the Department of Health has also been charged with creating a standard form DNR bracelet for out of hospital patients to wear for quick identification in emergency situations.

### **What documentation is required for a patient with a DNR order?**

- Emergency medical technicians/paramedics should attach a copy of the Out of Hospital DNR form, hospital DNR order and/or copy of the patient's chart to the patient care report, along with all other usual documentation. It should be noted on the patient care report that a written DNR order was present including the name of the physician, date signed and other appropriate information.
- If the cardiac/respiratory arrest occurred during transport, the DNR Form should accompany the patient so that it may be incorporated into the medical record at the receiving facility.
- Patients who are identified as dead at the scene need not be transported by ambulance; however, local EMS agencies should consider transportation for DNR patients who collapse in public locations. In these cases it may be necessary to transport the individual to a hospital without resuscitative measures in order to move the body to a location that provides privacy. Local policies need to be coordinated with the Medical Examiner/Coroner and law enforcement.

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.

### **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 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. The Department will not dispute decisions made by physicians on this subject if reasonable and made in good faith.

**Under what circumstances may an EMS provider disregard an Out of Hospital DNR order?**

- Any case where there is reasonable evidence to suggest that the DNR order has been revoked or cancelled.
- If the patient is conscious and states that they wish resuscitative measures, the DNR Form should be ignored.
- If the patient is unable to state his or her desire and a family member is present and requests resuscitative measures for the patient and a confrontational situation is likely to result, if the request is denied.
- A physician directs that the order be disregarded.

**Real Life Implications for EMS Personnel:**

**What procedures are and are not preformed if the patient presents a DNR?**

- Do not resuscitate (DNR) means, for the patient in cardiac or respiratory arrest, NO chest compressions, ventilation, defibrillation, endotracheal intubation, or medications.
- If the patient is NOT in cardiac or respiratory arrest, full treatment for all injuries, pain, difficult or insufficient breathing, hemorrhage and/or other medical conditions must be provided.
- Relief of choking caused by a foreign body is usually appropriate, although if breathing has stopped, ventilation should not be assisted.
- CPR must be initiated if no Out of Hospital or facility DNR is presented. If a DNR order is presented after CPR has been started, stop CPR.
- For unusual situations or questions on individual patient circumstances, contact medical control.

**Initiation of CPR**

The first responsibilities of an emergency medical technician (EMT) (including advanced EMTs and certified first responders) 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 EMTs 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 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 EMT 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 an EMT 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 EMT is exhausted and physically unable to continue resuscitation.

### **Liability Protections**

PHL Section 2977.12 "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 section ten of this section, or for other actions taken reasonably and in good faith pursuant to this section".

Department of Health Memo 92-32, 11/2/92

(<http://www.health.ny.gov/professionals/ems/pdf/srgdnr9232.pdf>);

Department of Health Memo 99-10, 12/30/99

(<http://www.health.ny.gov/professionals/ems/policy/99-10.htm>)

## **RELEVANT STATUTES**

### **NY PUBLIC HEALTH LAW § 2962: Presumption in favor of resuscitation; lawfulness of order; effectiveness of order; duty to provide information; no duty to expand equipment.**

1. Every person admitted to a hospital shall be presumed to consent to the administration of cardiopulmonary resuscitation in the event of cardiac or respiratory arrest, unless there is consent to the issuance of an order not to resuscitate as provided in this article.
2. It shall be lawful for the attending physician to issue an order not to resuscitate a patient, provided that the order has been issued pursuant to the requirements of this article. The order shall be included in writing in the patient's chart. An order not to resuscitate shall be effective upon issuance.
3. Before obtaining, pursuant to this article, the consent of the patient, or of the surrogate of the patient, or parent or legal guardian of the minor patient, to an order not to resuscitate, the attending physician shall provide to the person giving consent information about the patient's diagnosis and prognosis, the reasonably foreseeable risks and benefits of cardiopulmonary resuscitation for the patient, and the consequences of an order not to resuscitate.
4. Nothing in this article shall require a hospital to expand its existing equipment and facilities to provide cardiopulmonary resuscitation.
5. (a) The provisions of article twenty-nine-C of this chapter, governing health care proxies and agents, take precedence over conflicting provisions of this article.  
(b) When a patient who has a health care agent lacks capacity, the agent shall have the rights and authority that a patient with capacity would have under this article, subject to the terms of the health care proxy and article twenty-nine-C of this chapter.

### **NY PUBLIC HEALTH LAW § 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.

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.

