

## **Overview of End of Life Law in New York State**

**Jonathan J. Rikoon, Mordy Serle and Louise D. Yang**

The law concerning the end of a person’s life is fraught with confusion. Ethics, religious beliefs, medical opinions, and emotional and financial strains on the patient’s relatives all color and complicate the issue. Patients with the capacity to make their own medical decisions are permitted to consent to or refuse medical treatment, including life-sustaining treatment and artificial nutrition or hydration.<sup>1</sup> When patients lack such capacity, however, the law generally seeks to determine what decision the patient would have made and then to implement such decision. New York, as well as many other states, has attempted to address this issue by allowing patients – before they become incompetent – to appoint health care agents to make medical decisions on their behalf once they become incompetent, although most people fail to appoint such an agent. This article addresses and outlines current New York law with respect to end of life decisions where a health care agent either has or has not been appointed. The extent of the health care agent’s authority and the rights of the patient’s family are also explored, although the law surrounding patients who have mental retardation or developmental disability<sup>2</sup> is not addressed.

### **Extent of Health Care Agent’s Authority, Where Agent Has Been Appointed**

Pursuant to New York Public Health Law (“N.Y. Pub. Health”) Article 29-C, any competent adult may appoint a health care agent (an “Agent”) by executing a health care proxy in accordance with the terms set out in the statute.<sup>3</sup> When the patient is declared

---

<sup>1</sup> See *Fosmire v. Nicoleau*, 75 N.Y.2d 219, 226 (N.Y. 1990) (affirming *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, by stating that “[t]he common law of this State established the right of a competent adult to determine the course of his or her own medical treatment.”).

<sup>2</sup> See Surrogate’s Court Procedure Act § 1750-b (McKinney (2010)).

<sup>3</sup> See N.Y. Pub. Health Law (hereinafter “PHL”) § 2981 (McKinney (2010)).

incompetent, the Agent’s authority pursuant to the health care proxy automatically comes into effect. With the exception of any express limitations stated by the patient in the health care proxy, the Agent, on the patient’s behalf, may make any and all health care decisions that the patient could have made, and the Agent has priority over any other person with respect to such health care decisions.<sup>4</sup> The court in *Stein v. Co. of Nassau* concluded that this statutory authority includes decisions outside of the hospital context, such as choosing whether to receive treatment and at which hospital to receive treatment.<sup>5</sup> In *Stein*, the appointed Agent (the patient’s wife) demanded that the ambulance take the patient back to the hospital that had just released him, but the ambulance crew refused and took the patient to the nearest hospital. The court analyzed N.Y. Pub. Health Law §2982 and decided that the health care proxy was valid outside of a hospital setting “[b]ecause the statute empowers health care agents ‘to make any and all decisions’ that a principal can make, [which] means that health care agents *must* be able to make the kinds of decisions that do not take place in hospitals, and thus do not occur in hospital settings.”<sup>6</sup>

One major carve-out to the Agent’s otherwise broad authority relates to decisions regarding artificial nutrition and hydration.<sup>7</sup> The Agent is not authorized to make such decisions unless the patient’s wishes regarding such procedures are “reasonably known.”<sup>8</sup>

---

<sup>4</sup> *Id.* §§ 2982(1) and (4).

<sup>5</sup> *Stein v. Co. of Nassau*, 642 F. Supp. 2d 135 (E.D.N.Y. 2009).

<sup>6</sup> *Stein*, 642 F. Supp. 2d at 142.

<sup>7</sup> Although the Family Health Care Decisions Act (the “FHCDA”) permits a Surrogate to make decisions on artificial nutrition and hydration even when the patient’s wishes are unknown, the FHCDA did not change the law relating to health care agents. However, where the patient’s wishes regarding artificial nutrition and hydration (or in contested cases, other life-sustaining treatments) are unknown, commentators believe that the standards set out in PHL §2994(d)(5) should govern the Agent’s decision. *See* 1-3 Bender’s New York Elder Law § 3.06[7] (2010).

<sup>8</sup> PHL §2982(2).

