LU

CHAPTER 8

LAWS OF 20 10

SENATE BILL _____ ASSEMBLY BILL 7729-D

STATE OF NEW YORK

7729--D

2009-2010 Regular Sessions

IN ASSEMBLY

April 22, 2009

Introduced by M. of A. GOTTFRIED, SCHIMMINGER, BACALLES, BARRON, BOYLAND, BRENNAN, CAHILL, CASTRO, DelMONTE, DINOWITZ, FINCH, GABRYSZAK, GALEF, GUNTHER, JAFFEE, KELLNER, KOON, LANCMAN, V. LOPEZ, MAGNARELLI, PEOPLES-STOKES, SPANO, STIRPE, TOWNS, SCHROEDER, BRODSKY, HOYT, PERRY, CONTE, CHRISTENSEN -- Multi-Sponsored by -- M. of A. ABBATE, ALESSI, AUBRY, BENEDETTO, BING, BURLING, CALHOUN, CLARK, COOK, CROUCH, CYMBROWITZ, DESTITO, DUPREY, ENGLEBRIGHT, FIELDS, GANTT, GIANARIS, GIGLIO, GLICK, HIKIND, HOOPER, JACOBS, JOHN, LATIMER, LAVINE, LIFTON, LUPARDO, MAGEE, MAISEL, MARKEY, MAYERSOHN, McDONOUGH, McENENY, MENG, MILLMAN, MOLINARO, MORELLE, NOLAN, O'DONNELL, ORTIZ, PAULIN, PHEFFER, PRETLOW, REILLY, N. RIVERA, P. RIVERA, ROBINSON, ROSENTHAL, SCARBOROUGH, SCHIMEL, SKARTADOS, SWEENEY, THIELE, TITONE, WEINSTEIN, WEISENBERG, WRIGHT, ZEBROWSKI -- read once and referred to the Committee on Health -- reported and referred to the Committee on Codes -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee -- again reported from said committee with amendments, ordered reprinted as amended and recommitted to said committee -- again reported from said committee with amendments, ordered reprinted as amended and recommitted to said committee -- recommitted to the Committee on Health in accordance with Assembly Rule 3, sec. 2 -- reported and referred to the Committee on Codes -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

AN ACT to amend the public health law, the mental hygiene law and the surrogate's court procedure act, in relation to establishing procedures for making medical treatment decisions on behalf of persons who lack the capacity to decide about treatment for themselves; directing the New York state task force on life and law to form a special advisory committee to consider the procedures and practices for withholding or withdrawal of life sustaining treatment for patients with mental illness or mental retardation and developmental disabilities; and to repeal certain provisions of the public health law and the mental hygiene law relating thereto

S 3164-B Duane

DATE RECEIVED BY GOVERNOR:

MAR 05 2010

ACTION MUST BE TAKEN BY:

MAR 17 2010

DATE GOVERNOR'S ACTION TAKEN:

MAR 16 2010

SENATE VOTE 55 Y 3 N HOME RULE MESSAGE ___ Y ___ N

DATE 2/24/10

ASSEMBLY VOTE 137 Y 5 N

DATE 1/20/10

A7729-D Gottfried (MS) Same as S 3164-B DUANE

02/24/10	A7729-D	Senate Vote	Aye: 55	Nay: 3
01/20/10	A7729-D	Assembly Vote	Yes: 137	No : 5

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Floor Votes:

02/24/10 A7729-D Senate Vote Aye: 55 Nay: 3

Aye Adams	**Aye** Addabbo	**Aye** Alesi	**Aye** Aubertine
Aye Bonacic	**Aye** Breslin	**Aye** DeFrancisco	**Nay** Diaz
Aye Dilan	**Aye** Duane	**Aye** Espada	**Aye** Farley
Aye Flanagan	**Aye** Foley	**Aye** Fuschillo	**Nay** Golden
Aye Griffo	**Aye** Hannon	**Aye** Hassell-Thompson	**Aye** Huntley
Aye Johnson C	**Aye** Johnson O	**Aye** Klein	**Aye** Krueger
Aye Kruger	**Nay** Lanza	**Aye** Larkin	**Aye** LaValle
Aye Leibell	**Aye** Libous	**Aye** Little	**Aye** Marcellino
Aye Maziarz	**Exc** McDonald	**Aye** Montgomery	**Exc** Morahan
Aye Nozzolio	**Aye** Onorato	**Aye** Oppenheimer	**Aye** Padavan
Aye Parker	**Aye** Perkins	**Aye** Ranzenhofer	**Aye** Robach
Aye Saland	**Aye** Sampson	**Aye** Savino	**Aye** Schneiderman
Aye Serrano	**Aye** Seward	**Aye** Skelos	**Aye** Smith
Aye Squadron	**Aye** Stachowski	**Aye** Stavisky	**Aye** Stewart-Cousins
Exc Thompson	**Aye** Valesky	**Aye** Volker	**Aye** Winner
Aye Young			

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Floor Votes:

01/20/10 A7729-D Assembly Vote Yes: 137 No : 5

Yes Abbate	**Yes** Alessi	**Yes** Alfano	**Yes** Amedore
Yes Arroyo	**Yes** Aubry	**Yes** Bacalles	**Yes** Ball
Yes Barclay	**Yes** Barra	**Yes** Barron	**Yes** Benedetto
Yes Benjamin	**Yes** Bing	**Yes** Boyland	**Yes** Boyle
Yes Brennan	**ER** Brodsky	**Yes** Brook-Krasny	**Yes** Burling
Yes Butler	**Yes** Cahill	**Yes** Calhoun	**Yes** Camara
Yes Canestrari	**ER** Carrozza	**Yes** Castro	**Yes** Christensen
Yes Clark	**Yes** Colton	**Yes** Conte	**Yes** Cook
Yes Corwin	**Yes** Crespo	**Yes** Crouch	**No** Cusick
Yes Cymbrowitz	**Yes** DelMonte	**Yes** DenDekker	**ER** Destito
Yes Dinowitz	**Yes** Duprey	**Yes** Englebright	**Yes** Errigo
Yes Espaillat	**Yes** Farrell	**Yes** Fields	**Yes** Finch

No Fitzpatrick	**Yes** Gabryszak	**Yes** Galef	**Yes** Gantt
Yes Gianaris	**Yes** Gibson	**Yes** Giglio	**Yes** Glick
Yes Gordon	**Yes** Gottfried	**Yes** Gunther A	**Yes** Hawley
No Hayes	**Yes** Heastie	**Yes** Hevesi	**ER** Hikind
Yes Hooper	**Yes** Hoyt	**Yes** Hyer-Spencer	**Yes** Jacobs
Yes Jaffee	**Yes** Jeffries	**Yes** John	**Yes** Jordan
Yes Kavanagh	**Yes** Kellner	**No** Kolb	**Yes** Koon
Yes Lancman	**Yes** Latimer	**Yes** Lavine	**Yes** Lentol
Yes Lifton	**Yes** Lopez P	**Yes** Lopez V	**Yes** Lupardo
Yes Magee	**Yes** Magnarelli	**Yes** Maisel	**Yes** Markey
Yes Mayersohn	**Yes** McDonough	**Yes** McEneny	**Yes** McKevitt
Yes Meng	**Yes** Miller J	**Yes** Miller M	**Yes** Millman
Yes Molinaro	**Yes** Morelle	**Yes** Nolan	**Yes** Oaks
Yes O'Donnell	**Yes** O'Mara	**Yes** Ortiz	**Yes** Parment
Yes Paulin	**Yes** Peoples-Stokes	**Yes** Peralta	**Yes** Perry
Yes Pheffer	**Yes** Powell	**Yes** Pretlow	**Yes** Quinn
Yes Rabbitt	**Yes** Raia	**Yes** Ramos	**Yes** Reilich
Yes Reilly	**Yes** Rivera J	**Yes** Rivera N	**Yes** Rivera P
Yes Robinson	**Yes** Rosenthal	**Yes** Russell	**Yes** Saladino
Yes Sayward	**Yes** Scarborough	**Yes** Schimel	**Yes** Schimminger
Yes Schroeder	**Yes** Scozzafava	**Yes** Skartados	**Yes** Spano
Yes Stirpe	**Yes** Sweeney	**Yes** Tedisco	**Yes** Thiele
Yes Titone	**Yes** Titus	**No** Tobacco	**Yes** Towns
Yes Townsend	**Yes** Weinstein	**Yes** Weisenberg	**Yes** Wright
Yes Zebrowski K	**Yes** Mr. Speaker		

000004

THOMAS DUANE
SENATOR, 29TH DISTRICT

CHAIR
SENATE COMMITTEE ON HEALTH

COMMITTEES:
CHILDREN & FAMILIES
CODES
CRIME VICTIMS, CRIME & CORRECTION
CULTURAL AFFAIRS, TOURISM, PARKS & RECREATION
FINANCE
MENTAL HEALTH & DEVELOPEMENTAL DISABILITIES
RULES
SOCIAL SERVICES

THE SENATE
STATE OF NEW YORK
ALBANY

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March 15, 2010

VIA HAND DELIVERY

Hon. David A. Paterson
Governor
State of New York
Executive Chamber
State Capitol
Albany, NY 12224

Re: A.7229-D (Gottfried)/S.3164-A (Duane); Family Health Care Decisions Act

Dear Governor Paterson:

The above-referenced legislation (S.3164-A/A.7229-D) is currently on your desk for consideration. I am writing to urge you to sign this important and vital legislation into law. The Family Health Care Decisions Act ("FHCDA") has taken close to two decades to become a reality. This legislation allows family members and others close to a patient to make medical decisions for them when they lack the capacity to make their own decisions.

Current law permits an individual to execute a health care proxy appointing an agent to make health care decisions for them in the event of their incapacity. Unfortunately, without a court order, there is no other mechanism for the appointment of a health care agent in the event of incapacity where the patient has not executed a health care proxy. This legislation amends the Public Health law by adding a new Article 29-CC to establish a procedure for selecting a surrogate in a hospital setting and allowing him or her to make health care decisions for a patient lacking capacity to make their own decisions. The legislation also adds a new Article 29-CCC to the Public Health law creating a Nonhospital Orders Not to Resuscitate law expanding the provisions of the current nonhospital provisions in Section 2977 of the Public Health law.

The purpose of this legislation is to establish procedures for the selection and authorization of family members or other persons close to patients lacking capacity, to decide about treatment, in consultation with health care professionals. Surrogates are selected according to a specific order of priority. Surrogates are limited to making decisions about a patient's treatment based upon the patient's wishes,

including religious and moral beliefs, if known. If a patient's wishes and beliefs are not reasonably known and cannot be ascertained, the surrogate is allowed to make decisions based upon the patient's best interests, with specific limitations. Specified safeguards are included in the legislation for the patient lacking any family or close friends, minor patients, decisions about life sustaining treatment where the patient's beliefs and wishes are unknown, policies for do-not-resuscitate orders ("DNRs"), and instances where a health professional or other individual close to the patient objects to the surrogate's decision. If enacted, this measure would take effect immediately, with a delayed effective date for the surrogate selection and decision making provisions of June first. Hospitals are also allowed to immediately develop and implement policies regarding the selection of a surrogate for health care decisions.

The new Public Health law Article 29-CCC added by this legislation creates a more detailed Nonhospital Orders Not to Resuscitate law following some of the provisions of the current Public Health law section 2977. The new Article applies to emergency medical services personnel, home care services agency personnel, hospice personnel, and hospital emergency services personnel. In addition, the existing Article 29-B of the Public Health law is amended to apply to orders not to resuscitate for residents of mental hygiene facilities. Conforming amendments are also made to certain sections of the public health law and mental hygiene law to accommodate the new surrogate selection structure and orders not to resuscitate statutes. Lastly, this legislation also requires the New York State Task Force on Life and the Law to create a special six-member task force to study and consider the new provisions of the Family Health Care Decisions Act ("FHCDA") in the Article 29-CC created by this legislation and making statutory and/or regulatory recommendations regarding its applicability to patients with mental illness or mental retardation and developmental disabilities and other types of health care facilities.

This legislation seeks to finally put in place a uniform process for making decisions on behalf of incapacitated patients without health care proxies. It takes into account the patient's wishes and beliefs and provides for mechanisms to protect the patient's best interests in complex medical situations. By enacting the Family Health Care Decisions Act, New Yorkers are assured they will be cared for by family members or individuals close to them without the need for costly, time-consuming and often emotionally draining litigation.

Thank you for your consideration, and I urge you to once again sign FHCDA into law. Please do not hesitate to contact me, if I can provide any additional information.

Sincerely,

Thomas K. Duane

Thomas K. Duane
Chair, Senate Standing Committee on Health
29th District

TD/cfp
cc: Peter Kiernan, Counsel to the Governor
Richard F. Daines, M.D. Commissioner of Health
Assemblymember Richard N. Gottfried

NEW YORK STATE ASSEMBLY
MEMORANDUM IN SUPPORT OF LEGISLATION
submitted in accordance with Assembly Rule III, Sec 1(f)

BILL NUMBER: A7729D REVISED 1/26/10

SPONSOR: Gottfried (MS)

TITLE OF BILL: An act to amend the public health law, the mental hygiene law and the surrogate's court procedure act, in relation to establishing procedures for making medical treatment decisions on behalf of persons who lack the capacity to decide about treatment for themselves; directing the New York state task force on life and law to form a special advisory committee to consider the procedures and practices for withholding or withdrawal of life sustaining treatment for patients with mental illness or mental retardation and developmental disabilities; and to repeal certain provisions of the public health law and the mental hygiene law relating thereto

PURPOSE:; To establish procedures for making health care decisions on behalf of patients unable to decide about treatment for themselves.

SUMMARY OF PROVISIONS: Section one establishes a legislative intent for the Public Health Law Article 29-CC and 29-CCC, Family Health Care Decisions Act and Non-Hospital Orders Not To Resuscitate. The bill enables family members and others close to an incapacitated patient to make health care decisions in accord with special procedures, standards and safeguards.

Section two amends the Public Health Law by adding new Articles 29-CC and 29-CCC, entitled "Family Health Care Decisions Act" and "Non Hospital Orders Not To Resuscitate". Article 29-CCC makes 'conforming and technical changes with respect to New York's existing law on do-not-resuscitate orders.

The new family health care decision-making article would establish procedures authorizing family members, or other persons close to patients who lack decision-making capacity, to decide about treatment, in consultation with health care professionals and in accord with specified safeguards. The article includes special procedures and standards for decisions about life-sustaining treatments.

Section 2994-a defines several terms used in Article 29-CC as follows:

*"Hospital" means a general hospital (excluding OMH-licensed mental health units) and a residential health care facility as defined in Article 28 of the Public Health Law.

*"Patient" is defined as a person admitted to a hospital.

*A "surrogate" is a person selected to make a health care decision for a patient pursuant to the article. Certain definitions pertain to health care decisions for minor patients.

*A "parent" of a minor child is defined as a parent who has custody of,

or who has maintained substantial and continuous contact with, the minor patient.

*A "guardian of a minor" or "guardian" means a legal guardian of the person of a minor, or a "health care guardian," defined as a court appointed guardian authorized to decide about life-sustaining treatment pursuant to the article.

*"Emancipated minor patient" is a minor patient who is 16 years of age or older and living independently from his or her parents or guardian, or a minor who is the parent of a child.

*"Ethics review committee" means the interdisciplinary committee estab-lished in a hospital in accord with the requirements of the article.

*"Health care"' is any treatment, service or procedure to diagnose or treat an individual's physical or mental condition. Providing artificial nutrition and hydration orally, without reliance on medical treatment, is not health care under this article and is not subject to this arti-cle.

Section 2994-b provides that the act applies to health care decisions for care provided in a hospital. It also provides that the patient has a health care agent; decisions for the patient are governed by the health care proxy law, article 29-c of the Public Health Law. Similarly, if the patient has a guardian appointed under article 17 A of the Surro-gate's Court Procedure Act, or if surrogate decisions could be made for the patient pursuant to section 1750-b of the Surrogate's Court Proce-dure Act or pursuant to OMIT or OMRDD regulations, then decisions for the patient are governed by those laws or regulations and not by the provisions of this act.

Section 2994-c governs the determination of patient incapacity for purposes of authorizing surrogate decisions for adult patients. It creates a presumption that every adult has capacity to decide about treatment unless determined otherwise pursuant to procedures set forth in the section, or pursuant to court order. The section requires an attending physician to determine that a patient lacks capacity to make health care decisions. In a residential health care facility, at least one other health or social service practitioner employed by or otherwise formally affiliated with the facility must concur. In a general hospi-tal, this concurrence is required for a surrogate decision to forgo life-sustaining treatment. Hospitals must adopt written policies identi-fying the training and credentials of professionals qualified to provide the concurring opinion. For patients with a mental illness or develop-mental disability, a professional with training or expertise in diagnos-ing or treating the mental illness or developmental disability must provide the concurring opinion. Health care professionals must inform the patient of the determination of incapacity, if there is any indi-cation that the patient can understand the information. The person high-est on the surrogate list must also be informed. If the, patient objects to the determination of incapacity, the appointment of a surrogate, or to a surrogate's decision, the patient's objection prevails, unless a court determines otherwise. The attending physician must confirm that the patient lacks decision making capacity before complying with health care decisions. This confirmation is not required for treatments provided as part of a course of treatment authorized by consent provided at the time of the initial determination of incapacity.

Section 2994-d concerns adult patients who lack capacity to make particular health care decisions. It lists, in order of priority, the persons who may act as a surrogate, excluding administrators, employees and independent contractors ,of the hospital caring for the patient, unless they are related to the patient, or were a close friend of the patient before the patient's admission to the facility. A court-appointed guardian is the first person on the list, followed by: the spouse or domestic partner; child older than 18; a parent; a sibling; or a close adult friend or relative familiar with the patient's personal, religious and moral views regarding health care.

This section grants the surrogate authority to make all health care decisions for the patient that the adult patient could make for himself or herself, subject to the standards and limitations of the article. The section establishes the duty of health care providers to give the surrogate medical information and clinical records necessary to make informed decisions for the patient. Surrogates have a right and duty to seek this information.