**NY PUBLIC HEALTH LAW § 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 subparagraphs 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. However, such person may designate any other person on the list to be surrogate, provided no one in a higher class than the person designated objects:

(i) a guardian authorized to decide about health care pursuant to article eighty-one of the mental hygiene law or a guardian of a person appointed under article seventeen-A of the surrogate's court procedure act, provided that this paragraph shall not be construed to require the appointment of a guardian for the purpose of making the resuscitation decision;

(ii) the spouse, if not legally separated from the patient, or the domestic partner;

(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 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, 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.

#### **NY PUBLIC HEALTH LAW § 2994-cc: Consent to a nonhospital order not to resuscitate.**

1. An adult with decision-making capacity, a health care agent, or a surrogate may consent to a nonhospital order not to resuscitate orally to the attending physician or in writing. If a patient consents to a nonhospital order not to resuscitate while in a

correctional facility, notice of the patient's consent shall be given to the facility director and reasonable efforts shall be made to notify an individual designated by the patient to receive such notice prior to the issuance of the nonhospital order not to resuscitate.

Notification to the facility director or the individual designated by the patient shall not delay issuance of a nonhospital order not to resuscitate.

2. Consent by a health care agent shall be governed by article twenty-nine-C of this chapter.

3. Consent by a surrogate shall be governed by article twenty-nine-CC of this chapter, except that: (a) a second determination of capacity shall be made by a health or social services practitioner; and (b) the authority of the ethics review committee set forth in article twenty-nine-CC of this chapter shall apply only to nonhospital orders issued in a hospital.

4. (a) When the concurrence of a second physician is sought to fulfill the requirements for the issuance of a nonhospital 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 and community supervision or his or her designee.

(b) When the concurrence of a second physician is sought to fulfill the requirements for the issuance of a nonhospital 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.

5. Consent by a patient or a surrogate for a patient in a mental hygiene facility shall be governed by article twenty-nine-B of this chapter.

## **RELEVANT CASES**

**In re Finn:** 625 N.Y.S.2d 809 (Supreme Court of NY, 1995)

A severely mentally retarded man had an Article 17-A guardian, his sister, and she requested to doctors that her brother be given a DNR. Two doctors evaluated the patient and wrote the DNR order. The Chief Medical Officer of the facility questioned the appropriateness of the DNR, and examined the patient with another doctor from the facility. As per the law, the CMO is permitted to oppose the DNR in court, and she did so.

The Court found that the DNR was inappropriate because the first two physicians did not document a determination that the patient lacked capacity prior to completing the DNR order. Further, upon evaluation by the other two physicians as well as a court appointed independent physician, the patient's present medical condition was not one that would satisfy the conclusion that resuscitation would be medically futile.

The DNR order was rejected for failure to comply with the steps set forth in the legislation (Article 29-B of the Public Health Law), though the good faith measures of the physicians and the patient's sister were not questioned.

**Matter of Zornow:** 943 N.Y.S.2d 795 (Supreme Court of NY, 2011)

In this case, an elderly woman had two Article-81 guardians (2 of her children) who were able to make medical decisions for her, as she was found without capacity. They had decided to insert a feeding tube into the patient, though the other 4 siblings who were not guardians and a clergy member opposed the decision of that treatment.

Previously, the patient had requested food and water when she was sufficiently competent to make that health care decision and the nursing home staff understood her decision. Further, Her condition did not fulfill the conditions set forth by the FHCDA regarding life expectancy, so a decision to withdraw would have violated the statute. Appellate court found the guardians were correct in their decision to proceed with the NG tube because without it the patient would have died from starvation and not the underlying condition.

The patient had made the Catholic faith part of her wishes regarding medical decisions, so the family was correct to consult with clergy to determine the moral standards of the Catholic faith, which in essence conflicted with the decisions on the MOLST form. The differentiation between ordinary care and extraordinary care is pivotal to Catholic teachings, and feeding tube was determined to be ordinary care, thus not in violation of any part of the statutory requirements.

## **ACCESS TO FORMS**

Nonhospital DNR: <http://www.health.ny.gov/forms/doh-3474.pdf>

MOLST Form: <http://www.health.ny.gov/forms/doh-5003.pdf>

Sample Checklist for MOLST form completion:

[http://www.health.ny.gov/professionals/patients/patient\\_rights/molst/docs/checklist\\_1.pdf](http://www.health.ny.gov/professionals/patients/patient_rights/molst/docs/checklist_1.pdf)