In determining the patient's wishes in this regard, courts have applied a "clear and convincing" evidentiary standard, which must be met by the party wishing to withhold or withdraw the artificial nutrition and hydration. In *Borenstein v. Simonson*,<sup>9</sup> the patient's health care proxy named her daughter as her Agent but did not provide any indication with respect to her wishes regarding the administration of artificial nutrition and hydration. The Agent also failed to provide any evidence showing that the patient would wish to decline the insertion of a percutaneous endoscopic gastrostomy tube (a "PEG tube") to provide nutrition and hydration to the patient. Under such circumstances, the court concluded that it lacked "clear and convincing" evidence to allow the Agent to prevent the insertion of the PEG tube.<sup>10</sup>

The Agent, when making health care decisions on behalf of a patient, must consult with a licensed physician or other health care worker (as provided in the statute), and the Agent's decision must be in accordance with the patient's wishes (including any religious and moral beliefs).<sup>11</sup> The Agent has the right to receive all medical information and records necessary to make his or her decision,<sup>12</sup> but the required consultation need not take place at the hospital (it can be conducted via telephone) or at the same time as the Agent makes the decision (it may take place well in advance of the Agent's decision).<sup>13</sup> Additionally, if the patient's wishes are unknown, then a decision in the patient's best interest will be sufficient.<sup>14</sup>

---

<sup>9</sup> *Borenstein v. Simonson*, 8 Misc.3d 481 (N.Y. Sup. Ct. Queens Co., 2005).

<sup>10</sup> *Id.* at 495.

<sup>11</sup> PHL § 2982(2).

<sup>12</sup> PHL § 2982(3).

<sup>13</sup> *Stein*, 642 F. Supp. 2d at 142 (stating that "the statute imposes no temporal or physical limitation concerning where or when this 'consultation' must take place.").

<sup>14</sup> PHL §2982(2).

## **Revocation of and Challenges to the Health Care Agent's Authority**

Although lawmakers and the courts have tried to define and limit an Agent's authority as clearly as possible, this has not stopped challenges to an Agent's authority, nor are such challenges likely to cease altogether given the potential ramifications of such healthcare decisions. N.Y. Pub. Health § 2992 permits certain individuals, including the health care provider and the patient's family members and close friends, to challenge the patient's health care proxy (a) to determine the validity of the health care proxy,<sup>15</sup> (b) to remove the Agent on the grounds of unavailability or bad faith, or (c) to override the Agent's decision on the grounds of bad faith or because the decision was not in accordance with the requirements of §§ 2982(1) and (2).<sup>16</sup>

Several New York cases have addressed the second category of challenges, usually on the grounds of bad faith,<sup>17</sup> and such cases generally provide that mere disputes regarding the patient's religious beliefs are insufficient to challenge the Agent's authority. In *Borenstein*, in addition to challenging the Agent's authority to make decisions regarding artificial nutrition and hydration on behalf of the patient (see above), the patient's sister petitioned for the removal of the Agent after the Agent refused a PEG tube to be inserted into the patient even though the patient was "committed to traditional

---

<sup>15</sup> PHL § 2981(1)(b) presumes every adult to be competent to appoint a health care agent, and the burden of proving incompetence is on the challenger.

<sup>16</sup> PHL § 2982(1) subjects the Agent's authority to any express limitations set forth in the health care proxy, and PHL § 2982(2) requires that the Agent, when making the decision, consult with a listed health care worker and that the decision be in accordance with the patient's religious or moral beliefs or if not reasonably known, in accordance with the patient's best interests.

<sup>17</sup> Challenges based on unavailability have also been brought. *See e.g., In re Susan Jane G.*, 33 A.D.3d 700 (N.Y. App. Div. 2<sup>nd</sup> Dept. 2006) (finding the Agent "no longer reasonably available, willing, and competent to fulfill his obligations under Public Health Law article 29-C."). For challenges based on the validity of the health care proxy and to override the Agent's decision, *see S.I. v. R.S.*, 24 Misc.3d 567 (N.Y. Sup. Ct. Nassau Co., 2009).