Section 2994-d requires the surrogate to decide about the treatment based on the patient's wishes, including the patient's religious and moral beliefs, or, if the patient's wishes are not reasonably known and cannot with reasonable diligence be ascertained, based on the patient's best interest. The section authorizes decisions to withhold or withdraw life-sustaining treatment if treatment would be an extraordinary burden to the patient and the patient is terminally or permanently unconscious, or if the patient has an irreversible or incurable condition and the treatment would involve such pain, suffering or other burden that it would reasonably be deemed inhumane or excessively burdensome under the circumstances. The determination of terminal illness, permanent unconsciousness, or irreversible or incurable condition must be made by two physicians in accord with accepted standards of medical practice. The surrogate must determine if treatment would be an extraordinary burden in light of the patient's own wishes, preferences, and values, to the extent possible. In residential health care facilities, a surrogate can decide to forgo life-sustaining treatment for patients who are not terminally ill or permanently unconscious only if the Ethics Review Committee, including at least one physician not directly, responsible for the patient's care, or a court, reviews the decision and determine that the decision meets the standards set forth in the article for such decisions. In a general hospital, if the attending physician objects to a surrogate's decision to forgo artificial nutrition and hydration for a patient who is not terminally ill or permanently unconscious, the decision may not be implemented until the Ethics Review Committee, including at least one physician who is not directly responsible for the patient's care, or a court, reviews the decision and determines that it meets the. standards set forth in the article for such decisions. The words "excessive" and "excessively", in earlier versions of the bill, have been changed to "extraordinary" and extraordinarily". This change of words was made to follow the wording under Surrogate's Court Procedure Act § 1750-b. However this change in wording does not change the meaning of this provision.

Section 2994-e authorizes the parent or guardian of a minor patient to decide about life-sustaining treatment, in accord with the same standards that apply to surrogate decisions for adults. In addition, if a minor has the decisional capacity to decide about life-sustaining treatment, the minor's consent is required to withhold or to stop treatment. If the minor is emancipated and has decision-making capacity, the minor can decide to withhold or withdraw life-sustaining treatment• on his or

her own behalf, if: (i) the attending physician and the ethics review committee determine that the decision accords with the standards for surrogate decisions for adults, and (ii) the ethics review committee approves the decision. If the hospital can with reasonable efforts ascertain the identity of an emancipated minor's non custodial parent or guardian, the hospital must notify the parent prior to discontinuing treatment. If a parent or guardian objects to the decision, the article establishes his or her right to refer the matter to the ethics review committee.

Section 2994-f requires the attending physician to inform a surrogate promptly if the physician objects to a decision to withdraw or withhold life-sustaining treatment. The objecting physician must then either make all reasonable efforts to transfer the patient to another physician, if necessary, or promptly refer the matter to the ethics review committee. The section also obligates physicians to refer objections by or disagreement among family members and others close to the patient to the ethics review committee.

Section 2994-g establishes a procedure for making health care decisions for adult patients who have lost decision-making capacity and have no available family member or friend to act as a surrogate. It applies the same standards that govern decisions for adults by family or others close to them, including the special safeguards for decisions about life-sustaining treatment. The section authorizes the attending physician to decide about routine medical treatment for patients without surrogates. Routine treatment is defined to include only procedures for which physicians ordinarily do not seek specific consent from the patient or others. For decisions about major medical treatment, the attending physician must consult with hospital staff directly involved with the patient's care and at least one other physician selected by the hospital must concur in the appropriateness of the decision. A recommendation by an attending physician to withhold or withdraw life-sustaining treatment from a patient who does not have a surrogate may not be implemented unless it meets one of two requirements: One requirement is review and approval by a court. The court must determine whether the decision satisfies the specified standards for decision by surrogates to withhold or withdraw life-sustaining treatment. Alternatively, if the attending physician determines that: (i) life-sustaining treatment offers the patient no medical benefit because the patient will die imminently; and (ii) the provision of life-sustaining treatment would violate acceptable medical standards, and one other physician concurs in this determination, life sustaining treatment may be withdrawn or withheld without review by a court.

Section 2994-i sets forth specific policies for do-not-resuscitate (DNR) orders, requiring all such orders to be written in the patient's record and clarifying that the orders provide consent to withhold only cardiopulmonary resuscitation, not other treatments.

Section 2994-j establishes that a patient, surrogate, or parent or guardian of a minor patient may at any time revoke consent to withhold or withdraw life-sustaining treatment by notifying a physician or member of the nursing staff.

Section 2994-k states that hospitals must adopt written policies requiring implementation and regular review of decisions to withhold or withdraw life-sustaining treatment, in accord with accepted medical standards. It also provides that whenever an attending physician determines that a decision to withhold or withdraw life-sustaining treatment is no

longer appropriate or authorized because the patient's condition has improved, the physician must include this determination in the patient's chart, cancel any orders or plans of care to withhold or withdraw treatment, and notify the person who made the decision and facility staff directly responsible for the patient's care.

Section 2994-l governs inter-institutional transfers of patients with orders or plans of care to withhold or withdraw life-sustaining treatment. It establishes that orders remain effective at the receiving hospital until an attending physician first examines the patient. The physician must then either continue or cancel the prior orders.

Section 2994-m requires each hospital and nursing home to establish at least one ethics review committee or participate in a committee that serves more than one facility. The committee can be an existing ethics committee, a subcommittee of an existing ethics committee, or a new committee created to fulfill the requirements of this article. Hospitals must adopt a written policy governing committee functions, composition and procedure, in accord with specified requirements set forth in the section. Committees must be multidisciplinary and must include at least two individuals who have demonstrated an interest in or commitment to patients' rights or to the medical, public health, or social needs of those who are At least one member must not be affiliated with the hospital. In nursing homes, the Committees must include a member of the residents' council a person who is not affiliated with the facility who is a family member of a current or former resident at the same or a different facility, and a person who has demonstrated an interest in or commitment to patients rights or to the care and treatment of the elderly or nursing home residents through professional or community activities, other than activities performed as a health care provider.

Section 2994-m also specifies that recommendations and advice by the committee are advisory and non-binding, except for committee approval or disapproval of decisions to withdraw or withhold life-sustaining treatment in specified types of cases. A committee must permit patients, certain health care professionals, family members and other close to patients to present their concerns and views to the committee, and must inform these persons of the committee's response to the case.

Section 2994-m additionally requires the committee to issue a written statement of its reasons for approving or disapproving decisions to withhold or with draw life-sustaining treatment in certain types of cases. The committee must also routinely review surrogate and committee decisions in certain sensitive cases. Ethics review committee members are granted access to medical records and information necessary to perform their function, and are obligated to protect patient confidentiality. The section also protects the confidentiality of committee records and proceedings, but grants the Department of Health access to committee records and proceedings in any cases when the committee has the authority to approve a decision to forgo life-sustaining treatment. The Department may use,such records in any enforcement proceeding against a health care facility or an individual health care professional.

Section 2994-n sets forth the right of private hospitals and individual health care providers to refuse, on grounds of moral or religious conscience, to honor health care decisions made pursuant to Article 29-CC. For a hospital to assert a conscience objection the decision must be contrary to a formally adopted policy of the facility expressly based on sincerely held religious beliefs or sincerely held moral convictions.

Such ethical or religious convictions must be central to the facility's operating principles and cannot be based on administrative concerns. The policy statement must be specific in order to provide adequate notice to patients and surrogates of the fa- cility's actual policies and practices. In order to exercise an objection the facility must have informed the patient, family, or surrogate of its policy prior -to or upon admission, if reasonably possible. The section requires the hospital to cooperate in transferring the patient to another facility willing to honor the decision. If the transfer does not occur, the facility must seek judicial relief or honor the decision.

Section 2994-n also recognizes that individual health care professionals may refuse to honor treatment decisions that violate their sincerely held religious or moral convictions. Individual health care providers who assert conscience objections must promptly inform the health care facility and the person who made, the decision. The facility must then promptly transfer responsibility for the patient to another health care professional willing to honor the decision.

Section 2994-o provides protection from civil and criminal liability for acts performed by individuals reasonably and in good faith pursuant to the article as a consultant to or a member of an ethics review committee, or as a participant in an ethics review committee meeting. Health care providers who honor a health care decision reasonably and in good faith made pursuant to the article, or take other actions in good faith pursuant to the article, are protected from civil and criminal liability and charges of professional misconduct. Surrogates and parents and guardians of minor patients are also protected from civil and criminal liability for making a health care decision in good faith under the article,

Section 2994-p states that liability for the cost of health care provided to an adult patient under Article 29 D is the same as if the patient had consented to treatment.

Section 2994-q establishes that Article 29-c,c does not create, impair, or supersede any rights an individual may have to make health care decisions for him or herself. The section clarifies that a decision by a surrogate cannot supersede or override prior decisions, wishes, or instructions by a competent adult patient, expressed orally or in writing, unless the patients decision, wishes or instructions do not apply to the particular medical circumstances under consideration. The section also clarifies that the article does not affect existing law concerning implied consent to health care in an emergency or concerning sterilization, nor is it intended to permit or promote suicide, assisted suicide or euthanasia.

Section 2994-r authorizes certain persons with a close relationship to a patient to commence a special proceeding with respect to disputes arising under the article. The section specifically provides that courts can appoint any person from the surrogate list to act as surrogate, regardless of that person's" priority on the list, if the court determines that such appointment would best accord with the patient's wishes or, if the patient's wishes are unknown, the patient's best interests. The section also empowers a court to authorize the withholding or withdrawal of life sustaining treatment based on a determination that forgoing treatment accords with the patient's wishes, or, if such wishes cannot be ascertained, with the patient's best interests. In addition, the section establishes a procedure for appointing a health care guardian for a minor patient, specifying who has standing to seek an appointment.

The section provides that the court may only appoint a health care guardian if a minor's parent or legal guardian of the person is not available, willing and competent to decide about treatment for the minor.

Section 2994-s establishes that any hospital or attending physician that refuses to honor a health care decision made by a surrogate in accord with the standards set forth in Article 29-CC shall not be entitled to compensation for treatment, services, or procedures provided without the surrogate's consent, except under specified circumstances. The section does not impose a penalty, but equitably resolves the matter of medical fees in cases where a surrogate exercises authority granted by the article, and the hospital insists on providing care notwithstanding surrogate refusal.

Section 2994-t requires the Commissioner of Health to promulgate regulations necessary to implement the article. It also requires the Commissioner of Health, in consultation with the Commissioners of the Office of Mental Health and t Mental Retardation and Developmental Disabilities, to promulgate regulations identifying the credentials of health care professionals qualified to provide a concurring opinion of incapacity based on mental illness or developmental disability.

Under Section 2994-u, the Commissioner of Health must prepare a statement summarizing the rights, duties, and requirements of the article, and require the dissemination of the statement.

The bill also creates Article 29-CCC of the Public Health Law on "Non-Hospital Orders Not to Resuscitate" which largely reproduces the provisions currently set forth in Section 2977 of the Public Health Law. However, Article 29-CCC clarifies that home care services agency personnel and hospice personnel, as well as emergency medical services personnel and hospital emergency room staff, can honor non-hospital DNR orders. Section 2994-cc establishes that consent by a surrogate shall be governed by the policies set forth in Article 29-CC, except that the,authority of the ethics review committee shall not apply to non-hospital orders issued outside of a hospital. In addition, the qualifications for health care professionals authorized to provide a second opinion about the patient's decision-making capacity shall be defused by regulations promulgated by the Department of Health, not by hospital policies. This assures that non-hospital orders can be issued outside of a hospital, in a physician's office or in other settings. Section 2994-cc also provides that surrogate consent to a non-hospital DNR order issued for a patient in a mental hygiene facility will be governed by Article 29-B.

Section 3 amends section 2805-q of the public health law to protect the visitation rights of surrogates in health care facilities.

Section 4 renames Article 29-B as "Orders Not To Resuscitate For Residents of Mental Hygiene Facilities".

Sections 5 and 6 repeal sections of Article 29-B of the public health law that have been incorporated into Article 29-CCC by this bill.

Section 7 amends section 2961 of the public health law to add a definition of "domestic partner."

Section 8 clarifies that the attending physician in Article 29-B may not rely on the presumption that adults are capable of deciding about cardiopulmonary resuscitation if clinical indicia of incapacity are

present.

Section 9 repeals subdivision 3 of section 2964 of the public health law to eliminate the "therapeutic exception" from the DNR law.

Sections 10 through 21 reconcile Article 29-CC with the existing law on do-not resuscitate established by Article 29-B of the Public Health Law.

Section 22 of the bill amends the Health Care Proxy law (§2984, new subdivision 5) to provide that, when a health care agent directs the provision of life-sustaining treatment, the denial of which would likely result in the patient's death, a hospital or individual health care provider that does not wish to provide the treatment must comply with the agent's directions, pending transfer of the patient to a willing provider, or judicial review.

Section 23 of the bill adds the definition of "life-sustaining treatment" to the Health Care Proxy law (§2980, new subdivision 9:,a).

Section 24 of the bill amends section 81.22 of the Surrogate's Court Procedure Act to provide for guardians under Mental Hygiene Law Article 81 to act as surrogates under the Family Health Care Decisions Act, Public Health Law Article 29-CC.

Section 25 of the bill repeals section 81.29 of the Surrogate's Court Procedure Act, which had limited the authority of guardians under Mental Hygiene Law Article 81 to make decisions to withdraw life-sustaining treatment.

Section 26 of the bill amends section 1750-b of the Surrogate's Court Procedure Act ("Health Care Decisions for Mentally Retarded Persons") to insert a definition of "life-sustaining treatment" and to authorize the Willowbrook Consumer Advisory Board to act as guardian for certain members of the Willowbrook class action.

Section 27 of the bill directs the New York State Task Force on Life and the Law to form a special advisory committee to assist it in considering whether the Family Health Care Decisions Act should be amended to incorporate procedures, standards and practices for the withholding or withdrawal of life-sustaining treatment from patients with mental illness, or with mental retardation or development disabilities. It also directs the Task Force to consider whether the Family Health Care Decisions Act should be amended to apply in settings other than general hospitals and residential health care facilities.

Section 28 provides for an effective date of the act.

EXISTING LAW: Adults (who have capacity to make decisions) have a firmly established right to accept or reject medical treatment based on the common law principle that "every individual of sound mind and adult years has a right to determine what should be done with his own body." SCHLOENDORFF V. SOC'Y OF N.Y. HOSP., 211 N.Y. 125, 129-30, 105 N.E. 92 (1914) (Cardozo, J.).

A capable adult may not be treated without his or her consent, except in limited circumstances, such as in an emergency. The right to decide about treatment includes the right to refuse life- sustaining measures. IN RE EICHNER (IN RE STORAR)-, 52 N.Y.2d 363, 438 N.Y.S.2d 266 (1981).

This right is protected by the New York State and United States Constitutions. RIVERS V. KATZ, 67 N.Y.2d 485,504 N.Y.S.2d 74 (1986); CRUZAN V. DIRECTOR, MISSOURI DEPT. OF HEALTH, 110 S. Ct. 2841 (1990).

Two kinds of written instruments, generally referred to as "advance directives," enable persons to exercise this right after losing the ability to participate directly in decision-making: (i) written instructions about treatment, usually called a "living will," and (ii) the written appointment of a person to make health care decisions on the person's behalf. Patients can also leave advance oral instructions about treatment. The New York Court of Appeals has held that living wills and other written or oral evidence of treatment wishes provide a legal basis for withdrawing or withholding life-sustaining measures if the instructions constitute clear and convincing evidence of the patient's wishes. In re Eichner (in re Storar); In re Westchester County Medical Center (O'Connor), 72 N.Y.2d 517,534 N.Y.S.2d 886 (1988).

New York court decisions have repeatedly demonstrated the difficulty of satisfying the clear and convincing evidence standard. See, e.g., O'Connor, New York's health care proxy law, Article 29-C of the Public Health Law, allows adults to delegate authority to another adult to decide about all health care treatment, including life-sustaining measures. The agent must make decisions in accord with the patient's wishes, or, if they are not reason ably known, in accord with the patient's best interests. Health care providers must-honor the agent's decisions to the same extent as if they had been made by the patient, and are protected from liability for doing so. Although New York law does not explicitly recognize the authority of family members to consent to treatment for adult patients unable to decide for themselves, health care providers routinely turn to family members for consent. However, under legal doctrines enunciated by the New York Court of Appeals, family members or others close to patients cannot decide about life-sustaining treatment. In re Eichner (In re Storar).

The health care proxy law provides an important exception to this general rule, but only for individuals who have signed a proxy form. Article 29-B of the Public Health Law, governing do-not-resuscitate (DNR) orders, establishes another exception. This authorizes persons with a close relationship to the patient to decide about cardiopulmonary resuscitation. It permits a surrogate to consent to a DNR order under standards similar to those proposed for Article 29-CC. For example, the order must comport with the patient's wishes, or if they are not known, with the patient's best interests. Several other New York statutes and regulations authorize surrogate decisions for special patient populations. For example, Article 81 of the Mental Hygiene Law empowers courts to appoint a guardian to make financial and/or personal decisions for an incompetent adult. Under Article 17 -A of the Surrogate's Court Procedure Act, the court can appoint a guardian to make decisions for individuals who are mentally retarded or developmentally disabled, including decisions about life-sustaining treatment. Article 80 of the Mental Hygiene Law authorizes special interdisciplinary committees to decide about major or medical treatment for residents of mental hygiene facilities who are unable to decide for themselves and have no family members available to consent. A distinct body of law governs health care decisions about minors, In general, parents have the right and responsibility to make treatment decisions for their minor children. See, e.g., Public Health Law 2504(2). This right derives from parents' Constitutionally protected right to rear and raise their children free from state interference. Accordingly, parental treatment decisions are accorded great deference. See, e.g., SANTO SKY V. KRAMER, 455 U.S. 645

(1982); IN RE HOFBAUER, 47 N.Y.2d 648, 419 N.Y.S.2d 936 (1979).

Although persons younger than 18 years of age generally may not decide about their own health care, New York statutes contain important exceptions to this rule. For example, Section 2504(1) of the Public Health Law authorizes minors to consent to treatment if they are either married or a parent. If specified conditions are met, New York statutes also permit minors to consent to certain treatments. See, for example, Public Health Law 2305(2) (treatment for venereal disease); Mental Hygiene Law 9. 13 (a) and 33.21 (mental illness); Public Health Law 2504(3) (parental care); Public Health Law 3123 (blood donation); Mental Hygiene Law 21.11 and 33.21 (substance abuse); and Public Health Law 2781 (FIN-related testing).

In addition, the S.S law for Birth Control and under Article 29-B of the Public Health Law, a DNR order cannot be issued for a minor without the minor's consent if the minor possesses decisional capacity. New York courts have recognized the emancipated minor doctrine for health care decisions by minors. Under this doctrine, minors are considered emancipated when an intentional rending of the parent-child relationship has occurred: parents have intentionally relinquished control over the minor, and the minor has intention ally withdrawn from legitimate parental control and guidance. See, e.g., ZUCKERMAN V. ZUCKERMAN, 154 A.D.2d 666,546 N.Y.S.2d 666 (2d Dept. 1989); BACH V.LONG ISLAND JEWISH HOSP. ,49 Misc. 2d 207, 267 N.Y.S.2d 289 (Sup. Ct., Nassau Co. 1966).