or religious Judaism.”<sup>18</sup> The court reviewed differing Jewish views on artificial feeding before concluding that no evidence was offered suggesting that the Agent’s actions were in bad faith.<sup>19</sup> In a similar case, petitioners argued that the Agent (the patient’s wife) should be removed for acting in bad faith and contrary to petitioner’s Jewish beliefs by directing that life-sustaining procedures be discontinued, including that the patient’s mechanical ventilator be disconnected.<sup>20</sup> The petitioners in that case were Orthodox Jews who believed that an individual’s life should be prolonged using artificial nutrition and hydration, but the court determined that the patient did not share their beliefs after hearing testimony that the patient was not an Orthodox Jew and “wanted to live life to the fullest, not to merely exist”<sup>21</sup> (even though he was brought up in an Orthodox household and wanted his brother to officiate his funeral).<sup>22</sup> The court therefore found no grounds to remove the Agent. In general, once an Agent has been appointed, it has been difficult to prove that such Agent was acting in bad faith.

### **Who Makes Health Care Decisions When No Agent Has Been Appointed?**

As mentioned above, most individuals fail to appoint an Agent. In such cases, the Family Health Care Decisions Act (the “FHCDA”), enacted in 2010, permits the patient’s family members, domestic partner or close friends (a “Surrogate”) to make health care decisions upon the patient’s incapacity. Prior to the law’s enactment, New York law offered very little authority for family members to make health care decisions for incapacitated patients, even if the decision involved consent to a beneficial treatment.<sup>23</sup>

---

<sup>18</sup> *Borenstein*, 8 Misc.3d at 497.

<sup>19</sup> *Id.* at 497-501.

<sup>20</sup> *S.I. v. R.S.*, 24 Misc.3d 567 (N.Y. Sup. Ct. Nassau Co., 2009).

<sup>21</sup> *Id.* at 574.

<sup>22</sup> *Id.* at 572.

<sup>23</sup> See Robert N. Swidler, New York’s Family Health Care Decisions Act, 82 New York State Bar Journal 18, 20 (June 2010) (hereinafter “Swidler”) (stating that “there was

Limited protection may have been available under the informed consent statutes,<sup>24</sup> but many health care providers were unwilling to take the risk associated with allowing family members to make such decisions, especially when the decision involved removing life-sustaining treatment.<sup>25</sup> The applicability of the FHCDA with respect to patients with mental disabilities is complicated and, in general, the FHCDA does not replace previously enacted regulations regarding such patients.<sup>26</sup>

The FHCDA makes it clear that such a Surrogate should only be sought as a last resort when no Agent or surrogate has been appointed pursuant to other sections of New York law.<sup>27</sup> The FHCDA lists, in order of priority, the persons who may act as the Surrogate: the patient's guardian appointed by a court pursuant to Article 81 of the Mental Hygiene Law who is authorized to make decisions about health care,<sup>28</sup> the patient's spouse or domestic partner, the patient's adult child and so forth.

---

no statute or regulation that generally empowered family members to consent to treatment when the patient could not and scant caselaw support for such authority.”).

<sup>24</sup> See PHL § 2805-d(4)(c).

<sup>25</sup> See Swidler at 20.

<sup>26</sup> For a more detailed description of who has authority to make health care decisions for patients with mental disabilities, see Robert N. Swidler, Surrogate Decision-Making for Incapable Adult Patients with Mental Disabilities: A Chart of the Applicable Laws or Regulations (revised Jan. 12, 2011) <http://www.nysba.org/Content/NavigationMenu/PublicResources/FamilyHealthCareDecisionsActInformationCenter/CompleteChart1-12-11.PDF>.

<sup>27</sup> PHL §§ 2994-b(2) and (3) (stating that the attending physician has a duty to make reasonable efforts to determine whether a patient has an appointed health care agent pursuant to a valid health care proxy or has a mental disability such that the Mental Hygiene Law or the Surrogate's Court Procedure Act would apply.).

<sup>28</sup> N.Y. Mental Hygiene Law (hereinafter “MHL”) § 81.22(a)(8) was amended by the FHCDA to permit courts appointing a guardian to grant the guardian the power to act as the patient's Surrogate pursuant to PHL Art. 29-CC. Presumably, a guardian appointed after the enactment of the FHCDA must specifically be granted this power in order to be accorded the highest priority pursuant to PHL §§ 2994-d(1). Prior to

The FHCDA specifies that “[o]ne person” should be designated as the Surrogate. (Similarly, only one individual at a time may be designated as an Agent under a health care proxy.) If the patient has more than one adult child, then it is presumably the responsibility of the hospital or nursing home to determine who should be the Surrogate. Any disputes regarding whom should be appointed as Surrogate, if they cannot be resolved informally, should be resolved by the Ethics Review Committee.<sup>29</sup> Where disputes regarding the form of treatment arise between the Surrogate and another person lower down on the surrogate list, three options are generally available: an informal resolution, review by the Ethics Review Committee (although its decision is not binding except in the three particular circumstances specified in N.Y. Pub. Health Law § 2994-m(4)(a)), or a court order (for which the court will consider whether the Surrogate has fulfilled his or her duties).<sup>30</sup>

The FHCDA also provides a solution for cases where the patient does not have one of the listed persons to act as their Surrogate.<sup>31</sup> In such cases, the hospital is charged with determining whether its patient has a health care agent, guardian, or person who can serve as surrogate under N.Y. Pub. Health § 2994-d. If no such person is available and the patient lacks capacity to make health care decisions, the hospital is further charged with identifying the patient’s wishes and preferences, including his or her religious and

---

the amendment, MHL § 81.22(a)(8) permitted courts to grant the guardian authority to make certain health care decisions. It is likely that an Article 81 guardian appointed prior to the enactment of the FHCDA with the authority to make health care decisions would be accorded the same priority, although the FHCDA is unclear on this point. *See* PHL § 2994-d(1)(a) (giving priority to “[a] guardian authorized to decide about health care pursuant to article eighty-one of the mental hygiene law.”).

<sup>29</sup> PHL § 2994-m(2)(b)(iii).

<sup>30</sup> *See* FAQs of the New York State Bar Association FHCDA Resource Center (hereinafter FAQs), [http://www.nysba.org/Content/NavigationMenu/PublicResources/FamilyHealthCareDecisionsActInformationCenter/FAQ\\_HTML.htm](http://www.nysba.org/Content/NavigationMenu/PublicResources/FamilyHealthCareDecisionsActInformationCenter/FAQ_HTML.htm) (last accessed February, 2011).

<sup>31</sup> PHL § 2994-g.

moral beliefs, with respect to pending health care decisions. For routine medical treatment, the FHCDA allows the attending physician to make decisions on the patient's behalf. For major medical treatment, the attending physician must seek agreement from another health care professional directly responsible for the patient's care before making the decision. Stricter regulations are provided for decisions to withhold or withdraw life-sustaining procedures (see below).

The extent of the Surrogate's authority is similar to that provided to an Agent appointed in a health care proxy except that the FHCDA imposes a different standard for decisions to withhold or withdraw life-sustaining treatment (see below), and the authority of the Surrogate is limited to making health care decisions in general hospitals and nursing homes.<sup>32</sup> If the patient has already made a decision about the proposed health care (orally or in writing) or with respect to a decision to withdraw or withhold life-sustaining treatment (either orally, during hospitalization and in the presence of two witnesses over 18 years of age, or in writing), then the Surrogate's consent is not required.<sup>33</sup> If the Surrogate is called upon to make a decision, the decision must be made in accordance with the patient's wishes, including the patient's religious and moral beliefs, or if they are not known, in the best interests of the patient.<sup>34</sup>

### **Evidentiary Standard for Withholding or Withdrawing Life-Sustaining Procedures**

While many health care decisions made by an Agent or Surrogate are relatively non-controversial, decisions regarding life-sustaining procedures typically give rise to the most challenges. Life-sustaining procedures generally include cardiopulmonary resuscitation and mechanical ventilation. Some commentators distinguish artificial nutrition and hydration from the other types of life-sustaining procedures because, unlike air, "[t]he patient does not live in an environment of food, ready for intake ... [food] must

---

<sup>32</sup> PHL § 2994-b(1).

<sup>33</sup> PHL § 2994-d(3)(a)(ii).

<sup>34</sup> PHL § 2994-d(4).

be supplied, and in this regard ceasing to provide nutrition and hydration takes on more the flavor of denying the patient air, not just assistance in breathing.”<sup>35</sup> As a result of this distinction, artificial nutrition and hydration were singled out for special treatment in N.Y. Pub. Health Article 29-C, which provides that the Agent shall not have authority to make decisions on artificial nutrition and hydration if the patient’s wishes regarding them are not reasonably known and cannot with reasonable diligence be ascertained.