STATEMENT IN SUPPORT: Every year in health care facilities across New York State thousands of treatment decisions are made for patients unable to decide for themselves, including children, elderly patients, those temporarily impaired, those who will not regain capacity, and those never able to decide about treatment. The question for New York State policy is not whether surrogate decisions will be made, but who will make them and by what criteria. Article 29-CC provides responsible policies for decisions on behalf of patients unable to decide about treatment for themselves.

In practice, most health care providers consult family members prior to rendering.treatment to an incapacitated person. However, existing law requires that a previously competent adult patient must have signed a health care proxy or left clear evidence of his or her wishes in order to forgo life-sustaining treatment. This standard is at odds with the laws of most other states, where either statutes or court decisions expressly permit family members to decide about life- sustaining treatment, subject to public standards. New York and Missouri are the only two states where the law explicitly denies family members this authority.

Clear evidence of the patient's wishes is extraordinarily difficult to provide in an age of rapid medical advances, even for medical experts. Studies also show that only 10-15% of the adult population has signed a proxy or other advance directive such as a living will. For children, neither clear evidence of wishes nor a health care proxy is ever a possibility. Most people would want and expect family members or others close to them to decide about treatment when they become too ill to decide for themselves. Our law denies this basic expectation. It also leaves family members unable to refuse treatment despite their deep commitment to respect the patient's values or their desire to discontinue treatment that imposes excessive burdens on the patient without offering hope for cure, recovery or relief of suffering.

This legislative proposal recognizes that few families have the emotional or financial resources to pursue judicial relief. It establishes a process to review sensitive cases and to resolve disputes within health care facilities, relying on the courts only as a last resort. This approach is consistent with the guidelines on decisions about life-sustaining treatment prepared for state court judges. Those guidelines state that "the courts should not be used as a clearinghouse for the rendering of medical decisions which are best made by the patient and family and physician of the patient. A trial court must protect itself from inappropriate involvement in a life-sustaining medical treatment case and should decline jurisdiction if there is no justifiable controversy."

With respect to the new subdivision 5 of §2984, relating to an agent who directs the provision of life-sustaining treatment, it is intended that a court reviewing the agent's direction may override the direction only on one of the three grounds specified in §2992 or on the grounds that compliance with the agent's direction is not required by this new subdivision 5. The words "but not limited to" in §2992 allow an appropriate court to consider other sorts of disputes that may arise under the article; they do not expand the grounds on which the court may override an agent's direction to provide life-sustaining treatment, For patients without family members or close friends, existing practices to decide about treatment are generally informal. They do not adequately protect these patients' right to receive treatment or their interests when decisions about life-sustaining ,treatment must be made. This is a diverse patient population, including individuals who are elderly, mentally ill or homeless. Many physicians and health care facilities now decide about treatment for these patients, including decisions to provide major medical treatment or to stop life-sustaining measures. In rare cases, a health care facility or public official seeks a court order authorizing treatment, or a committee or guardian of the person has been appointed and decides about treatment. More often, the expenses and delays associated with court proceedings are avoided, Sometimes health care professionals wait until a patient's condition deteriorates and major medical interventions are authorized under the emergency exception to the requirement of informed consent. Other times, a patient receives treatment, but health care providers proceed without a clear legal substitute for patient or family consent. In either case, decisions are routinely made on an informal basis, without prospective or retrospective review. The proposed legislation provides a decision-making process for this patient population that will facilitate their access to needed treatment and permit the discontinuation of life-sustaining measures in accord with publicly approved procedures and patient-centered standards. For patients without family members or close friends, judicial approval is required for decisions to withhold or withdraw life-sustaining treatment.

Overall, the proposed legislation promotes the wishes and interests of incapacitated patients by establishing a process for determining incapacity, a priority list of those who may act as surrogate, and specific standards for surrogate decisions. The bill contains many safeguards to protect the patient's interests: a family member or someone else with a close personal relationship to the patient must decide in accord with standards based on the patient's wishes and best interests; life-sustaining treatment can only be discontinued if it is an excessive burden to the patient and specified medical criteria are satisfied; anyone on the list of potential surrogates can challenge the decision triggering further review within the facility; and, decisions that t are especially

sensitive must be reviewed routinely by a multidisciplinary committee.

The New York State Task Force on Life and the Law concluded that decisions about life-sustaining treatment are best made in the context of the family or other personal relationships; with appropriate safeguards. This is what most people would want and choose for them- selves. It also recognizes the importance of family and other close relationships at a time of illness. These individuals are most likely to know the patient's own views about treatment, including the patient's religious and moral beliefs. They are also most likely to be dedicated to the patient's well being, For patients who have no natural surrogates and are therefore most vulnerable, the proposed legislation will facilitate access to needed treatment and fulfill society's obligation to ensure that timely, responsible decisions are made on their behalf.

The bill also integrates policies set forth in Article 29-CC with Article 29-B on orders not to resuscitate. This is necessary because Article 29-CC covers all treatment decisions, including decisions about cardiopulmonary resuscitation in hospitals. Two separate laws, one for resuscitation decisions and one for other treatments would be confusing and hard to implement for patients, for surrogates and for health care providers.

The policies set forth in Article 29-CC build on the policies and experience gained with Article 29-B. Article 29-B will continue to apply to decisions about cardiopulmonary resuscitation in mental hygiene facilities because those facilities are not covered by Article 29-CC. The policies on non-hospital orders not to resuscitate that will be reenacted by the bill are essential to protect the wishes and well being of terminally ill patients who are cared for at home and in other community settings.

LEGISLATIVE HISTORY:
1994: A7166-B - advanced to 3rd reading
1996: A6791 - reported to Rules Committee;
1995: A6791 - advanced to 3rd reading
1998: A7026 - reported to Rules Committee;
1997: A7026 - reported to Codes Committee
1999 and 2000: reported to Rules Committee
2001: A5523 - advanced to 3rd reading;
2002: A5523-A - referred to Health Committee
2003: A6315 - referred to Health Committee;
2004: A6315-A - reported to Codes Committee
2005: A5406 - reported to Codes Committee;
2006: A5406-B - passed Assembly
2007: A6993 - reported to Codes Committee;
2008: A6993-A - reported to Rules Committee

BUDGET IMPLICATIONS: The bill will have no appreciable budgetary impact.

EFFECTIVE DATE: Immediately; provided that sections 1 - 25 of the act shall take effect on the first day of the June after enactment, and provided further that effective immediately it shall be lawful for a hospital, as defined in the act, to adopt a policy that is consistent with the requirements of the act, and for a health care provider to

accept and carry out a health care decision in accordance with such requirements for a patient in a hospital that has adopted such policy.

C 8

DIVISION OF THE BUDGET BILL MEMORANDUM

Session Year 2010

SENATE:
No.

ASSEMBLY:
No. A7729-D

Primary Sponsor: Gottfried

Law: **Public Health Law**
Mental Hygiene Law
Surrogate's Court Procedure Act

Sections: **2994 (New) and various other**
81.22; 81.29
1750-b

Division of the Budget recommendation on the above bill

APPROVE: ___ **NO OBJECTION: X**

1. Subject and Purpose:

This bill enacts the Family Health Care Decisions Act to establish procedures for authorizing family members, domestic partners, close friends or other surrogates, not otherwise identified in a health care proxy or other legal instruments, to make health care decisions on behalf of an incapacitated individual, including decisions regarding life sustaining treatment. The bill does not make any changes to existing procedures for establishing health care proxies or other advance directives. The bill also sets procedures for establishing and implementing non-hospital orders not to resuscitate.

Specifically, the major components of the bill:

- Establish procedures for adult (over age 18) family members, domestic partners, close friends or other surrogates to make health care decisions in a hospital on behalf of an incapacitated individual. These procedures would not apply if the individual has a health care proxy or a court-appointed guardian.

- Requires attending physicians to identify if an individual has an existing health care proxy or court-appointed guardian and to make an initial determination on the capacity of an individual to make their health care decisions and the extent to which their ability to make decisions will improve. A concurrent review of an individual's decision making capability is required in certain instances, particularly those involving life sustaining treatment, and requires differences between the initial and concurrent determinations to be resolved through an ethics review committee.

- Preserves patients' rights to reject choice of surrogate and/or health care decisions they make provided that the individual is capable of making these decisions.

- Require surrogates to act in accordance with patients' wishes, including religious and moral beliefs or, if unknown, the patient's best interest. A surrogate's decision to withhold life

sustaining treatment is limited to instances where a patient would suffer extraordinary pain or discomfort, is likely to die within six months with or without treatment, is permanently unconscious. For patients in a residential health care facility a concurrent decision would be required from an ethics review panel. Under this bill, if an attending physician disagrees with a surrogate's treatment decision, the decision is not implemented and is referred to an ethics review panel or court for a determination.

- Establish procedures for non-hospital orders not to resuscitate (similar to do not resuscitate orders in health care facilities). Under the bill, an individual's physician would issue the order in the individual's medical record. The individual would wear an identifying bracelet to notify emergency medical or home health care personnel of their wish not to be resuscitated. Medical personnel would be required to consent to the order and are indemnified for acting on the order in good faith.

- The Department of Health (DOH) would be required to issue regulations to implement the provisions of this bill.

2. Budget Implications:

The Office of Mental Retardation and Developmental Disabilities (OMRDD) estimates that this bill will generate $7 million in savings, as it would give the agency's Consumer Advisory Board (CAB) the ability to make end of life decisions for certain individuals with mental retardation and developmental disabilities. Currently, the CAB is required to use a court appointed guardian, which costs OMRDD about $2,000 per individual.

DOH does not anticipate that the issuance of regulations or general oversight of these bill requirements will result in additional State costs.

3. Recommendation: No Objection

This bill enacts the Family Health Care Decisions Act to establish procedures for authorizing family members, domestic partners, close friends or other surrogates, not otherwise identified in a health care proxy or other legal instruments, to make health care decisions on behalf of an incapacitated individual, including decisions regarding life sustaining treatment. The bill also sets procedures for establishing and implementing non-hospital orders not to resuscitate. This bill provides an option for family members and friends to implement a patient's medical treatment wishes where they have not already been legally established. The procedures are medically determined and directed by a physician, provide protections to retain patient choice where possible and establish procedures to resolve disputes. This bill is also expected to generate State savings by reducing legal costs associated with determining end-of-life decisions for certain OMRDD recipients. Accordingly, the Division of the Budget has no objection to this bill.

Validation: Document ID: 429111211-29
Robert L. Megna, Director of the Budget
By Daniel B. Sheppard
Date: 3/14/2010 11:04:00 AM

STATE OF NEW YORK
DEPARTMENT OF STATE
ONE COMMERCE PLAZA
99 WASHINGTON AVENUE
ALBANY, NY 12231-0001

DAVID A. PATERSON
GOVERNOR

LORRAINE A. CORTÉS-VÁZQUEZ
SECRETARY OF STATE

MEMORANDUM

To: Honorable Peter J. Kiernan, Esq.
Counsel to the Governor

From: Matthew W. Tebo, Esq.
Legislative Counsel

Date: March 8, 2010

Subject: A.7729-D (M. of A. Gottfried)
Recommendation: No comment

The Department of State has no comment on the above referenced bill.

If you have any questions or comments regarding our position on the bill, or if we can otherwise assist you, please feel free to contact me at (518) 474-6740.

MWT/mel

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THE STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234

Acting Counsel and Deputy Commissioner for Legal Affairs
Tel. 518-474-6400
Fax 518-474-1940

March 9, 2010

TO: Counsel to the Governor

FROM: Erin M. O'Grady-Parent

SUBJECT: A.7729-D

RECOMMENDATION: No Objection

REASON FOR RECOMMENDATION:

The State Education Department has no objection to the enactment of this bill which addresses an omission in law that does not provide for decision-making in health care for persons who lose capacity prior to making provisions for their health care.

While the Department has no objection to the enactment of this bill, we recommend Chapter Amendments to clarify the language. First, in the definition of "close friend", such status may be established by a person simply submitting a letter to the treating physician asserting the existence of a relationship. The Department suggests the source of such a letter should be defined and not simply be one written by a person claiming to be a close friend. Secondly, the term "minor" is defined as "any person who is not an adult." The Department suggests that the definition also consider the status of an "emancipated minor."

STATE OF NEW YORK
OFFICE OF MENTAL HEALTH
COUNSEL

JOHN V. TAURIELLO
Deputy Commissioner and Counsel

44 Holland Avenue
Albany, New York 12229

March 15, 2010

Honorable Peter J. Kiernan
Counsel to the Governor
Executive Chamber
State Capitol Building
Albany, NY 12224

A.7729-D

Dear Mr. Kiernan:

The Office of Mental Health (OMH) has no objection to the above-referenced legislation, which is before the Governor for Executive action.

This legislation repeals and amends various sections of the Public Health Law to create the Family Health Care Decisions Act (FHCDA). This legislation establishes procedures, standards and safeguards to address the many important and difficult issues to permit family members and other surrogates to make health care and treatment decisions for incapacitated persons who are treated in general hospitals and nursing homes. Furthermore, section 28 of this legislation requires the "Task Force on the Life and the Law" to form a special advisory committee to make recommendations for future statutory or regulatory changes to address life-sustaining treatment issues for persons with mental illness and for persons who are mentally retarded or developmentally disabled, including those who reside in mental hygiene facilities.

The FHCDA is the latest action taken to establish the statutory rules under which appropriate persons may authorize the provision of necessary health care for an incapacitated person.

New York's health care proxy law, Public Health Law article 29-C, establishes procedures under which adults may delegate authority to another trusted "health care agent" who can authorize all health care treatment for the person, including life-sustaining measures. The agent must make decisions in accordance with the patient's wishes, or if they are not reasonably known, in accordance with the patient's best interests. Health care providers must honor a health care agent's decisions to the same extent as if they had been made by the patient, and they are protected from liability for doing so.

Article 29-B of the Public Health Law authorizes Do-Not-Resuscitate (DNR) orders, applying surrogate decision-making principles to authorize consent for an order not to resuscitate. The DNR law establishes a statutory list of surrogates who may authorize the withdrawal or withholding of cardiopulmonary resuscitation through a DRN order, for persons who lack capacity to consent.

Article 81 of the Mental Hygiene Law empowers courts to appoint a guardian to make financial, personal and/or health care decisions for an adult that lacks capacity. Additionally, Article 80 of the Mental Hygiene Law authorizes Surrogate Decision-Making Committees to make decisions about major medical treatment for residents of mental hygiene facilities who lack capacity to make health care decisions, and who have no family members available to provide consent.

This legislation, establishing the FHCDA, addresses one of the last major gaps in existing statutory law regarding surrogate decision-making rules on behalf of incapacitated patients. New York statutory law currently does not explicitly recognize the authority of family members (or others close to the individual) to consent to treatment for adults who lack the ability to consent to health care, yet health care providers routinely have turned to family members for such consent. This legislation will provide clear and uniform rules by which family and other surrogates may consent to health care and treatment. The new law will establish a list of surrogates to make health care decisions if the patient lacks capacity and a health care proxy was not signed. The law also describes the procedures which must be followed by general hospitals and nursing homes to ensure that surrogates can successfully authorize treatment for persons who lose capacity.

Furthermore, this bill provides specific rules for the withdrawal of life sustaining treatment based upon decisions by authorized surrogates. Under legal doctrines enunciated by the New York Court of Appeals, family members or others close to patients cannot decide about life-sustaining treatment for a person without capacity. In the absence of a statutory basis for surrogate decisions for life sustaining treatments, New York court decisions have required "clear and convincing evidence" of the patient's intent regarding the withdrawal of life sustaining treatment when he or she had capacity. The courts have also made it clear that it is very difficult to demonstrate that a patient has previously stated his or her wishes with regard to life sustaining treatment with sufficient clarity to meet the clear and convincing evidence standard.

Under this legislation, the surrogate decision-making principles would be the same for mentally ill persons who are being treated in general hospitals and nursing homes, as all other patients, except that: 1) a psychiatrist would have to confirm incapacity of a person with mental illness; 2) for patients transferred from facilities licensed or operated by OMH, existing law and OMH regulations would continue to govern surrogate decisions; and 3) standards for decisions about the withdrawal or withholding of life-sustaining treatment from patients with mental illness or mental retardation or developmental disabilities, and for patients residing in mental health facilities, are not directly addressed.

With regard to life sustaining treatment decisions affecting persons with mental disabilities section 28 of A.7729-D requires a special advisory committee to be established to support the Task Force on the Life and Law to review procedures for authorizing such treatment. The Task Force will consist of six members selected by the Chair of the Task Force, three persons selected by the Commissioner of OMH, and three persons selected by the Commissioner of the Office of Mental Retardation and Developmental Disabilities (OMRDD). Specifically, under the legislation, the Task

Force is charged with considering whether the FHCDA should be amended or regulations amended to incorporate procedures, standards and practices for decisions about the withdrawal or withholding life-sustaining treatment from patients with mental illness or mental retardation or developmental disabilities, including patients who reside in mental hygiene facilities.

In summary, OMH has no objection to this legislation that provides the statutory framework for the appointment and powers of surrogates of patients in general hospitals and nursing homes that do not have decision-making capacity. OMH is supportive of the measure that authorizes the Task Force, with representation recommended from OMH and OMRDD, to establish a special advisory committee to develop a governing statute and/or regulations to address life-sustaining treatment issues for persons with mental illness and for persons with mental retardation and developmental disabilities.

Thank you for the opportunity to comment on this legislation.

Sincerely,

John V. Tauriello

John V. Tauriello
Deputy Commissioner and Counsel

STATE OF NEW YORK
DEPARTMENT OF HEALTH
Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.
Commissioner

Wendy E. Saunders
Executive Deputy Commissioner

Memorandum

TO: Peter Kiernan, Counsel to the Governor

FROM: James W. Clyne Jr., Executive Deputy Commissioner

SUBJECT: Assembly Bill 7729-D

DATE: March 15, 2010

Your office has requested the Department's comments on Assembly Bill 7729-D, the Family Health Care Decisions Act (Act), which is before the Governor for executive action. The Act would, among other things, amend the Public Health Law (PHL) to establish procedures for making health care decisions on behalf of persons without health care proxies who are unable to make decisions about treatment for themselves.

The Act would create a new PHL Article 29-CC to provide for surrogate decision-making on behalf of patients who lack the capacity to make decisions for themselves, including decisions about do not resuscitate (DNR) orders. The Act would also create a new PHL Article 29-CCC, which would contain provisions for nonhospital DNR orders. It would also amend existing PHL Article 29-B, relating to DNR orders, and limit the application of its provisions only to residents of mental hygiene facilities.

The new PHL Article 29-CC would govern health care decisions about care provided in a general hospital or residential health care facility for patients or residents who do not have a health care proxy or a court-appointed guardian.