Although several decisions have addressed the required standard for withholding or withdrawing life-sustaining procedures (including artificial nutrition and hydration), the stringency of the standard is still unclear. It is also unclear whether courts will apply a different standard for artificial nutrition and hydration than for other forms of life-sustaining treatment when an Agent has been appointed; the court in *S.I.* believed that the legislature, in passing Article 29-C in 1990, replaced the clear and convincing standard with a “reasonableness standard” in situations where a health care proxy has been created.<sup>36</sup> The seminal case in New York on this issue is *In re O’Connor*<sup>37</sup> (decided prior to the enactment of N.Y. Pub. Health Article 29-C), in which the court concluded that the record lacked “clear and convincing proof” (which burden is borne by the party wishing to withdraw or withhold life-sustaining treatment) that the patient had made a “firm and settled commitment, while competent,” to decline the type of medical assistance at issue under the circumstances. Testimony in the O’Connor case indicated that the patient had stated to several witnesses over a period of several years that she did not want to be kept alive using artificial means, but such testimony was found to be insufficient to meet the

---

<sup>35</sup> *Borenstein*, 8 Misc.3d at 493.

<sup>36</sup> *S.I.*, 24 Misc.3d at 569-71 (stating that “[w]hile it appears to this Court, based upon the memoranda supporting the bill’s passage, which contrasted the *O’Connor* decision and the reasonableness standard set forth in the statute, that the legislature rejected the clear and convincing standard when a health care proxy has been created, some courts are still applying the more stringent standard, thereby continuing the legacy of confusion and legal uncertainty.”).

<sup>37</sup> *In re O’Connor*, 72 N.Y.2d 517 (N.Y. 1988).

required standard. The *O'Connor* standard has been eroded in subsequent years as lower courts found the requirements to be too stringent.<sup>38</sup> In *In re Christopher*,<sup>39</sup> the court found clear and convincing evidence showing that the patient would not wish a PEG tube to be inserted after distinguishing the circumstances from those in *O'Connor* by using the fact that the patient in *O'Connor* had a gag reflex problem, which prevented her from swallowing, whereas the patient in *In re Christopher* did not.<sup>40</sup> The court in *In re Chantel R.*<sup>41</sup> also sought to escape the harshness of *O'Connor* by distinguishing between patients who had previously been competent to make medical decisions and patients who are mentally challenged and therefore had been incapable to make such decisions even when they were in good health.

In any event, the clear and convincing standard is still applied in New York courts even in cases involving health care proxies – although it is unclear how stringent this standard is, since the cases in which this standard has been applied tend to have very little evidence indicating whether the patient would wish to have the life-sustaining treatment withdrawn or withheld.

One case, *In re Balich*,<sup>42</sup> has been cited as upholding the clear and convincing standard. In this case, the patient stated on her health care proxy that she did not wish to be given tube feedings if she had irreversible brain damage. However, instead of applying the clear and convincing standard to the patient's wishes, the court required

---

<sup>38</sup> See Bernadette Tuthill, *Want to Terminate Life Support? Not in New York: Time to Give New Yorkers a Choice*, 26 *Touro L. Rev.* 675 (2010) (stating that “the dissent’s prediction that the standard would prove unworkable or inhumane began to come to fruition as lower courts scrambled to distinguish *O'Connor*.”).

<sup>39</sup> *In re Christopher*, 675 N.Y.S.2d 807 (Sup. Ct. Queens Co. 1998).

<sup>40</sup> *Id.* at 809.

<sup>41</sup> *In re Chantel R.*, 791 N.Y.S.2d 324 (Surr. Ct. N.Y. Co. 2004).

<sup>42</sup> *In re Balich*, No. 10487/03, 2003 WL 21649907 (N.Y. Sup. Ct. Suffolk Co. Jul. 10, 2003).

clear and convincing evidence that the patient had sustained irreversible brain damage. The court defined the standard as “the highest level of proof in a civil case” and cited *Matter of Storar*<sup>43</sup> for the proposition that the standard “forbids relief whenever the evidence is loose, equivocal or contradictory.”<sup>44</sup> The court determined that there was no clear and convincing medical evidence to establish that the patient had suffered irreversible brain damage where several nurses testified to having conversations with the patient and the testifying doctor was unaware of such communications by the patient.