The Act continues the legal presumption that each patient has decision-making capacity, but consistent with current law, allows a physician, with the concurrence of another clinician acting within his or her scope of practice, to determine that a patient lacks capacity. Notice of a determination that a surrogate will make health care decisions because the patient has been determined to lack decision-making capacity must be given to the patient, if there is any indication the patient can understand the information, and to the highest available person on a patient's surrogate list.

The Act establishes a prioritized list of persons who can act as a surrogate, which would include domestic partners. The definition of "domestic partner" in this legislation would

mirror the definition of "domestic partner" contained in PHL § 2805-q, which concerns hospital visitations, and PHL § 4201, which relates to the disposition of remains.

The Act would authorize the surrogate to make health care decisions based on the patient's wishes, and if his or her wishes are not known, based upon the patient's best interests. Decisions to withhold or withdraw life-sustaining treatment would be required to meet several conditions. Treatment could be withheld or withdrawn if two physicians concur that: (1) treatment would be an extraordinary burden to the patient and the patient can be expected to die within six months regardless of the treatment or the patient is permanently unconscious; or (2) treatment would involve a burden deemed inhumane or extraordinarily burdensome and the patient has an irreversible or incurable condition. Consent to withhold or withdraw life-sustaining treatment can be revoked.

Under the provisions of the Act, if the patient is a minor, the decision to withhold or withdraw life-sustaining treatment could be made with the consent of the parent or guardian, provided that the decision may only be implemented with the consent of the minor if the minor has the capacity to make such a decision. The Act also includes provisions allowing an "emancipated minor," including a sixteen or seventeen-year-old living independently from his or her parents or guardian, to make decisions about life-sustaining treatment for himself or herself.

The Act would also include provisions regarding health care decision-making when a patient does not have a health care proxy and no surrogate can be found. In these circumstances, the hospital is required to the extent reasonably possible, to determine the patient's wishes and preferences. The health care decision-making process would vary depending upon whether the decision relates to routine medical treatment, major medical treatment or decisions to withhold or withdraw life-sustaining treatment. Attending physicians would be permitted to make routine medical decisions for a patient without a surrogate. An attending physician would need a concurring opinion to make a decision concerning major medical treatment. Decisions relating to withdrawing or withholding life-sustaining treatment could be made with court approval. Alternatively, life-sustaining treatment could be withheld or withdrawn if the physician determines, and one other physician concurs, that the treatment offers no medical benefit because the patient will die imminently even if the treatment is provided and the treatment would violate accepted medical standards.

The Act would require hospitals to adopt written policies requiring implementation and regular review of decisions to withhold or withdraw life-sustaining treatment. It would also require hospitals and nursing homes to have an ethics review committee. The determinations of the ethics review committee would be advisory and nonbinding, except for determinations regarding decisions to withhold or withdraw life-sustaining treatment.

Under the provisions of the Act, health care providers could refuse to honor health care decisions that violate their religious or moral beliefs; however, they would be required to notify the facility and the person who made the decision. The facility would then be required to transfer the patient to another health care provider willing to honor the decision.

The Act also authorizes courts to hold special proceedings commenced by a member of an ethics review committee or any person connected with the case arising under the Act. Courts can designate surrogates, appoint guardians for minors, and order the withholding or withdrawing of life-sustaining treatment. Orders to withhold or withdraw life-sustaining treatment can be made if a patient lacks the capacity to make the decision and the determination of the court complies with the standards established for surrogate decision-making. Under the Act, any hospital that refuses to comply with a surrogate's health care decision to refuse treatment would not be entitled to compensation for treatment. This would not preclude other legal remedies against facilities.

Surrogates and guardians, providers and members of ethics review committees acting reasonably and in good faith under the Act would be immune from civil and criminal liability.

The bill would also create a new Article 29-CCC for nonhospital DNR orders. This new Article would restate many of the existing provisions of PHL § 2977. It would clarify the existing law by requiring home care services agencies and hospice personnel to honor nonhospital DNR orders. It would also reference the requirements of the new Article 29-CC pertaining to consent by surrogates.

The bill would amend the existing PHL Article 29-B pertaining to DNR orders so that the Article would only apply to DNR orders for residents of mental hygiene facilities. The revised 29-B would now include domestic partners in the list of surrogates for the purpose of making resuscitation decisions.

The bill would require the Task Force on Life and the Law, which was established by executive order in 1984, to make regulatory and statutory recommendations relating to the Act.

A possible consequence of the Act is that it could be interpreted to change the clinical criteria to put DNR orders in place for some patients who do not have the capacity to make their own health care decisions. This issue should be promptly reviewed.

This Act would empower family agents to manage patient care and help to ease the burden families face when a patient is unable to communicate his or her wishes. The Department of Health recommends the approval of Assembly Bill 7729-D.

David A. Paterson
Governor

Michael J. Burgess
Director

New York State OFFICE for the AGING

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March 10, 2010

Peter J. Kiernan, Esq.
Counsel to the Governor
Executive Chamber
Room 210
State Capitol
Albany, New York 12224

Re: A.7729D/S.3164-B

Dear Mr. Kiernan:

This legislation would amend the Public Health Law by the addition of a new article 29-CC that would establish procedures authorizing family members or other persons close to patients, who lack decision-making capacity with regard to their health care, to decide about treatment, in consultation with health care professionals and in accord with specified safeguards. It also directs the New York State Task Force on Life and Law to form an advisory committee to consider the procedures and practices for withholding or withdrawal of life sustaining treatment for patients with mental illness or mental retardation and developmental disabilities.

Article 29-CC would only apply in situations in which no one has legal authority to make health care decisions on behalf of the patient who lacks capacity to make health care decisions while hospitalized or residing in a residential health care facility. It would establish a process to review situations involving withdrawal or withholding of life sustaining medical treatment. The legislation also gives family members and other surrogate decision-makers access to the medical records of the incapacitated patient necessary for making informed decisions and to advocate effectively on the patient's behalf. In addition, this legislation would facilitate access to routine care or major medical treatment for incapacitated patients who have no family or friends available to make decisions.

A surrogate would make health care decisions based on the patient's wishes or, if the patient's wishes are not reasonably known and cannot with reasonable diligence be ascertained, based on the patient's best interests. The surrogate's decisions would be subject to statutory standards and safeguards. If the patient objects to the determination of incapacity, the appointment of a surrogate, or to a surrogate's decision, the patient's objection prevails, unless a court determines otherwise. The attending physician is responsible for reassessing and confirming the patient's ability to make his or her own decisions about treatment. There are many other safeguards built into the Act including a requirement that a facility or group of facilities establish an interdisciplinary ethics review committee to review sensitive cases, including decisions made by a surrogate to withhold or withdraw life-sustaining treatment, and to resolve disputes between

and among family members and health care professionals.

In summary, this legislation would settle the question of who will make decisions on behalf of a patient who is unable to decide about his or her own treatment while in the care of a hospital or residential health care facility. Although most health care providers consult family members prior to treating an incapacitated person, existing law requires that a previously competent adult patient must have signed a health care proxy or left clear evidence of his or her wishes in order to forgo life-sustaining treatment. The laws of most states permit family members to make the decisions in such situations. If enacted, New Yorkers also would have assurance that if they are incapacitated to make decisions about treatment a family member or close friend would be able to make important medical decisions without the need for a court proceeding.

This is very important legislation for New York's older residents who make up a substantial portion of the population residing in residential health care facilities or being cared for in a hospital. Although current law permits a person to complete some form of advanced planning, including executing a health care proxy or other form of advanced directive communicating his or her wishes regarding treatment, very few do so. This legislation provides a thoughtful and comprehensive framework that would permit family members or close friends to advocate for treatment and make informed decisions on behalf of a patient who is unable to make health care decisions while safeguarding the patient's expressed preferences and best interests.

Please be advised that NYSOFA encourages the passage of this legislation. Thank you for soliciting our comments.

Sincerely,

Jennifer Seehase
General Counsel

DAVID A. PATERSON
GOVERNOR

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COMMISSION ON QUALITY OF CARE AND ADVOCACY
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JANE G. LYNCH
CHIEF OPERATING OFFICER

BRUCE BLOWER
PATRICIA OKONIEWSKI
MEMBERS

March 12, 2010

The Honorable Peter J. Kiernan
Counsel to the Governor
Executive Chamber
State Capitol
Albany, NY 12224

RE: Assembly Bill No. 7729-D

Dear Mr. Kiernan:

The Commission on Quality of Care and Advocacy for Persons with Disabilities recommends that the Governor approve the subject bill enacting the Family Health Care Decision Act. This recommendation is based on the Commission's experience administering the Surrogate Decision-Making Committee Program (SDMC) authorized by Mental Hygiene Law Article 80 and, under certain circumstances, applying the Health Care Decisions Act (HCDA). SDMC trained volunteers make non-emergency health care treatment decisions in accordance with those laws for persons with mental disabilities who lack capacity and have no surrogate to their behalf. Our experience indicates that the HCDA standards have appropriately afforded the SDMC panel and other authorized surrogates governed by the HCDA a prescription to avoid both over-treatment and under-treatment of people who cannot make their own decisions with regard to life sustaining treatment.

While recommending approval, the Commission recognizes that the proposed law provides for an Advisory Committee to be established to support the Task Force on Life and the Law review of appropriate procedures for decisions affecting persons with mental disabilities. We note the need for consideration and guidance on the following issues and are available to assist the Advisory Committee as needed.

First, the proposed law provides that the surrogate's decision should be governed by the wishes of the individual. Additional clarification would be desirable to provide that a person's competent wishes should govern and that full consideration should be given to the wishes of the individual in determining the person's best interests.

Second, the provisions governing hospital and non-hospital do not resuscitate orders and protections appear confusing when applied to persons within or transferred from mental hygiene facilities. These provisions should be consolidated and clarified. As currently written, such situations may be governed by four distinct articles of law to provide appropriate protections for a population at risk of being left out of decision-making concerning his or her own body and life; subject to over-treatment; or subject to under-treatment as compared to other persons. Withdrawal of life sustaining treatment, and hospital do not resuscitate and do not intubate orders will be governed by the Family Health Care Decision Act for persons transferred from a mental hygiene facility licensed by the Office of Mental Health to a hospital since the Mental Hygiene Law Article 80 governing the SDMC has not been amended to include those decisions. However, application by the hospital or someone else on behalf of the persons receiving

services from a facility licensed or operated by OMH for consent to treatment such as a feeding tube or a tracheotomy or any major medical treatment can be accepted by the SDMC for a determination of whether the person has the capacity to make the decision, or has an available surrogate, and if not whether the treatment is in the person's best interests.

Third, Section 2994-b implicitly defers to the SDMC enabling statute, Article 80 of the Mental Hygiene Law and regulations promulgated thereto, but we recommend that the applicability of Article 80 be specifically set forth as controlling when the SDMC process is employed and any appeals thereto are initiated, similar to the reference to health care agent decisions at section 2994-b(2).

Fourth, requirements for notice to mental hygiene facility directors of surrogate decisions and life sustaining treatment decisions are not explicitly set forth in the bill, other than with regard to a notice of incapacity of a person/resident of mental hygiene facility. We recommend a future amendment to address this issue or, since the bill has a provision to defer to Mental Hygiene Law and regulations, the mental hygiene agencies and the Department of Health could, by regulation, require notice to the mental hygiene facility for persons transferred to the hospital from a mental hygiene facility when the person, surrogate or doctors make major medical and life sustaining treatment decisions. The mental hygiene facility director is considered "a person connected with the case" so s/he could bring a matter to the hospital ethics committee, to SDMC or a court of law in accordance with the bill language, but would need to have received notice of the decision.

Similarly, a future amendment and/or regulation should clarify that the attending physician has special qualifications or seeks a concurring physician or health or social services practitioner with special qualifications whenever the attending determines that the person lacks capacity due to mental disability, even for consent to major medical treatment decisions. That appears to be the intent of 2994-c(3)(c).

Finally, the bill provides that medical record documentation will be in accordance with hospital policies in regard to documentation of surrogate and medical provider decisions. We recommend a future amendment and /or that the Department of Health and the Task Force provide standards for such documentation to deter phone consultations when sound medical practice and /or the law require personal examination, to accommodate appropriate standards for telephone and verbal consents, and to ensure documentation of continued lack of decision-making capacity (2994-c(7).

If you need further assistance or information, please contact us.

Very truly yours,

Patricia W. Johnson

Patricia W. Johnson
Assistant Counsel

THE STATE UNIVERSITY *of* NEW YORK

March 8, 2010

Office of the University Counsel and Vice Chancellor for Legal Affairs

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MEMORANDUN FOR PETER J. KIERNAN
COUNSEL TO THE GOVERNOR

FROM: NICHOLAS ROSTOW

SUBJECT: A7729D/S3164-B

RECOMMENDATION: Support

HANYS Healthcare Association of New York State

Proud to serve New York State's Not-For-Profit Hospitals, Health Systems, and Continuing Care Providers

Daniel Sisto, President

March 8, 2010

Honorable David A. Paterson
Governor
Executive Chamber
State Capitol
Albany, NY 12224

RE: A.7729-D (Gottfried)/S.3164-A (Duane)

Dear Governor Paterson:

I write to express the strong support of the Healthcare Association of New York State (HANYS) for the above-referenced bill, which has been delivered to you for action. The Family Health Care Decisions Act would establish procedures for making medical treatment decisions on behalf of people who lack the capacity to dictate their own treatment decisions. HANYS strongly supports this bill and urges you to sign it.

In the absence of this legislation, which has been deliberated for 17 years, countless families have been forced to endure the tragic human cost of being prevented from making informed, thoughtful decisions. This legislation, which addresses serious gaps in current law, would relieve patients, families, loved ones, and providers from agonizing scenarios that could be avoided.

Lost in the gaps of existing law, many families have witnessed what they knew to be the ardent desires of their incapacitated loved ones go unfulfilled for weeks and months, while every participant—from the patient, to family members, to the professionals providing care—has anguished. At the same time, families have been frozen by the lack of legal means to honor the deeply personal wishes of their loved ones.

With your approval, family members finally will have the legal authority to make health care treatment decisions when their loved ones are incapacitated and have no health care proxy. This legislation takes a step further and provides a uniform, legal process for making decisions on behalf of patients with no remaining family

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members. This legislation is long overdue in helping to resolve these extraordinarily sensitive and personal decisions.

This bill would allow medical treatment decisions to be made privately by the patient's family or friends with advice from physicians and based upon the reasonably known wishes of the patient. If the wishes of the patient were not reasonably known, and could not be ascertained, the bill would require that decisions be made in the best interest of the patient. For some decisions, or in certain circumstances in which decisions could not be reached, the bill would provide for the additional concurrence by an ethics committee.

Above all else, the legislation would require all decisions to be made out of respect for, and in consideration of, the individual dignity and uniqueness of the patient.

This legislation is the end product of nearly two decades of deliberation by health care providers, legal experts, and patient advocates and is intended to overcome the limitations of the current Do-Not-Resuscitate Law, Health Care Proxy Law, and the court-developed "clear and convincing evidence" requirement.

For all of these reasons, HANYS respectfully urges signing of this legislation.

Sincerely,

Daniel Sisto
President

cc: Peter Kiernan

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MEDICAL SOCIETY
of the
STATE OF NEW YORK

Gerard L. Conway, Esq.
Senior Vice President/
Chief Legislative Counsel

Division of Governmental Affairs
MEMORANDUM IN SUPPORT

IN SENATE HEALTH COMMITTEE — **S.3164-A (DUANE)**

ON ASSEMBLY HEALTH COMMITTEE AGENDA — **A.7729-C (GOTTFRIED)**

AN ACT to amend the public health law, the mental hygiene law and the surrogate's court procedure act, in relation to establishing procedures for making medical treatment decisions on behalf of persons who lack the capacity to decide about treatment for themselves; directing the New York state task force on life and law to form a special advisory committee to consider the procedures and practices for withholding or withdrawal of life sustaining treatment for patients with mental illness or mental retardation and developmental disabilities; and to repeal certain provisions of the public health law and the mental hygiene law relating thereto

This measure would establish procedures authorizing family members or other persons close to patients who lack decision-making capability to decide about treatment, in consultation with health care professionals and in accord with specified safeguards. **The Medical Society of the State of New York supports this bill.**

The bill would grant the surrogate authority to make all health care decisions for the patient that the adult patient could ordinarily make for himself or herself, subject to certain standards and limitations defined in Article 29-CC of the bill. It establishes the duty of health care providers to give the surrogate medical information and clinical records necessary to make informed decisions for the patient. The surrogate is required to decide about treatment based on the patient's wishes, including the patient's religious and moral beliefs, or, if the patient's wishes are not reasonably known, and cannot, with reasonable diligence, be ascertained, based on the best interests. This authority includes withdrawal of life-sustaining treatment if the patient is terminally or permanently unconscious , or has an irreversible or incurable condition and the treatment would involve such pain, suffering, or other

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burden that it would be reasonably deemed inhumane or excessively burdensome under the circumstances.

New York and Missouri are the only two states where the law explicitly denies family members the authority to make decisions on behalf of an incapacitated patient. Studies have shown that only 10-15% of the adult population has signed a proxy or other advance directive such as a living will.

For some, such as children, mentally ill or developmentally disabled adults, neither clear evidence of wishes nor a health care proxy is a possibility. Family members or others close to the patient are expected to decide about treatment. Current law does not allow that basic expectation. It also leaves family members or close friends unable to refuse treatment despite their commitment to respect the patient's values or desire to discontinue treatment that imposes excessive burdens on the patient without hope of cure, recovery or relief of suffering. This legislation protects the interests and wishes of incapacitated patients by establishing a process for determining incapacity, a priority list of those who make act as surrogate, and specific standards for surrogate decisions. The bill contains many safeguards to protect the patient's interests; a family member or someone else with a close personal relationship to the patient must decide in accordance with standards based on the patient's wishes and best interests; life sustaining treatment can only be discontinued if it is an excessive burden to the patient and specified medical criteria are satisfied; anyone on the list of potential surrogates can challenge the decision, triggering further review within the facility; and, decisions that are especially sensitive must be reviewed routinely by a multidisciplinary committee.

The New York State Task Force on Life and the Law stated that decisions about life-sustaining treatment are best made in the context of the family or other personal relationships, with appropriate safeguards. This is what most people would want for themselves. It also recognizes the importance of family and other close relationships at a time of illness. These individuals are most likely to know the patient's feelings about treatment, including religious and moral beliefs. This bill will facilitate access to needed treatment and ensure that timely, responsible decisions are made on their behalf.

For the above reasons, **the Medical Society of the State of New York supports this bill and urges that it be passed.**

Respectfully submitted,

1/8/10 – Support
BKE

GERARD L. CONWAY, ESQ.

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NEW YORK STATE
NYSHFA
HEALTH FACILITIES ASSOCIATION, INC.

Legislative Bulletin

A Respected Leader In Long Term Health Care

March 8, 2010

Governor David A. Paterson
State Capitol
Albany, NY 12224

RE: **Memorandum of Support A7729 (Gottfried, et al)**

Dear Governor Paterson:

This bill repeals and amends various sections of the Public Health Law thereby creating the Family Health Care Decision Making Act. The legislation establishes procedures for family members, surrogates, and other individuals closely acquainted with an incapacitated patient to make health care and treatment decisions for the patient who has not in the past appointed a proxy and is now unable to make decisions for him/herself. A series of procedures, standards and safeguards are set up for this decision making process. In constructing this important step, it is imperative that we be vigilant to ensure that the professional and individual beliefs of the patient, surrogate and health care provider are respected.

The New York State Health Facilities Association, representing some 260 skilled nursing and assisted living facilities in the state and serving approximately 50,000 patients, strongly urges your support of **A7729,** the Family Health Care Decision Making Act. The Association, an active member of the Family Decisions Coalition, believes it is time for New York to realize and act on the need to provide incapacitated patients' family and friends the opportunity to make decisions on their behalf. At present, facilities are unable to provide treatments or care decisions on behalf of some incapacitated residents. The only option for these incapacitated residents, at present, is to petition the courts for intervention which often unnecessarily delays the appropriate action and leaves the difficult decisions in the hands of those who may have little or no knowledge of the patient.

Some time ago, the New York State Task Force on Life and the Law was appointed to make recommendations on appropriate health care decision making situations. This nationally recognized group made a series of recommendations approved by the Legislature and signed by the Governor which included legislation on "Do Not Resuscitate" (DNR) and Health Care Proxy's authorization. Whereas as these were positive and appropriate steps, they do not and cannot address the issues of decision making by patients who legally lack the capacity to make health care decisions on their own behalf. Despite intensive education and communication efforts, the majority of New Yorkers have not executed DNR orders or a Health Care Proxy. This leaves these New Yorkers, once they lack capacity, powerless to have decisions made in their behalf by family or friends should they lose the ability to make those decisions.

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Since the purpose of **A7729** is laudable and meritorious in purpose and is the next logical recommendation of the esteemed Task Force on Life and Law, we ask your support. Most importantly, we seek your support on behalf of all of our patients who lack capacity. The Family Decision Making Act provides both a logical and appropriate mechanism to insure decisions are made in a patient's best interest by those they would choose to make these decisions.

Sincerely,

Robert J. Murphy

Robert J. Murphy, CAE
Executive Vice President, Governmental Affairs

RJM/lao

NEW YORK STATE
Unified Court System
OFFICE OF COURT ADMINISTRATION

ANN PFAU
CHIEF ADMINISTRATIVE JUDGE

MARC C. BLOUSTEIN
LEGISLATIVE COUNSEL

March 8, 2010

Hon. Peter J. Kiernan
Counsel to the Governor
Executive Chamber
State Capitol
Albany, New York 12224

Re: Assembly 7729-D

Dear Mr. Kiernan:

Thank you for requesting the comments of this Office on the above-referenced measure, which would create a process for surrogate decision-making on behalf of an ill person who is not competent to make decisions for himself or herself concerning life-extending treatment under circumstances where he or she has filed no health care proxy or other recognized instruction.

We have NO OBJECTION to approval of this measure, there being little or no likelihood of it having any impact on court administration.

Very truly yours,

Marc Bloustein

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New York State Bar Association

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Memorandum in Support

NYSBA Memorandum #15-A

January 15, 2010

A. 7729-D
S. 3164-B

By: M. of A. Gottfried
By: Senator Duane
Assembly Committee: Codes
Senate Committee: Health
Effective Date: On the 1st of June next succeeding the year in which it shall have become a law

AN ACT to amend the public health law, in relation to establishing procedures for making medical treatment decisions on behalf of persons who lack the capacity to decide about treatment for themselves and to repeal certain provisions of such law relating thereto

THE NEW YORK STATE BAR ASSOCIATION SUPPORTS THIS LEGISLATION

This legislation would add a new article 29-CC to the Public Health Law (PHL) to establish the "Family Health Care Decisions Act" (FHCDA), which would establish procedures authorizing family members or other persons close to patients who lack decision-making capacity to decide about treatment, in consultation with health care professionals and in accord with specified safeguards. The article includes special procedures and standards for decisions about life-sustaining treatments. The legislation would also add PHL Article 29-CCC to make conforming and technical changes with respect to New York's existing law on do-not-resuscitate orders.

Under current New York law, family members have no legal authority to consent or object to medical treatment for a patient who lacks decision-making capacity. Although hospitals and other providers customarily turn to close family members for agreement, only courts, court-appointed guardians, and health care agents (i.e., persons appointed by a health care proxy) have real legal authority.

Moreover, under current New York law, life-sustaining treatment can be withdrawn or withheld only if the patient signed a health care proxy or left "clear and convincing evidence" of his or her wish to forego treatment. Otherwise, no one – not the patient's family, not the patient's physician, not even a court – has authority to withhold or withdraw life-sustaining treatment for a patient who lacks decision-making capacity. Most people never sign a proxy or leave this kind of evidence.

As a result of current New York law, some incapacitated patients are denied appropriate treatment, while others are subjected to burdensome treatments that violate their wishes, values, or religious beliefs.

This legislation was originally recommended in 1992 by the New York State Task Force on Life and the Law. The Task Force was created in 1985, charged with devising public policy on a host of issues arising from medical advances, including: the determination of death, the withdrawal and withholding of life-sustaining treatment, organ transplantation, and new technologies and practices to assist reproduction. The Task Force encompasses expertise from many disciplines, and also reflects the wide spectrum of opinion and belief about bioethics issues in New York State.

The New York State Task Force on Life and the Law concluded that decisions about life-sustaining treatment are best made in the context of the family or other personal relationships, with appropriate safeguards. This is what most people would want and choose for themselves. It also recognizes the importance of family and other close relationships at a time of illness. These individuals are most likely to know the patient's own views about treatment, including the patient's religious and moral beliefs. They are also most likely to be dedicated to the patient's well being. For patients who have no natural surrogates and are therefore most vulnerable, the proposed legislation will facilitate access to needed treatment and fulfill society's obligation to ensure that timely, responsible decisions are made on their behalf.

The legislation would promote the wishes and interests of incapacitated patients by establishing a process in the law for determining incapacity, a priority list of those who may act as surrogate, and specific standards for surrogate decisions. The bill contains many safeguards to protect the patient's interests: a family member or someone else with a close personal relationship to the patient must decide in accord with standards based on the patient's wishes and best interests; life-sustaining treatment can only be discontinued if it is an excessive burden to the patient and specified medical criteria are satisfied; anyone on the list of potential surrogates can challenge the decision triggering further review within the facility; and, decisions that are especially sensitive must be reviewed routinely by a multidisciplinary committee.

Under the FHCDA, any family member or close friend of the patient has a right to challenge the surrogate's decision, either in the ethics committee or court, if they believe that the surrogate is not acting in accordance with the patient's wishes or best interests. Therefore, if a patient's spouse and parents strongly disagree about the patient's wishes regarding artificial nutrition and hydration -- as in the **Schiavo** case -- in all likelihood the case would end up in court. Judicial review is appropriate when persons close to the patient have such diametrically opposed views about what the patient would have wanted.

Health care providers and patient advocates agree that, in the overwhelming majority of cases, there is no disagreement about who should be making decisions for the patient. The reason the FHCDA is important is not that there are frequent disputes among patients' relatives and friends – in reality, disputes like the Terri Schiavo case are exceedingly rare.

Instead, the problem is that the law does not give patients' relatives and friends the authority to make treatment decisions even when everyone is in agreement.

Most states have statutes that grant family members and others close to the patient the right to make medical decisions for patients without capacity. Case law in most other states grants family members and others similar authority. Here in New York State forty-eight civic, medical, legal and religious organizations support the FHCDA legislation.

Recently, the bill was amended to specify the circumstances in which a provider may rely upon a prior oral decision by a patient to forgo life-sustaining treatment, without having to seek a surrogate decision. That amendment adds a reasonable safeguard, and warrants support.

Based on the foregoing, **the New York State Bar Association SUPPORTS this legislation**, a proposal of the Association's Health Law Section.

New York State
NURSES
ASSOCIATION

March 8, 2010

Honorable Peter J. Kiernan
Counsel to the Governor
Executive Chamber
State Capitol
Albany, NY 12224

RE: A7729-D/S3164-B

AN ACT to amend the public health law, , in relation to establishing procedures for making medical treatment decisions on behalf of persons who lack the capacity to decide about treatment for themselves and to repeal certain provisions of such law relating thereto

Dear Mr. Kiernan:

NYSNA is the oldest and largest state nurses' association in the nation, representing approximately 37,000 nurses across New York State. On behalf of the Association and the patients we serve, thank you for the opportunity to comment on this legislation. NYSNA supports the above referenced bill that allows health care decisions to be made for patients who lack capacity and an appointed proxy.

The significant number of New Yorkers who have failed to execute a proxy form should be offered no less protection by the law, no less compassion by the courts, and no less care from health care providers than those who have appointed a proxy. State law must protect the rights of all patients, ensuring that they can live with dignity and receive care consistent with their own wishes and beliefs.

The bill allows family members or others close to the patient to make health care treatment decisions when the patient cannot. NYSNA is pleased to see that the bill includes language that recognizes today's families, including 'non-traditional' families. Bill language is devised within a system of guidelines designed to reach a decision that the patient would have wanted. The religious, ethical and philosophical attitudes of the patient towards treatment, including life-sustaining procedures, are given the highest priority in determining care.

The bill recognizes that for some patients there is no family member or caring friend able to make such decisions. In those cases the proposal would allow decisions to be made by a committee with input from the patient's care providers. The proposal clearly recognizes the role of nurses in the interdisciplinary care team, and stipulates that any recommendations from the nurses who care for a patient must be included in the surrogate decision making process.

New York State
NURSES
ASSOCIATION

The Do Not Resuscitate and Health Care Proxy Laws work for New Yorkers. The Legislature must extend those protections to patients who have failed to explicitly state their wishes or name their surrogates. Enactment of a proposal to establish a standard and a process for making decisions for patients without capacity is humane. This proposal will allow nurses to deliver care in a manner consistent with the patient's wishes and beliefs. The nursing community cannot ask for more than that.

Therefore, the New York State Nurses Association strongly supports this legislation and urges the Governor to sign this bill into law.

Shaun Flynn
Director of Governmental Affairs
New York State Nurses Association

NEW YORK STATE CATHOLIC CONFERENCE

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RICHARD E. BARNES
EXECUTIVE DIRECTOR

March 10, 2010

Hon. David Paterson
Governor, State of New York
Executive Chamber
State Capitol
Albany, NY 12224

Re: A.7729-D, Gottfried / S.3164-B, Duane
In relation to Medical Decision-making for the Incapacitated

Dear Governor Paterson,

The above-mentioned bill has passed both Houses of the Legislature and will soon be before you for Executive action. You have kindly asked for our comments and recommendations with regard to this matter.

The New York State Catholic Conference has been actively engaged in collaborative dialogue on the issue of family health care decision-making for more than fifteen years. As the largest non-profit provider of health care services in the state, we have a direct stake in the outcome of this policy discussion. It is, therefore, with profound disappointment and a great deal of frustration that the New York State Catholic Conference must once again oppose this legislation, which no longer contains protections for pregnant patients and their children.

In previous years, the Conference and other stakeholders had worked with both Houses of the Legislature to draft a version of this legislation that was acceptable to all. That bill (A.5406-A of 2005) was favorably reported from the Assembly Health Committee. The New York State Catholic Conference was satisfied that all threshold issues of concern had been adequately addressed, and therefore withdrew opposition to the bill.

Unfortunately, that legislation, which enjoyed strong bipartisan support, was not enacted. The bill has subsequently been amended to its current form, a form which ignores one of the threshold issues for the Catholic Bishops of New York State: special consideration for end-of-life decision-making involving pregnant patients. The following language, which had previously been included in the decision-making considerations in the 2005 bill, continues to be absent from the legislation now before you:

> "for patients who are pregnant, the impact of treatment decisions on the fetus and on the course and outcome of the pregnancy."

This language is absolutely necessary because treatment decisions for pregnant patients are inherently different from medical decisions for non-pregnant patients; they involve another human being whose life and health must be taken into account.

Therefore, without the inclusion of the above-language, the New York State Catholic Conference opposes this bill and respectfully requests it not be signed into law.

Thank you for your consideration of our comments.

Respectfully submitted,

Richard E. Barnes

CENTER FOR DONATION & TRANSPLANT
NEW YORK – VERMONT

March 19, 2010

The Honorable David A. Paterson
Governor, State of New York
State Capitol
Albany, N.Y. 12224

Dear Governor Paterson:

On behalf of the Center for Donation & Transplant, I would like to thank you for signing the Family Health Care Decisions Act into law earlier this week. The Act establishes procedures for making medical treatment decisions on behalf of people who lack the capacity to dictate their own treatment decisions.

The Center for Donation & Transplant commends the leadership in the Legislature and the Executive branch for providing families the legal authority to make health care decisions when their loved ones are incapacitated and have no health care proxy. New York joins 48 other states that provide this authority to resolve these sensitive and personal decisions.

Thank you again for signing this long overdue measure.

Sincerely,

Jeffrey P. Orlowski, MS, CPTC
Chief Executive Officer

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Katharine Wilson Conroy
President

NYSARC Inc. Established 1949

Marc N. Brandt
Executive Director

A family-based organization working with and for people who have intellectual and other developmental disabilities.

March 9, 2010

Honorable David Paterson
Governor
State of New York
Executive Chamber
State Capitol
Albany, New York 12224

Re: S.3614-B/A.7729-D – The Family Health Care Decisions Act

Dear Governor Paterson:

I am writing to you on behalf of NYSARC, Inc., an 80,000 member parent and family-centered non-profit Organization, and the nation's largest private provider of supports and services to New Yorkers with intellectual and other developmental disabilities [ID/DD] to strongly urge you to sign Assembly bill 7729-D by Gottfried, the Family Health Care Decisions Act (FHCDA).

The FHCDA would allow family members and other surrogates to make a decision to withhold or withdraw life-sustaining treatment from a patient without the capacity to make his or her own decision. The bill includes standards and procedures for making this decision with compassion and dignity for the patient.

Critically, the bill finally resolves a problem posed by case law which has existed for over two decades. Under existing law and individual must clear and convincing evidence of their wishes before life-sustaining treatment can be withheld or withdrawn even though such treatment merely serves to prolong the agony of death.

Many persons never leave such evidence or are not capable of doing so. New York's harsh law has been the subject of intense controversy and created enormous suffering. This bill finally resolves that controversy and ends that suffering.

The bill prudently continues to rely on Section 1750-b of the Surrogates Court Procedure Act - The Health Care Decisions Act for Persons with Mental Retardation (HCDAPMR) - for decisions concerning the withholding and withdrawal of life-sustaining treatment for persons with intellectual and other similar developmental disabilities. [NOTE AN IMPORTANT EXCEPTION REGARDING DNR'S - SEE ATTACHMENT]. That law has been vetted by the courts and through practice. It is effective, humane and recognizes the rights of these individuals.

Finally, the FHCDA recognizes that there may be merit in incorporating standards and procedures for making decisions regarding life-sustaining treatment for persons with mental retardation into the FHCDA. Therefore it directs the Governor's Task Force on Life and the Law to study that matter and make a recommendation to the Legislature. (Attached for your convenience are issues NYSARC would like to advance as part of this study.)

Once again, NYSARC strongly urges you to sign this profoundly important bill. We believe that this historic legislation will finally bring humane and dignified treatment to all of our State's citizens. It is utterly essential and long overdue.

Sincerely,

Marc N. Brandt
Executive Director

MNB/baf

Attachment

ATTACHMENT - issues to be address by the Governor's Task Force on Life and the Law as required by the FHCDA and through regulations to effectuate the FHCDA.

We gratefully acknowledge the assistance, support and cooperation of the Governor's legal and program staff and that of the involved Senate and Assembly committees in preserving the HCDAPMR, and we look forward to working with the new subcommittee of the Governor's Task Force on Life and the Law, as it examines the interplay between the FHCDA and the HCDAPMR, and certain apparent inconsistencies between these statutes, and the possible eventual integration of the processes provided for in the two laws.

Our concerns emanate out of two sets of facts: the FHCDA generally and properly re-integrates cardio-pulmonary resuscitation [CPR] and do-not resuscitate orders [DNR] into the general category of life-sustaining treatment [LST] decision-making. In 1987, when Public Health Law Article [PHL] 29-B was enacted, DNR was extracted from the general definition of LST largely because the Governor's Task Force on Life and the Law was, at that time, unable to reach consensus legislative recommendations on the balance of LST issues, principally the discontinuance of LST including artificial nutrition and hydration. Part of the FHCDA [section 27 of the bill] provides a new definition of LST for purposes of the HCDAPMR [SCPA 1750-b, subsections 1. and 4.] which specifically includes CPR, as to which either a 17-A guardian or a "qualified family member", inter alia, can initiate decisions on behalf of the incapacitated person. Note that the HCDAPMR is not "setting-specific". Decisions can be initiated and made in any treatment or living environment, subject to being recorded by the attending physician in the person's appropriate hospital or facility record.

On the other hand, the FHCDA is almost entirely setting-specific. It's three main components [at least for purposes of this analysis] are new Public Health Law Article 29-CC, which deals with health care decisions in acute care hospital settings; new Public Health Law Article 29-CCC, Nonhospital Orders Not To Resuscitate; and an extensively amended Public Health Law Article 29-B, newly entitled Orders Not To Resuscitate for Residents of Mental Hygiene Facilities.

New PHL Article 29-CC explicitly: redefines [for the article] "life-sustaining treatment" to include "cardiopulmonary resuscitation"; and, directs that acute care hospitals "divert" patients who may be incapacitated and have a history of ID or DD to the decision-making mechanisms [including LST decisions] which already exist in statute and regulation [e.g., SCPA 1750-b and 14 NYCRR 633.11]. Those provisions are found very close to the beginning of PHL Article 29-CC at new sections 2294-a 19. and 2994-b 3.

However, new PHL Article 29-CCC directs, at PHL section 2994-cc 5. that [DNR] "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." Former [existing] PHL Article 29-B covers both inpatient acute-care facilities and other facilities including mental hygiene facilities. It contain surviving [as far as we can tell] language as to presumptive consent to CPR at PHL section 2962 1., which reads "every person admitted to a hospital shall be presumed to consent to the administration of cardiopulmonary resuscitation....", which would seem to mean that the presumption does NOT apply while the person is in the mental hygiene facility – the setting to which this entire article now applies.