*Borenstein*, discussed above, seems to have applied both the “reasonably known” and the “clear and convincing” standards, and the court found the standards not to have been met. The court stated that “it is conceded that [the patient’s] wishes in that regard are not reasonably known and cannot with reasonable diligence be ascertained. There is surely no ‘clear and convincing’ evidence on this specific issue.”<sup>45</sup>

*In re Univ. Hosp. of State Univ. of N.Y.*<sup>46</sup> offers a bit more insight into what evidence the courts will consider in determining whether the clear and convincing standard has been met. In that case, petitioners wanted to remove life sustaining treatments, including a tracheostomy (which provided the patient with oxygen) and a PEG tube. The court considered various factors in determining whether the petitioner’s burden had been met, including “the validity of the instruments which purportedly reflect the desire of the patient; the medical and physical condition of the patient both at the time of execution and at present; any intervening factors that may have occurred between the period of execution and the present; the medical testimony and opinions offered as to the medical testimony and opinions offered as to the patient’s existing condition and

---

<sup>43</sup> *Matter of Storar*, 52 N.Y.2d 363, 379 (N.Y. 1981).

<sup>44</sup> *In re Balich*, 2003 WL 21649907, at \*5.

<sup>45</sup> *Borenstein*, 8 Misc.3d at 495.

<sup>46</sup> *In re Univ. Hosp. of State Univ. of N.Y.*, 194 Misc.2d 372, 377 (N.Y. Sup. Ct. Onondaga Co. 2002).

prognosis concerning her capability of recovery; her expressions of desire and intent; and the patient's expressed religious and moral beliefs."<sup>47</sup> The patient had signed a living will indicating a desire to be removed from life-sustaining treatment, but the court found the living will had been revoked because the patient did not understand its meaning and would not have intended the withdrawal of life-sustaining treatment because she was a devout Catholic. The court therefore concluded that the petitioner had not met its burden of proof.

The clear and convincing standard may have been eroded in one respect by the enactment of the FHCDA, which provides its own standards for withholding or withdrawing life-sustaining procedures where a Surrogate has been appointed pursuant to N.Y. Pub. Health Article 29-CC.<sup>48</sup> The Surrogate must first comply with the requirements of N.Y. Pub. Health Law § 2994-d(4) (namely that the decision must be in accordance with the patient's religious and moral beliefs, or if they are not known, in the patient's best interests).<sup>49</sup> If the Surrogate completes that analysis and determines, for example, that the patient wanted to have treatment withheld or withdrawn under the current circumstances, that decision cannot be implemented unless one of the following two additional conditions is satisfied.<sup>50</sup> First, the procedures may be withheld or withdrawn if the Surrogate decides that the procedures would be an extraordinary burden to the patient and the attending physician determines, along with another physician, that (a) the patient's illness will cause death within six months, whether or not treatment is

---

<sup>47</sup> *Id.* at 377.

<sup>48</sup> PHL § 2994-d(5).

<sup>49</sup> *See In re Zornow*, 2010 WL 5860446, at \*2 (N.Y. Sup. Ct. Monroe Co. 2010) (in a contest over whether artificial feeding should be withdrawn, where no health care proxy or advance directive was provided, the court suggested that the religious and moral beliefs of the patient take precedence over the standards required by PHL § 2994-d(5)(a) if the patient's beliefs are inconsistent with the standards required by the statute, at least if those beliefs favor administration of treatment).

<sup>50</sup> PHL § 2994-d(5).

provided, or (b) the patient is permanently unconscious. Second, the procedures may be withdrawn if the Surrogate decides that the procedures would involve such pain, suffering or other burden as to result in it being inhumane or extraordinarily burdensome and the patient has an irreversible or incurable condition as determined by the attending physician and another independent physician.