More troubling is the fact that the FHCDA now creates two separate processes for surrogate consent to DNR, one at amended SCPA 1750-b 4., and the other in amended PHL article 29-B. To the extent that this is seen as remediable by regulation, NYSARC would greatly prefer the HCDAPMR process, in part because "qualified family members" acting as surrogate decision-makers, must by OMRDD regulation be "actively involved" in

the lives of the patient [14 NYCRR 633.10 (a)(7)(b)(iv)]. The surrogate list set forth at PHL section 2965 2. (a) simply empowers certain people related by blood or marriage to the patient to make the DNR decision.

Perhaps the more important reason for preferring SCPA 1750-b DNR decision-making is that the FHCDA, in amending PHL article 29-B systematically stripped out of the article all rights of the mental hygiene facility director to notification of decisions and the right to object and seek review of such decisions – see existing PHL sections 2963 4., 2963 4., 2965 4. (c), 2966 2., 2967 2. (c), and 2973 1., e.g. Please note that, other than some of the small number of DDSO's [see Mental Hygiene Law sec. 13.17] which still have inpatient facilities, virtually no existing residential facility licensed or operated by OMRDD employs a licensed physician, so that any process relying upon an attending physician for determinations of capacity, medical condition or prognosis would be taking place outside the facility. We simply think that the legislature did not properly reflect upon the parens patriae authority previously conferred by statute upon residential providers of services to persons with ID/DD [both the state and non-profits, such as NYSARC], many of whom simply have no INVOLVED family member who knows what the resident values, needs or wants at the end of life. The FHCDA continues to explicitly recognize the protections provided by notice and right to object in facility directors at SCPA 1750-b 4. (e). 5. and 6.

Finally, it does not appear to us that there is any clear direction [except, perhaps that the HCDAPMR survives] as to how DNR decisions are to be made for persons who are incapacitated, have ID or DD and do not reside in a facility. Again, some regulatory clarification that the HCDAPMR is the preferred decision-making vehicle as to all LST decisions for persons who are incapacitated and have ID or DD would suffice until the Governors Task Force on Life and the Law can convene and recommend. Such regulatory action is also fully consistent with the clear and explicit intent of the FHCDA.

Should you or your staff want clarification of some of the technical matters raised in this letter please contact NYSARC General Counsel Paul R. Kietzman at 518-439-8311 or kietzmanp@nysarc.org.

NYAHSA | New York Association of Homes & Services for the Aging

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March 11, 2010

David A. Paterson
Governor
New York State Capitol
Albany, NY 12224

Re: A. 7729-D (Gottfried)/S.3164-B (Duane)

Dear Governor Paterson:

The New York Association of Homes and Services for the Aging (NYAHSA), representing nearly 600 not-for-profit and public long-term care providers, including nursing homes, home care agencies, senior housing, retirement communities, assisted living, adult care facilities, adult day health care and managed long term care, supports A.7729-D/S.3164-B, an act establishing procedures for making medical treatment decisions on behalf of persons who lack the capacity to decide about treatment for themselves and urges, and urges you to sign it into law.

This bill would establish procedures and standards to allow family members and others close to a patient or resident to make medical treatment decisions on the patient's behalf when they are not able to make those decisions themselves. NYAHSA supports this proposal because it would allow medical treatment decisions to be made at the bedside by the resident's family or friends. Decisions would be made with advice from physicians and based upon the reasonably known wishes of the resident, or, in the absence of family or friends, by a person chosen for that purpose through a process carefully set forth in the bill. If the wishes of the resident were not reasonably known and could not be ascertained, the bill requires that decisions would be made based on the best interests of the patient, including consideration of the patient's religious and moral values. For some kinds of decisions and/or in certain circumstances, the bill would require additional concurrence by a bioethics committee, with review by a physician.

Many residents of nursing homes have neither a living will nor a health care proxy. In the absence of these protections, health care providers and family members are forced to turn to the courts in order to make a treatment decision. Often that decision is sought more for the legal protection of those who must carry out the decision than for any heightened awareness of the appropriateness of the medical treatment. Courts are reluctant to make these kinds of decisions and are often unable to respond quickly. Furthermore, the adversarial nature of the court system can create further anxieties among family members or friends when discussing and resolving these sensitive issues.

NYAHSA believes that this proposal represents a far more humane process than that which is currently available, without sacrificing either attention to standards or sensitivity to the moral values and religious beliefs of residents and their families, as well as those of the health care facility in which care is being provided. The bill is the product of several years of work by the Task Force on Life and the Law, and reflects the input of health care providers, consumers, academics, religious communities, and other interested persons. This legislation will provide important protections for patients, their families and friends, and the health care providers who are forced to deal with these problems on a regular basis.

For these reasons, NYAHSA supports this legislation and urges your signature.

Sincerely,

Dennis R Bozzi

Dennis R. Bozzi
President/CEO

NYS Office of Mental Retardation and Developmental Disabilities
Putting People First

David A. Paterson, Governor
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March 11, 2010

Honorable Peter Kiernan
Counsel to the Governor
Executive Chamber
State Capitol Building
Albany, New York 12224

Re: A.7729-D

Dear Mr. Kiernan:

As requested, the Office of Mental Retardation and Developmental Disabilities (OMRDD) is providing comments on the above-referenced legislation now awaiting Executive action. This bill would establish a procedure by which a surrogate can make health care decisions on behalf of an individual who lacks the capacity to make his or her own health care decisions, in situations in which the individual has not appointed a health care agent or provided clear and convincing evidence of his or her treatment wishes. Standards and safeguards are written into the legislation.

OMRDD recommends that the Governor approve this legislation, which adds the Family Health Care Decisions Act (FHCDA) to the Public Health Law. Although this legislation provides for the continued applicability of the Health Care Decisions Act for Persons with Mental Retardation (HCDAPMR) for most of the individuals we serve, we recognize the significance of this legislation for all New York residents.

OMRDD requested that the HCDAPMR process be continued for the individuals we serve, due to the fact that it differs from the FHCDA process in a number of ways. However, we look forward to the recommendations of the Task Force on Life and the Law regarding the possible expansion of the FHCDA to the population we serve.

It appears that this legislation lacks some clarity about the appropriate DNR Order process for individuals with developmental disabilities. The HCDAPMR, as amended by this legislation, would appear to encompass all DNRs for individuals who are developmentally disabled, regardless of the setting. At the same time the HCDAPMR, as amended by this legislation, could be read to conflict with certain provisions of Articles 29-CC and 29-B of this legislation, or to provide a parallel means to obtain a DNR order for residents of mental hygiene facilities. While it may be possible to address this by regulation, it is more

likely that a chapter amendment will be necessary so that hospitals and other providers can readily avail themselves of appropriate procedures to provide for decision-making and protection for this vulnerable population. Because of the immediacy of the problem, it would not be prudent to await the recommendations of the Life and the Law Task Force on this particular drafting issue. This one issue should not deter the Governor from signing this important legislation, however.

Finally, OMRDD strongly supports the portion of this bill which amends the HCDAPMR to authorize the Consumer Advisory Board (CAB) to make decisions regarding the withholding or withdrawing of life sustaining treatment for Willowbrook class members who lack capacity to make their own health care decisions, who are fully represented by the CAB, and who do not have a guardian or qualified family member to make such a decision on their behalf.

Thank you for the opportunity to review and comment on this bill.

Sincerely,

Patricia Martinelli
Deputy Commissioner and Counsel

PM:jf

NEW YORK
CITY BAR

Contact: Maria Cilenti - Director of Legislative Affairs - mcilenti@nycbar.org - (212) 382-6655

REPORT ON LEGISLATION BY THE COMMITTEE ON HEALTH LAW AND THE COMMITTEE ON BIOETHICAL ISSUES

S.3164-B **Senator Duane**
A.7729-D **M. of A. Gottfried**

An act to amend the public health law (i) to establish procedures for selecting and empowering a surrogate to make health care decisions for persons who lack capacity to do so on their own behalf and who have not otherwise appointed an agent to make such decisions under Article 29-C of the Public Health Law and (ii) to repeal certain provisions of such law relating thereto.

THIS BILL IS APPROVED

A. The Committees strongly endorse the Bill and urge its swift passage.

The Committee on Health Law and the Committee on Bioethical Issues of the New York City Bar Association ("the Association") strongly endorse the Family Health Care Decisions Act and urge swift passage of this urgently needed legislation. The Association has submitted position statements in favor of similar legislation in 1993, 1994, 1996, 2001, 2007 and 2009.

The Association is an organization of over 23,000 lawyers and judges dedicated to improving the administration of justice. The members of the Committees on Health Law and Bioethical Issues include attorneys, physicians, and in-house hospital counsel who grapple daily with issues involving medical decision making and end-of-life care. The Association has always taken great interest in the legal, social and public policy aspects of medical care, as well as in other public health issues, and through its various committees, regularly issues reports and policy statements, and testifies at hearings.

We live in a time when medical technology can extend life well beyond what many would want. Without the legal right to refuse treatment at some point, medical technology can impose enormous personal burden and suffering upon the very patients the technology was intended to aid. Every day vital health care and treatment decisions are being made in New York State by persons other than health care agents on behalf of incapacitated patients. These crucial decisions must be made for the patients' well-being, as they were yesterday and will be tomorrow. The central issue presented by this bill is not whether such treatment decisions should be made by a surrogate but rather who should legally be vested with the decision making authority and what criteria should be used for making those decisions.

The Family Health Care Decisions Act provides legal authority for a decision making system that effectively balances empowerment of a surrogate and adequate protections for incapacitated patients. The Act specifically establishes procedures for: (i) honoring patient wishes and values, as best they can be ascertained; (ii) involving family and loved ones in decision making for incapacitated patients; and (iii) ensuring safeguards to prevent inappropriate decisions particularly in cases where the wishes of the incapacitated patient are unknown and there are no primary advocates involved.

Existing New York law recognizes and honors health care wishes of a competent adult. But New York law permits health care decisions to be made for an incompetent adult in only five circumstances: 1) when a health care agent has been appointed by the patient or by a court; 2) when the patient, while competent, has prepared a written directive; 3) when a family member of a mentally retarded patient is acting as their guardian, whether or not they have been appointed by a court; 4) when the health care decision is to refuse cardiopulmonary resuscitation and (5) decisions made on behalf of mentally retarded and developmentally disabled individuals . In other cases New York has severely circumscribed the right to make health care decisions for an incapacitated patient by imposing an often unrealistic burden of proof on family members, friends or others who seek to act on the patient's behalf. Unless they can prove a patient's precise wishes by "clear and convincing evidence," family members and loved ones have no legal authority with respect to these crucial medical treatment decisions. The proposed bill, however, delegates such decision making authority to family members and others close to the patient, without the need to satisfy a burden of proof with respect to the patient's wishes.

B. Current Law: Competent adults fully control their medical treatment decisions.

The right of a competent adult to accept or reject medical treatment is a firmly established legal principle. "Every human being of adult years and sound mind has a right to determine what shall be done with his own body." Schloendorff v. The Society of New York Hospital, 211 N.Y. 125, 129 (1914) (Cardozo, J.). The right of a patient to refuse treatment has been expressly recognized by the New York Court of Appeals. Eichner v. Dillon (In re Storar), 52 N.Y.2d 363 (1981). Furthermore, that right is protected under the Due Process Clause of the State Constitution (see Rivers v. Katz, 67 N.Y.2d 485 (1986)). The United States Supreme Court has found that the refusal of life sustaining medical treatment implicates a liberty interest protected under the United States Constitution. Cruzan v. Missouri Department of Health, 497 U.S. 261 (1990). This body of strong case law has clearly established the right of competent adult patients to make all decisions regarding their medical treatment, even when death will result from the refusal of treatment.

C. Current Law: A competent adult may delegate authority to make health care decisions in the event of incapacitation by completing a health care proxy.

1. Advance directives are authorized by New York law.

Article 29-C of the Public Health Law is a powerful and extremely useful instrument in the compassionate delivery of care, allowing competent adults to express their wishes in anticipation of becoming incapacitated. Competent adults may delegate health care decision making authority to another adult, should they become unable to make such decisions themselves, by completing a health care

proxy. Alternatively, competent adults may leave written instructions as to specific wishes regarding medical treatment in the form of a "living will".

Both federal and state law strongly support the use of such written advance directives to honor the wishes of patients who have lost the ability to make medical treatment decisions. The Patient Self-Determination Act of 1991, 42 U.S.C. 1395cc(a) et. seq.; In the Matter of Westchester County Med. Center (O'Connor), 72 N.Y. 2d 517, 530-531, (1988); Eichner v. Dillon (supra).

2. Yet few people take advantage of advance directives.

Most adults in New York do not prepare advance directives. Despite vigorous efforts to educate people regarding the wisdom of executing advance planning mechanisms, only a small proportion of patients have a health care proxy or a living will. A 2001 study of New York seniors found that two out of three seniors responding had not completed advance directives despite the fact that all of the research sites had previously conducted programs to educate them about the importance of having a health care proxy. When asked whom they trust the most to make medical decisions for them, the vast majority (79%) mentioned a spouse or other family member. Only 17% mentioned their physician. More than half of those studied indicated they believed family decision making was legal in New York State without a designated health care proxy even after reading a statement that the law states otherwise. Results of Literacy Study Reinforce Need for the Family Health Care Decisions Act, Sarah Lawrence College, Health Advocacy Program.

D. Current Law: Where there is no health care proxy a surrogate may consent to a "do-not-resuscitate" order.

Absent a health care proxy, Public Health Law 29-B authorizes a surrogate who has a close relationship with the incapacitated patient to consent to a "do-not-resuscitate" order not to attempt cardiopulmonary resuscitation in the event the patient suffers cardiac or respiratory arrest.

E. Current Law: Without an advance directive, clear and convincing evidence must be shown to withdraw or withhold life sustaining measures.

The New York Court of Appeals has held that evidence of treatment wishes provides a basis for withdrawing or withholding life sustaining measures from an incapacitated patient only if it is clear and convincing. (see In re Eichner (supra)).

"Every person has the right to life, and no one should be denied essential medical care unless the evidence clearly and convincingly shows that the patient intended to decline the treatment under some particular circumstances...*This is a demanding standard, the most rigorous burden or proof in civil cases.*" (emphasis added). In re O'Connor, supra at 530-531.

F. Several burdens on families, health care providers and the courts are imposed by the current state of the law, while possibly extending the pain and suffering of incapacitated patients unnecessarily. The Family Health Care Decisions Act will alleviate those burdens and that suffering.

1. The clear and convincing standard poses a formidable barrier to both families and health care providers. Surrogate decision making under the proposed bill provides a workable, timely and financially less burdensome alternative.

(i) Clear and convincing evidence is a demanding standard: With the exception of cardiopulmonary resuscitation, in the absence of a health care proxy, medical treatments must be continued regardless of the consequences to the patient unless clear and convincing evidence can be shown as to the patient's wishes to the contrary. As the Court of Appeals stated, this is a demanding standard, the most rigorous burden of proof in civil cases. O'Connor (supra, at 531).

The "clear and convincing" evidence standard does not work. Rather than facilitate a health care provider's ability to follow patient choice about treatment, this standard poses a formidable barrier to both families and providers. A majority of courts in other states has found the "clear and convincing" evidence standard to be unworkable and overly burdensome in these cases.

The "clear and convincing" standard is predicated on the notion that a person, while competent, would have clearly expressed his or her wishes regarding end-of-life decisions in some manner. However, for many people discussion of end-of-life matters is a personally uncomfortable subject, such that they refrain from expressing their wishes in this area. In addition, the cultural backgrounds of some New Yorkers make it extremely difficult, if not impossible, to even mention their own death and dying, let alone to articulate "clear and convincing" plans for it.

Under the proposed bill, there is no need for the surrogate to show clear and convincing evidence of the patient's wishes with respect to medical treatment. This is balanced by a set of workable safeguards. The proposed legislation is in line with the laws of the vast majority of other States in allowing a surrogate to make health care decisions free from the clear and convincing evidence standard.

(ii) Court proceedings necessitated by the "clear and convincing" evidence standard are costly for families: Even if the patient's condition is terminal and hopeless and even if medical interventions are not in the patient's best interest and such interventions increase rather than decrease the patient's immediate suffering, treatment must continue, unless clear and convincing evidence can be shown. That showing may require the expense of a court proceeding, leaving those closest to a terminally ill

patient who may be unable to bear that expense helpless to prevent the initiation of further medical treatment, even though they know deep in their hearts that their loved one would never have permitted it. The proposed bill alleviates this problem.

(iii) Court proceedings are time consuming and extend patient suffering: Meeting the clear and convincing burden of proof in a court proceeding as may now be required by New York law may extend the pain and suffering of a patient who would otherwise have wished for the cessation of further medical treatment.

(iv) Experience with DNR decisions has shown that clear and convincing evidence is not required: New York does not require "clear and convincing" evidence of a patient's wishes in cardiopulmonary resuscitation decisions. There has been no evidence to date that the current, less burdensome statutory standard for refusing cardiopulmonary resuscitation on behalf of incapacitated patients leaves those patients unprotected or vulnerable to decisions that are not in their best interests.

2. **Current New York Law denies legal decision making power to those closest to the patient. The proposed legislations vests health care decision making power in a person most likely to know the patient's wishes or act in the patient's best interests.**

(i) Under current New York law, families have no legal decision making authority: While it is the practice of many health care providers to turn to the family of an incapacitated adult patient for consent to treatment, family members and close friends do not have any legal right to provide or withhold that consent. Inevitably, cases arise when those most intimate with the patient lack the authority to protect the patient from unwanted medical treatment and must stand by and endure the knowledge that further medical treatment is only prolonging suffering.

(ii) Leading authorities advocate surrogate decision making by a person close to the patient.

1. Task Force. The New York State Task Force on Life and the Law, recognized as a model of sound public policy study of important issues of life and death, has addressed this issue. The Task Force has included leaders in the fields of law, medicine, nursing, philosophy and bioethics, as well as patient advocates and representatives of diverse religious communities. In 1992, the Task Force published When Others Must Choose; Deciding for Patients Without Capacity. This report included a legislative proposal for surrogate decision making in those cases where the patient has not (or could not) execute a health care proxy.

2. Presidential Commission. The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research has strongly held that decision making for patients who lack capacity is best discharged by those who know and care for the patient, rather than health care providers or courts, to whom the patient is a stranger. Deciding to Forego Life-Sustaining Treatment: Ethical, Medical, and Legal Issues in Treatment Decisions (1983).

(iii) Court adjudication is inappropriate for many end-of-life decisions.