Where no health care agent, guardian, or surrogate is available to make the decision on the patient's behalf, the FHCDA authorizes the withholding or withdrawal if (a) approved by a court or (b) the attending physician, with independent concurrence of a second physician designated by the hospital, determines to a reasonable degree of medical certainty that the life-sustaining treatment is of no medical benefit to the patient and the provision of such treatment would violate accepted medical standards.<sup>51</sup>

Since the FHCDA has been in effect for less than a year, the case law interpreting its standard for withdrawing or withholding life-sustaining treatment is limited. One recent case is *In re Zornow*, in which the children of a devout Catholic patient with no health care proxy disagreed about whether their mother should be provided with artificial nutrition and hydration. The court had previously appointed co-guardians for the patient pursuant to Mental Hygiene Law Article 81, and its decision focused on providing guidelines of authority (derived from N.Y. Pub. Health Law § 2994-d(5)) for the co-guardians in making end of life decisions for the patient. The court stated that the FHCDA statute changed the presumption when the patient has not indicated his or her wishes regarding life-sustaining treatment from a "presumption of life" to a "presumption of termination."<sup>52</sup> The court considered the conditions set out in N.Y. Pub. Health Law §

---

<sup>51</sup> PHL § 2994-g(5).

<sup>52</sup> *In re Zornow*, 2010 WL 5860446, at \*3 (stating that "[i]ronically, now when a principal selects a person whom he or she trusts in a health care proxy to make decisions on his or her behalf, the law of that proxy is that, absent an indication to the contrary, that person must provide food and water [citation omitted], while someone designated by statute in whom the patient may have no trust whatsoever, can terminate his or her life earlier than his or her natural death by such deprivation of food and water, despite the principal never having indicated a desire for such

2994-d(5) (discussed above) and relied on the position of the Catholic Church on such conditions to reach the conclusion that, except under certain exceptional circumstances such as imminent death, the patient must be provided with food and water even if administered artificially.<sup>53</sup>

The *Zornow* court was not faced with a circumstance in which the patient's expressed or implied wishes or best interests, determined under 2994-d(4), supported withholding or withdrawing treatment, because in that case the court found at least an implied wish in favor of artificial nutrition and hydration. Under 2994-d(5), it seems clear from the face of the statute, even if the first inquiry yields the opposite result – i.e., wishes or best interests in favor of withholding or withdrawing – treatment (including nutrition and hydration) may nevertheless not be withheld or withdrawn unless there is also compliance with the stringent additional requirements of 2994-d(5).<sup>54</sup>

### **The Effect of Advance Directives on the Agent's or Surrogate's Authority**

Given the need to establish a patient's prior wishes with respect to end of life decisions, many patients have attempted to use advance directives, such as a medical directive, a Do Not Resuscitate (“DNR”) order, or a Medical Orders for Life Sustaining Treatment (“MOLST”) form, in order to make their wishes clearly known.

---

earlier termination.”). Nevertheless, PHL § 2994-d(5) provides very substantial safeguards against ill-considered withholding or withdrawing of treatment.

<sup>53</sup> *Id.* at \*4.

<sup>54</sup> Under N.Y. Pub. Health Law § 2994-d(5), any decision to withhold or withdraw life-sustaining treatment is authorized only if:

- (A) (i) the treatment would be an “extraordinary burden” to the patient and (ii) two physicians – one of them independent – determines that the patient will die within six months or the patient is permanently unconscious, or
- (B) (i) the treatment would involve “inhumane or extraordinarily burdensome” pain or suffering and (ii) the patient has a irreversible or incurable condition.

A medical directive, which often accompanies a health care proxy, sets out the patient's wishes for health care in the event the patient is unable to make decisions regarding his or her own health care. As alluded to above, there is no statutory authority supporting the usage of a medical directive, although its use became widespread after the *O'Connor* decision requiring "clear and convincing" evidence before life-sustaining treatment can be withdrawn or withheld. If the medical directive constitutes "clear and convincing" evidence, then the expressed wishes regarding life-sustaining treatment will take precedence over any decision made by the Surrogate pursuant to the FHCDA<sup>55</sup> or can be used to challenge the authority of the Agent if the Agent reaches a contrary decision. Likewise, if the medical directive contains the patient's wishes regarding non-life-sustaining treatment, the statutory duties imposed upon the Surrogate and the Agent generally require him or her to honor such wishes.

When the patient has a cardiac or respiratory arrest, a DNR order will prevent medical personnel from attempting cardiopulmonary resuscitation ("CPR"). If a patient does not have a DNR, he or she will be presumed to consent to CPR.<sup>56</sup> Prior to the enactment of the FHCDA, New York law provided for both a statute regulating DNR orders in hospitals and nursing homes and a statute regulating non-hospital DNR orders. The FHCDA repealed the sections relating to DNR orders in hospitals and nursing homes (although DNR orders for residents of mental hygiene facilities and nonhospital DNR orders were preserved). Decisions regarding DNR orders in hospitals and nursing homes must now follow the standards and procedures set out in the FHCDA because a DNR order is viewed as a type of decision to withhold or withdraw life-sustaining treatment.<sup>57</sup>

---

<sup>55</sup> See FAQs (stating that "a prior oral or written decision to withdraw or withhold life-sustaining treatment should be sufficiently specific to have met the 'clear and convincing evidence' standard before it may be relied upon without seeking a surrogate decision, inasmuch as the clause was not intended to change pre-FHCDA reliability standards for prior decisions by the patient himself or herself.").

<sup>56</sup> PHL § 2962(1).

<sup>57</sup> PHL § 2994-a(19).

First, the order must be written in the patient's medical record.<sup>58</sup> Second, under constitutional and common law, a patient with capacity can consent to a DNR order.<sup>59</sup> Third, if the patient does not have capacity, their Surrogate can consent to a DNR order if the decision is made in accordance with the standards set out in N.Y. Pub. Health §§ 2994-d(4) and (5). Fourth, if a patient does not have a Surrogate, a DNR order can be entered by the attending physician if the decision is made in accordance with the standards set out in N.Y. Pub. Health § 2994-g(5)(b) for withholding or withdrawing life-sustaining treatment. If, however, a patient without capacity to make health care decisions has an appointed health care agent, then the Agent will have the authority to consent to a DNR.<sup>60</sup>

A MOLST form is generally completed by the treating physician in conjunction with the patient and is appropriate for patients in long-term care facilities with serious health conditions who want to avoid life-sustaining treatments. A MOLST form can combine both a hospital DNR and a nonhospital DNR as well as specify other end of life decisions. The form is honored in hospitals and nursing homes as well as in nonhospital settings.<sup>61</sup> Unlike a health care proxy, which requires a determination that the patient lacks capacity before becoming effective, the orders on the MOLST form are effective

---

<sup>58</sup> PHL § 2994-i.

<sup>59</sup> See *Fosmire*, 75 N.Y.2d at 226 (stating that “we affirmed the basic right of a competent adult to refuse treatment even when the treatment may be necessary to preserve the person’s life”); FAQs (stating that “[a]s a matter of constitutional and common law, it is clear that a patient with capacity can consent to a DNR or DNI order, just as a patient with capacity can direct the withdrawal or withholding of other life-sustaining treatments.”).

<sup>60</sup> PHL § 2962(5).

<sup>61</sup> See PHL Art. 29-CCC.

immediately.<sup>62</sup> Consent for a MOLST form can be provided by the patient if the patient has capacity to consent or by the Agent (or Surrogate) if one was appointed.<sup>63</sup>

The effect of a DNR order or a MOLST form on the Agent's or Surrogate's authority will depend on who consented to the DNR order or the MOLST form. If consent was given by the patient when the patient had capacity to give such consent, the Agent (or the Surrogate, although a Surrogate should not be appointed if the patient had previously made the decision) may not be able to override the expressly stated decision. If the consent was given by the Agent or Surrogate, then the consent may be challenged in the same manner as other decisions made by the Agent or Surrogate.

## **Conclusion**

Generally, New York has tried to implement a system whereby a patient's wishes regarding medical treatment in connection with the end of his or her life are adhered to as closely as possible. A patient may choose to appoint an Agent in advance of incapacity, may have a Surrogate appointed for them, and may even attempt to explicitly declare their wishes pursuant to an advance medical directive. The legislature and courts, however, have left any decisions open to challenge in order to prevent abuses or misuses of the system.

---

<sup>62</sup> 1-3 Bender's New York Elder Law § 3.05[5].

<sup>63</sup> See PHL § 2994-cc.