1. Courts are ill-equipped. A clear consensus has evolved in both the legal and medical literature that courts of law, in most instances, are inadequate to address fundamental end-of-life decisions. Also clear is that judges are not particularly desirous of being asked to make such personal decisions for others. Given the highly nuanced, clinically oriented nature of these decisions, judges and courts of law are largely ill equipped to consider such matters competently and compassionately. Furthermore, in many situations, taking end-of-life decisions to court may unduly delay resolution and unnecessarily prolong suffering.

2. The Bill brings decision making out of the courtroom and to the patient's bedside. Under the proposed legislation courts are used as a forum of last resort. The decision making process is in the hands of a person who would most likely know the wishes of the patient or act in the patient's best interests. The surrogate's decisions are also informed by the health care providers who are taking care of the patient. In other words, the decision making process is brought out of the courtroom and to the patient's bedside where a family member or close friend makes decisions informed by knowledge of the patient as an individual and by health care providers advising that decision maker.

3. **Health care professionals feel legally vulnerable if they withdraw or withhold medical treatment. This fear of legal action can lead to over-treatment. The bill provides immunity for health care providers who honor health care decisions made in accordance with the proposed Bill.**

Under existing law, clinicians often feel legally vulnerable if they submit to the family's compassionate and common sense pleas. As a result, fear of legal attack may lead to over-treatment of an incapacitated individual. This is

treatment that provides neither benefit nor palliation and may even increase suffering, but is provided out of fear of liability if such interventions are withheld.

In a 2002 study, Common Good, a bi-partisan organization composed of leaders in government, education, health care, law, business and public policy, interviewed physician regarding how fear of litigation impacts the practice of medicine. The study found that when looking at patient end of life issues 61% of physicians have noticed physicians being reluctant to make what they believe to be humane choices because of concerns that a family member might bring suit. Half (50%) have noticed a physician resorting to aggressive treatments of terminally ill patients because of liability concerns. Just under half (42%) have noticed a physician or staff member going against a patient's expressed wishes concerning life-prolonging medical interventions because of concerns that a family member might bring suit. Fear Of Litigation Study, Common Good, April 11, 2002.

4. **Health care decisions are now open to intervention by third parties. The Bill would foreclose intervention.**

Under current law third parties unknown to the patient or the State could attempt to intervene in medical treatment decisions with respect to an incapacitated patient. Since the bill delegates the decision making authority to the surrogate, such attempted interventions would be statutorily barred. Only certain persons close to the patient may commence a special proceeding if they disagree with the surrogate's decisions.

G. The Bill safeguards the rights and interests of the patient.

A concern raised by those who would oppose the bill is that it does not sufficiently protect patients against families and health care institutions that may not be willing to act consistently with the patient's best interests. The Family Health Care Decisions Act, however, imposes numerous substantive and procedural safeguards intended to ensure that the rights and interests of vulnerable patients are appropriately considered and weighed in the decision making process.

The safeguards afforded by the Act are wide-ranging. They include, among others, the following: (1) In the determination of incapacitation, at least one other health care professional must concur with the attending physician's determination; (2) Notwithstanding a determination of incapacity in an adult patient, the patient's objection prevails over the surrogate's health care decision or the determination of incapacity, absent a court finding or another legal basis for overriding the patient's decision; (3) Before a surrogate's decision to withdraw or withhold life sustaining treatment may be carried out, specific medical criteria must be met and confirmed by two physician; (4) Decisions to withhold or withdraw life-sustaining treatment when the patient is not suffering from a terminal condition or permanent unconsciousness require review and approval by an attending physician and the institution's Ethics Review Committee, which must include at least one physician not directly responsible for the patient's care; (5) A treating physician may object to a surrogate's decision to withdraw or withhold life

sustaining treatment, resulting in the delay of such action until reviewed by either the Ethics Review Committee or a court of competent jurisdiction; (6) The bill authorizes persons with a close relationship to a patient to commence a special proceeding if they object to the surrogate's decision; and (7) If the decision is contrary to a private hospital's policy based on religious or moral convictions central to that facility's operating principle and that policy was communicated to the patient, family or surrogate before admission, if reasonably possible, the bill provides for a prompt transfer of the patient to another facility. If the family is unable or unwilling to make the transfer the hospital may facilitate such transfer, seek judicial relief or honor the surrogate's decisions.

H. The Committees urge swift passage of the Family Health Care Decisions Act.

New York law honors the prior written expression of patients' wishes through living wills and health care proxies. New York is one of only two states, however, that currently have no effective mechanism to follow the wishes of the majority of incapacitated patients who have left no advance directive. The clear and convincing standard required under current law is a demanding standard and is burdensome on families and health care providers who wish to aid a suffering patient. The need for legislative action on this issue is indisputable and urgent.

The Family Health Care Decisions Act is a comprehensive and thoughtful approach to health care decision making for the incapacitated patient without a health care proxy. The proposed legislation would establish a system sensitive to the clinical reality in which decision are being made.[1] It balances the vesting of decision making authority with several safeguard provisions. Most important, it is a patient centered bill which will simultaneously provide for the best interests of the patient and the reduction of stress families face in an already painful and difficult time by giving them decision making authority and by blocking the intervention of third parties unknown to the patient in such decisions.

The need to take up the plight of incapacitated patients for whom health care decisions must be made is genuine and imperative. The Committees urge the swift passage of this bill.

Reissued January 2010

[1] The Committees do note, however, that the legislation's reach is currently limited to hospitals and nursing homes. The Committees urge the swift amendment of this legislation once passed to include decisions made by surrogates in the home care and hospice settings.

LTCCC LONG TERM CARE COMMUNITY COALITION

Working to improve long term care through research, education & advocacy

March 8, 2010

Governor David Paterson
State Capitol
Albany, NY 12224

Re. A.7729-D

Dear Governor Paterson:

I am writing to you on behalf of the Long Term Care Community Coalition regarding Assembly bill A7729-D, the Family Healthcare Decision Act. The Coalition is a non-profit organization that has been dedicated to improving long term care in New York State for almost 30 years. We are comprised of over two dozen civic, grassroots and professional organization from across the state. On behalf of the Coalition, I urge you to sign this bill.

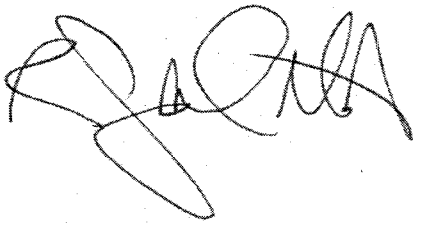
This bill, if it became law, would allow the family and friends of incapacitated people to make health care decisions in consultation with physicians to ensure that the wishes of the patient are carried out in his or her best interest. The FHCDA establishes clear procedures for selecting a surrogate from a list of family members and close friends, and decision making standards by which the surrogate must abide. The surrogate would be authorized to make all health care decisions that a patient with capacity would be able to make.

Currently, in New York State the only way families and friends of people who do not, or never had, the ability to make their own health care decisions can intervene to make those decisions on the patient's behalf is if the patient has signed a health care proxy or has left "clear and convincing evidence" of his wishes. Without a proxy or evidence, the hospital or nursing home is allowed to make these decisions. Millions of New Yorkers are in danger of having the most important and personal decisions in their lives in the hands of strangers. For those who are already incapacitated or who were born incapacitated, it is too late.

The power to make health care decisions should be in the hands of those who understand the unique values, choices and morals of the patient.

Thank you for your kind attention to this matter.

Sincerely,



Richard J. Mollot
Executive Director
Long Term Care Community Coalition
242 West 30th Street, Suite 306
New York, NY 10001
Phone: 212-385-0355
Email: richard@ltccc.org

March 1, 2010

The Honorable Peter J. Kiernan
Counsel to the Governor
Executive Chamber
State Capitol
Albany, New York 12224

Re: A.7729-D Gottfried - An act to amend the public health law, in relation to establishing procedures for making medical treatment decisions on behalf of persons who lack the capacity to decide about treatment for themselves.

Dear Mr. Kiernan:

AARP supports the above bill and recommends that Governor Paterson sign the bill into law.

AARP policy supports legislative initiatives that would authorize nonjudicial surrogate decision making in the event an incapacitated patient has not executed an advance directive.

Currently, New York State lags behind the rest of the nation in not permitting close family members to make health care decisions for incapacitated patients. Only a court appointed guardian or a judge is permitted to consent to treatment for patients who lack the capacity to decide for themselves. This is true even when the patient has a spouse or other family members willing and able to act on the patient's behalf. This rule often results in a considerable delay in administering health care, as well as added expense to the health care system.

The Family Health Care Decision Act (A.7729-D) would enable family members and others close to the patient to decide about treatment for incapacitated patients who have not signed a health care proxy or left specific oral or written treatment instructions. It would also cover treatment decisions for patients who have no available family or friends to decide for them.

The surrogate decision maker's primary function would be to consult with physicians and other professionals responsible for the care of the patient, and to advocate on the patient's behalf. The surrogate decision maker would be required to make decisions consistent with the incapacitated patient's wishes, including their religious or moral beliefs.

In the event the patient's wishes are not reasonably known, the decisions would have to be in the best interest of the incapacitated patient. Decisions to withhold or withdraw life-sustaining treatment would be authorized only if specific medical criteria were satisfied. Any disputes among family members or between family members and health care professionals would automatically trigger review by an interdisciplinary ethics committee. In addition, the bill would apply in general hospitals and residential care facilities, such as nursing homes. It would not cover mental hygiene facilities, the psychiatric units of general hospitals, or outpatient settings such as clinics or doctors' offices.

AARP believes that A.7729-D clearly provides a set of procedures for decision making that protects the incapacitated patient. Legislation similar to the Family Health Care Decision Act has proved effective in numerous other states, and AARP believes this legislation would undoubtedly work well in New York. It will provide needed guidance for family members and health care providers, and enable timely decision making on critical treatment matters. The law would eliminate litigation that is costly to individuals, health care facilities, and the state.

For the above reasons, AARP urges the Governor to sign this legislation into law.

Please contact Bill Ferris or David McNally at (518) 434-4194 with any questions related to this.

Sincerely,

L Aronstein

Lois Aronstein
State Director
AARP New York

THE CITY OF NEW YORK
OFFICE OF THE MAYOR
NEW YORK, N.Y. 10007

March 9, 2010

A.7729-D by M. of A. Gottfried

AN ACT to amend the public health law, in relation to establishing procedures for making medical treatment decisions on behalf of persons who lack the capacity to decide about treatment for themselves and to repeal certain provisions of such law relating thereto

APPROVAL RECOMMENDED

Hon. David Paterson
Governor of the State of New York
Executive Chamber
Albany, New York 12224

Dear Governor Paterson:

The above-referenced bill is now before you for executive action.

This bill establishes the Family Health Care Decisions Act. The legislation enables family members and others close to an incapacitated patient to make health care decisions in consultation with health care professionals and in accord with special procedures and standards for decisions about life-sustaining treatments established in the legislation.

The City of New York supports this legislation to eliminate the legal and ethical gap regarding decision-making for incapacitated adults in need of medical treatment or end of life care. New York is one of only two states to require that patients have previously provided "clear and convincing evidence" of treatment recommendations or a signed health care proxy in order for a family member to make decisions on behalf of the patient. The vast majority of New Yorkers and a disproportionate number of economically disadvantaged patients do not have a health care proxy or make their treatment wishes known, leaving vulnerable patients without a voice in this important process. As a result, some patients are subjected to treatments contrary to their wishes, while other patients are denied treatment entirely.

This *ad hoc* system has created inconsistencies of care across the state, as different institutions are left to interpret the existing, ambiguous standards. The New York City Department for the Aging (DFTA) supports a clear delineation of surrogate authority to help carry out the wishes of incapacitated patients across the state in order to provide medical treatment. In fact, the City pledged its support for the bill in DFTA's *Age Friendly NYC* initiative released last year.

Accordingly, it is urged that this bill be approved.

Very truly yours,

MICHAEL R. BLOOMBERG, Mayor

By: Micah C. Lasher
Director

MD

FRIA *The Voice and Resource for Quality Long Term Care*

A New York non-profit consumer advocacy organization working since 1976

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March 2010

MEMORANDUM OF SUPPORT
Family Health Care Decisions Act
S.3164-b/A.7729-d

FRIA urgently requests that you sign the Family Health Care Decisions Act (FHCDA). New York remains only one of two states that do not provide for family participation in making health care decisions for individuals who lack capacity and have not appointed a health care proxy. The FHCDA would enable family members and others close to an incapacitated patient to make treatment decisions based on the wishes of that person and to have access to important medical information.

Statistics show that only approximately 20% of New Yorkers have filled out health care proxies naming agents. Despite educational efforts, many New Yorkers continue to believe they won't need a legal document to make medical decisions for a child, spouse, parent or partner.

Our constituents, family members and friends of long term care residents who have not signed a health care proxy, are routinely kept from participating in important medical decisions, refused access to medical records for oversight and prevented from determining the best approach to care. As a result, resident care is left solely in the hands of medical providers who have little personal connection to the patient and have no knowledge of their wishes, values and religious beliefs, while families and friends stand by helplessly.

This bill has the support of a broad range of organizations, consumers, providers and professionals. This legislation offers a clear way to identify a substitute decision-maker for incapacitated patients and ensures that medical decisions, including end-of-life care, are likely to reflect the wishes, experience and values of the patients themselves.

FRIA respectfully urges you to sign this legislation which would improve the quality of life of all New Yorkers by giving them the protections they deserve.

GNYHA STATEMENT OF SUPPORT

March
Eight
2010

TO: Peter J. Kiernan
Counsel to the Governor

FROM: Greater New York Hospital Association

RE: A. 7729-D/S. 3164-B - Family Health Care Decisions Act

A. 7729-D/S. 3164-B would amend the Public Health Law by creating a process for allowing surrogates to make decisions on behalf of patients who become incapacitated but have neither appointed a health care proxy nor provided "clear and convincing" evidence of his or her wishes. Additionally, the legislation would create a process for family members, surrogates and others close to the incapacitated patient to make treatment decisions on behalf of those patients unable to make such treatment decisions for themselves. GNYHA strongly supports A. 7729-D/S. 3164-B insofar as it addresses glaring gaps that currently exist in New York State law, and urges enactment of this bill into law.

GNYHA has a long-standing interest in respecting the rights of patients to have their wishes with regard to medical care followed or to decline unwanted treatment. GNYHA strongly supported the enactment of New York's Health Care Proxy Law and the Do-Not-Resuscitate Law. However, by themselves, these laws do not adequately address the confusion that exists in New York State law with respect to decision-making in the area of life-sustaining treatment by surrogates for individuals who have no one to speak on their behalf.

Under current New York State law, no one, not even concerned family members, can make health care decisions to forgo life-sustaining treatment for patients who have lost capacity unless the patient has signed a health care proxy or has left "clear and convincing evidence" of his or her treatment wishes. An even larger gap exists for those individuals who have never had the capacity to articulate their wishes or may never be able to appoint a proxy. The result of those gaps is often the provision of unwanted, unnecessary burdensome and non-beneficial treatment. In addition, patients who have lost decision-making capacity face delays in necessary treatment due to the lack of legal authorization. A. 7729-D/S. 3164-B addresses these gaps sensitively as most other states have done through similar legislation and/or judicial actions.

Clearly, New York State law demands reform on the issue of withdrawing or withholding life-sustaining treatment and treatment decisions for patients who have no surrogate. New York must have a process for recognizing patient rights and dignity beyond the limited areas covered by the State's Do-Not-Resuscitate Law and beyond situations in which patients have the ability and foresight to appoint health care proxies to speak and act on their behalf. GNYHA believes A. 7729-D/S. 3164-B corrects these deficiencies in current New York State law yet affords sufficient procedural safeguards to protect the patients involved. The legislation provides a sensitive approach to making treatment decisions on behalf of individuals who have surrogates available and creates a thoughtful process for respecting the rights and dignity of individuals who may have no one to speak on their behalf.

GNYHA points out that many of the cases that have underscored the need for this legislation pertain to artificial nutrition and hydration. GNYHA understands that the intent language that states the legislation does not authorize a surrogate to deny personal services such as food and water are not intended to interfere with the surrogate's authority to withhold or withdraw artificial nutrition and hydration pursuant to procedures set forth in the legislation.

For the reasons outlined above, GNYHA strongly supports enactment into law of A. 7729-D/S. 3164-B.

GREATER NEW YORK HOSPITAL ASSOCIATION
555 W 57TH STREET, SUITE 1500 • NEW YORK, NY • 10019 • 212.246.7100

From: Linda Lambert [llambert@nyacp.org]
Sent: Friday, March 05, 2010 4:46 PM
To: Legislative Secretary
Subject: RE: A.7729-D

WE ARE VERY SUPPORTIVE OF THIS LEGISLATION – URGE GOVERNOR TO SIGN

Linda A. Lambert, CAE
Executive Director
New York Chapter, American College of Physicians
744 Broadway
Albany, NY 12207

email: llambert@nyacp.org
phone: 518-427-0366
Fax: 518-427-1991

From: Legislative Secretary [mailto:Legislative.Secretary@chamber.state.ny.us]
Sent: Friday, March 05, 2010 4:18 PM
To: 'James Malatras (james.malatras@oag.state.ny.us)'; Jamie elacqua (JElacqua@osc.state.ny.us); Kathleen Dillman (kdillman@osc.state.ny.us); Mary Ledbetter (mary.ledbetter@dos.state.ny.us); Matthew Tebo (matthew.tebo@dos.state.ny.us); Susan Watson (susan.watson@dos.state.ny.us); Greg Olsen (Greg.Olsen@ofa.state.ny.us); Jennifer Seehase (Jennifer.Seehase@ofa.state.ny.us); Catherine Schuth (catherine.schuth@ocfs.state.ny.us); charlene.mondun@ocfs.state.ny.us; Karen Walker Bryce (Karen.walkerbryce@ocfs.state.ny.us); laura.etlinger@ocfs.state.ny.us; Niko Ladopoulos (niko.ladopoulos@ocfs.state.ny.us); Amy Nickson (ajn01@health.state.ny.us); Erin Hammond (eah04@health.state.ny.us); James Clancy (jmc36@health.state.ny.us); Paul Zuckerman (pzuckerm@ins.state.ny.us); Stacey Rowland (srowland@ins.state.ny.us); David Wollner (coledvw@omh.state.ny.us); John Tauriello (colejvt@omh.state.ny.us); Cynthia McDonough (Cynthia.McDonough@omr.state.ny.us); Patricia Martinelli (patricia.martinelli@omr.state.ny.us); pat.johnson@cqcapd.state.ny.us (pat.johnson@cqcapd.state.ny.us); Robert J. Boehlert (robert.boehlert@cqcapd.state.ny.us); Michael Morgan (michael.morgan@suny.edu); Nicholas Rostow (nicholas.rostow@suny.edu); Linda Ashline (lashline@cityhall.nyc.gov); Steve Williams (swilliams1@cityhall.nyc.gov); Kathy Cunningham (kcunnin1@courts.state.ny.us); Marc Bloustein (mblouste@courts.state.ny.us); Linda Wagner (linda@nysacho.org); Mary Armao McCarthy (info@nyspha.org); Kenneth Raske (raske@gnyha.org); Karen Bonilla (kbonilla@hanys.org); Robin Frank (rfrank@hanys.org); Robert Murphy (rmurphy@nyshfa.org); Gary Fitzgerald (gfitzgerald@iroquois.org); Amy Schnauber (ASchnauber@NYAHSA.org); Carl Young (cyoung@nyahsa.org); Laura Turnblom (lturnblom@malkinross.com); Lisa Newcomb (lnewcomb1@aol.com); Al Cardillo (acardillo@hcanys.org); Cynthia Rudder (cynthia@ltccc.org); Richard J. Mollott (richard@ltccc.org); Sara Rosenberg (sara@ltccc.org); Charles Blum (cblum@vnsny.org); Christy Johnston (johnston@nyshcp.org); Margaret Gorman (gorman@nyshcp.org); Elizabeth Swain (eswain@chcanys.org); Kate Breslin (kbreslin@chcanys.org); Kathy McMahon (kmcmahon@hpcanys.org); John A. Chermack (jchermack@chpnet.org); Alan Lewis (Alan_Lewis@rmetro.com); Michael J. Mastrianni Jr. (president@nysvara.org); Andrea Kosier DeBow (adebow@cvsconsulting.com); Matt Harrison (matth@transcare.com); Arthur Levin (medconsumers@earthlink.net); Lara Kassel (lkassel@rochestercdr.org); Elisabeth Benjamin (elisabeth.benjamin@cssny.org); David Leven (ny@compassionandchoices.org); Laura A. Cameron (laura@nysaaaa.org); Bill Ferris (wferris@aarp.org); Dave McNally (dmcnally@aarp.org); KRISTEN j Smith (kjsmith@aarp.org); Michael Burgess (swnys@aol.com); Betti Weimersheimer (bweimers@fria.org); Karlin Mbah (kmbah@fria.org); Jeff Liberman (ciadny@aol.com); Elizabeth Dears Kent (ldears@mssny.org); Gerry Conway (gconway@mssny.org); Linda Lambert; Amy Clinton (clinton@bennettfirm.com); Heather Bennett (bennett@bennettfirm.com); Joanne Tarantelli (nyscacep@aol.com); New York State Academy of Family Physicians (fp@nysafp.org); Stephen Hanse (sbh@fcwc-law.com); Seth Gordon (sgordon@thenpa.org); Megan Eiser (legislative@nysna.org); Shaun Flynn (shaun.flynn@nysna.org); Andy Fogarty (afogarty@nyhpa.org); Sheila

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Subject: A.7729-D

NYACP
New York Chapter
American College of Physicians, *Services Inc.*
Advancing Internal Medicine; Improving Patient Care
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Albany, NY 12207
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Toll-free: 1-800-446-9746

To: Honorable Members of the NYS Legislature

From: New York Chapter, American College of Physicians Services, Inc.

Date: January 19, 2010

Subject: **Family Health Care Decisions Act**
A.7729d Gottfried and S.3164b Duane

The New York Chapter of the American College of Physicians, representing more than 11,000 physicians specializing in Internal Medicine, is deeply committed to the passage of the Family Health Care Decisions Act. Since 1993, we have worked with many of you in the hopes of achieving what 48 other states have achieved, a law that allows us to treat our patients and families with the dignity and respect they deserve at the end of life.

We have collected numerous clinical case "stories" from practicing internists who are ACP members. Below are two that highlight how New York's lack of a surrogate-decision making law adversely affects our patients and their families and why passage of this critical legislation is so urgently needed.

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"As Chairman of an institutional Ethics Committee, I can verify the absolute necessity for establishing a rational approach for health care decisions for those who do not have the competence to do so for themselves. Our estimate of those with Health Care Proxies admitted to the Hospital is far less than 25% although many family members come forth with very specific instructions for their ill relatives. In short, they take a logical view of caring for their loved ones who are ill and often have clear (but not convincing) information about what that ill person would have wanted. When faced with legal barriers (they do not have a written document or health care proxy), they cannot understand why they cannot participate in the critical care of their seriously ill loved one ... Sometimes I hear complaints about New York State's regulations on this issue as compared to the other 48 States that have some form of Family Health Care Decision Acts."

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A sixty year-old man who had been beaten and robbed 25 years ago, was admitted to our hospital.... while at breakfast with several other residents in this supervised housing setting, he suddenly collapsed. As his fellow residents gasped, staff called for an ambulance and began cardiopulmonary resuscitation. However, a pulse could not be restored until he was in the emergency room. Initially, not even the functions of his brain stem, controlling the size of his pupils and the reflexes to blink and to breathe were working. He was dependent on a ventilator... The cardiologists wondered whether continued intensive care was for the best...The ethics committee was consulted... The staff of the housing unit ... felt certain that he would not want to continue the ventilator, but had no authority to decide on his behalf. The patient had no one else in the world to care for him except for them. The staff and directors of this church-affiliated agency were so convinced that continuing the ventilator was wrong that they felt a duty of advocacy—they filed a petition with the courts to appoint them as his medical decision makers. The hospital staff largely agreed with them, so the hospital chose to inform the court that it had no plans to contest such a decision... Unfortunately, it snowed on the day of the original trial date and the case was postponed for another month... In the meantime, the patient still languished on a ventilator in our intensive care unit, brain damaged twice in his life—once by thieves and then a second time by medicine, unable to give him the release that everyone involved suspected he would want.

All because New York State law would not allow anyone to be empowered to act as his legal decision maker. The patient died of recurrent septic shock, still on the ventilator, the day before the court was to hear his case, after sixteen weeks of suffering in the hospital.

We respectfully urge you to pass a unified version of the Family Healthcare Decisions Act. It is time that the Legislature meets the needs of dying patients and their families and brings New York law into the national mainstream regarding end-of-life decision making. Thank you for your thoughtful consideration. Our patients and their families appreciate your advocacy.

STATE OF NEW YORK

7729--D

2009-2010 Regular Sessions

IN ASSEMBLY

April 22, 2009

Introduced by M. of A. GOTTFRIED, SCHIMMINGER, BACALLES, BARRON, BOYLAND, BRENNAN, CAHILL, CASTRO, DelMONTE, DINOWITZ, FINCH, GABRYSZAK, GALEF, GUNTHER, JAFFEE, KELLNER, KOON, LANCMAN, V. LOPEZ, MAGNARELLI, PEOPLES-STOKES, SPANO, STIRPE, TOWNS, SCHROEDER, BRODSKY, HOYT, PERRY, CONTE, CHRISTENSEN -- Multi-Sponsored by -- M. of A. ABBATE, ALESSI, AUBRY, BENEDETTO, BING, BURLING, CALHOUN, CLARK, COOK, CROUCH, CYMBROWITZ, DESTITO, DUPREY, ENGLEBRIGHT, FIELDS, GANTT, GIANARIS, GIGLIO, GLICK, HIKIND, HOOPER, JACOBS, JOHN, LATIMER, LAVINE, LIFTON, LUPARDO, MAGEE, MAISEL, MARKEY, MAYERSOHN, McDONOUGH, McENENY, MENG, MILLMAN, MOLINARO, MORELLE, NOLAN, O'DONNELL, ORTIZ, PAULIN, PHEFFER, PRETLOW, REILLY, N. RIVERA, P. RIVERA, ROBINSON, ROSENTHAL, SCARBOROUGH, SCHIMEL, SKARTADOS, SWEENEY, THIELE, TITONE, WEINSTEIN, WEISENBERG, WRIGHT, ZEBROWSKI -- read once and referred to the Committee on Health -- reported and referred to the Committee on Codes -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee -- again reported from said committee with amendments, ordered reprinted as amended and recommitted to said committee -- again reported from said committee with amendments, ordered reprinted as amended and recommitted to said committee -- recommitted to the Committee on Health in accordance with Assembly Rule 3, sec. 2 -- reported and referred to the Committee on Codes -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

AN ACT to amend the public health law, the mental hygiene law and the surrogate's court procedure act, in relation to establishing procedures for making medical treatment decisions on behalf of persons who lack the capacity to decide about treatment for themselves; directing the New York state task force on life and law to form a special advisory committee to consider the procedures and practices for withholding or withdrawal of life sustaining treatment for patients with mental illness or mental retardation and developmental disabilities; and to repeal certain provisions of the public health law and the mental hygiene law relating thereto

EXPLANATION--Matter in ***italics*** (underscored) is new; matter in brackets [-] is old law to be omitted.

LBD05935-16-0

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. Legislative intent. Under article 29-C of the public health law, competent adults have a powerful way to control their medical treatment even after they lose decision-making capacity, by appointing someone they trust to decide on their behalf. This legislation fills a gap that remains in New York law. It adds, inter alia, a new article 29-CC to the public health law, which establishes a decision-making process, applicable to decisions in general hospitals and nursing homes, whereby a surrogate is selected and empowered to make health care decisions for patients who lack capacity to make their own health care decisions and who have not otherwise appointed an agent to make health care decisions pursuant to article 29-C of the public health law or provided clear and convincing evidence of their treatment wishes.

The legislature does not intend to encourage or discourage any particular health care decision or treatment, or to create or expand a substantive right of competent adults to decide about treatment for themselves, or to impair the right of patients to object to treatment under applicable law including court decisions. Further, the legislature does not intend to authorize a surrogate to deny to the patient personal services that every patient would generally receive, such as appropriate food, water, bed rest, room temperature and hygiene. This legislation establishes a procedure to facilitate responsible decision-making by surrogates on behalf of patients who do not have capacity to make their own health care decisions.

This legislation affirms existing laws and policies that limit individual conduct of patients with or without capacity, including those laws and policies against homicide, suicide, assisted suicide and mercy killing.

§ 2. The public health law is amended by adding two new articles 29-CC and 29-CCC to read as follows:

ARTICLE 29-CC

FAMILY HEALTH CARE DECISIONS ACT

Section 2994-a. Definitions.
2994-b. Applicability; priority of certain other surrogate decision-making laws and regulations.
2994-c. Determination of incapacity.
2994-d. Health care decisions for adult patients by surrogates.
2994-e. Decisions about life-sustaining treatment for minor patients.
2994-f. Obligations of attending physician.
2994-g. Health care decisions for adult patients without surrogates.
2994-i. Specific policies for orders not to resuscitate.
2994-j. Revocation of consent.
2994-k. Implementation and review of decisions.
2994-l. Interinstitutional transfers.
2994-m. Ethics review committees.
2994-n. Conscience objections.
2994-o. Immunity.
2994-p. Liability for health care costs.
2994-q. Effect on other rights.
2994-r. Special proceeding authorized; court orders; health care guardian for minor patient.
2994-s. Remedy.

2994-t. Regulations.
2994-u. Rights to be publicized.

§ 2994-a. Definitions. The following words or phrases, 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 has married.

2. "Attending physician" means a physician, selected by or assigned to a patient pursuant to hospital policy, who has primary responsibility for the treatment and care of the patient. Where more than one physician shares such responsibility, or where a physician is acting on the attending physician's behalf, any such physician may act as an attending physician pursuant to this article.

3. "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 function in the absence of an arrest.

4. "Close friend" means any person, eighteen years of age or older, who is a close friend of the patient, or a relative of the patient (other than a spouse, adult child, parent, brother or sister), who has maintained such regular contact with the patient as to be familiar with the patient's activities, health, and religious or moral beliefs, and who presents a signed statement to that effect to the attending physician.

5. "Decision-making capacity" means the ability to understand and appreciate the nature and consequences of proposed health care, including the benefits and risks of and alternatives to proposed health care, and to reach an informed decision.

6. "Developmental disability" means a developmental disability as defined in subdivision twenty-two of section 1.03 of the mental hygiene law.

7. "Domestic partner" means a person who, with respect to another person:

(a) is formally a party in a domestic partnership or similar relationship with the other person, entered into pursuant to the laws of the United States or of any state, local or foreign jurisdiction, or registered as the domestic partner of the other person with any registry maintained by the employer of either party or any state, municipality, or foreign jurisdiction; or

(b) is formally recognized as a beneficiary or covered person under the other person's employment benefits or health insurance; or

(c) is dependent or mutually interdependent on the other person for support, as evidenced by the totality of the circumstances indicating a mutual intent to be domestic partners including but not limited to: common ownership or joint leasing of real or personal property; common householding, shared income or shared expenses; children in common; signs of intent to marry or become domestic partners under paragraph (a) or (b) of this subdivision; or the length of the personal relationship of the persons.

Each party to a domestic partnership shall be considered to be the domestic partner of the other party. "Domestic partner" shall not include a person who is related to the other person by blood in a manner that would bar marriage to the other person in New York state. "Domestic partner" also shall not include any person who is less than eighteen years of age or who is the adopted child of the other person or who is

related by blood in a manner that would bar marriage in New York state to a person who is the lawful spouse of the other person.

8. "Emancipated minor patient" means a minor patient who is the parent of a child, or who is sixteen years of age or older and living independently from his or her parents or guardian.

9. "Ethics review committee" means the interdisciplinary committee established in accordance with the requirements of section twenty-nine hundred ninety-four-m of this article.

10. "General hospital" means a general hospital as defined in subdivision ten of section twenty-eight hundred one of this chapter excluding a ward, wing, unit or other part of a general hospital operated for the purpose of providing services for persons with mental illness pursuant to an operating certificate issued by the commissioner of mental health.

11. "Guardian of a minor" or "guardian" means a health care guardian or a legal guardian of the person of a minor.

12. "Health care" means any treatment, service, or procedure to diagnose or treat an individual's physical or mental condition. Providing nutrition or hydration orally, without reliance on medical treatment, is not health care under this article and is not subject to this article.

13. "Health care agent" means a health care agent designated by an adult pursuant to article twenty-nine-C of this chapter.

14. "Health care decision" means any decision to consent or refuse to consent to health care.

15. "Health care guardian" means an individual appointed by a court, pursuant to subdivision four of section twenty-nine hundred ninety-four-r of this article, as the guardian of a minor patient solely for the purpose of deciding about life-sustaining treatment pursuant to this article.

16. "Health care provider" means an individual or facility licensed, certified, or otherwise authorized or permitted by law to administer health care in the ordinary course of business or professional practice.

17. "Health or social service practitioner" means a registered professional nurse, nurse practitioner, physician, physician assistant, psychologist or licensed clinical social worker, licensed or certified pursuant to the education law acting within his or her scope of practice.

18. "Hospital" means a general hospital or a residential health care facility.

19. "Life-sustaining treatment" means any medical treatment or procedure without which the patient will die within a relatively short time, as determined by an attending physician to a reasonable degree of medical certainty. For the purpose of this article, cardiopulmonary resuscitation is presumed to be life-sustaining treatment without the necessity of a determination by an attending physician.

20. "Mental hygiene facility" means a facility operated or licensed by the office of mental health or the office of mental retardation and developmental disabilities as defined in subdivision six of section 1.03 of the mental hygiene law.

21. "Mental illness" means a mental illness as defined in subdivision twenty of section 1.03 of the mental hygiene law, and does not include dementia, such as Alzheimer's disease, or other disorders related to dementia.

22. "Minor" means any person who is not an adult.

23. "Order not to resuscitate" means an order not to attempt cardiopulmonary resuscitation in the event a patient suffers cardiac or respiratory arrest.

24. "Parent", for the purpose of a health care decision about a minor patient, means a parent who has custody of, or who has maintained substantial and continuous contact with, the minor patient.

25. "Patient" means a person admitted to a hospital.

26. "Person connected with the case" means the patient, any person on the surrogate list, a parent or guardian of a minor patient, the hospital administrator, an attending physician, any other health or social services practitioner who is or has been directly involved in the patient's care, and any duly authorized state agency, including the facility director or regional director for a patient transferred from a mental hygiene facility and the facility director for a patient transferred from a correctional facility.

27. "Reasonably available" means that a person to be contacted can be contacted with diligent efforts by an attending physician, another person acting on behalf of an attending physician, or the hospital.

28. "Residential health care facility" means a residential health care facility as defined in subdivision three of section twenty-eight hundred one of this chapter.

29. "Surrogate" means the person selected to make a health care decision on behalf of a patient pursuant to section twenty-nine hundred ninety-four-d of this article.

30. "Surrogate list" means the list set forth in subdivision one of section twenty-nine hundred ninety-four-d of this article.

§ 2994-b. Applicability; priority of certain other surrogate decision-making laws and regulations. 1. This article shall apply to health care decisions regarding health care provided in a hospital to a patient who lacks decision-making capacity, except as limited by this section.

2. Prior to seeking or relying upon a health care decision by a surrogate for a patient under this article, the attending physician shall make reasonable efforts to determine whether the patient has a health care agent appointed pursuant to article twenty-nine-C of this chapter. If so, health care decisions for the patient shall be governed by such article, and shall have priority over decisions by any other person except the patient or as otherwise provided in the health care proxy.

3. Prior to seeking or relying upon a health care decision by a surrogate for a patient under this article, if the attending physician has reason to believe that the patient has a history of receiving services for mental retardation or a developmental disability; it reasonably appears to the attending physician that the patient has mental retardation or a developmental disability; or the attending physician has reason to believe that the patient has been transferred from a mental hygiene facility operated or licensed by the office of mental health, then such physician shall make reasonable efforts to determine whether paragraphs (a), (b) or (c) of this subdivision are applicable:

(a) If the patient has a guardian appointed by a court pursuant to article seventeen-A of the surrogate's court procedure act, health care decisions for the patient shall be governed by section seventeen hundred fifty-b of the surrogate's court proceedure act and not by this article.

(b) If a patient does not have a guardian appointed by a court pursuant to article seventeen-A of the surrogate's court procedure act but falls within the class of persons described in paragraph (a) of subdivision one of section seventeen hundred fifty-b of such act, decisions to withdraw or withhold life-sustaining treatment for the patient shall be governed by section seventeen hundred fifty-b of the surrogate's court procedure act and not by this article.

(c) If a health care decision for a patient cannot be made under paragraphs (a) or (b) of this subdivision, but consent for the decision may be provided pursuant to the mental hygiene law or regulations of the office of mental health or the office of mental retardation and developmental disabilities, then the decision shall be governed by such statute or regulations and not by this article.

4. If, after reasonable efforts, it is determined that a health care decision for the patient cannot be made pursuant to subdivision two or three of this section, then the health care decision shall be made pursuant to this article.

§ 2994-c. Determination of incapacity. 1. Presumption of capacity. For purposes of this article, every adult shall be presumed to have decision-making capacity unless determined otherwise pursuant to this section or pursuant to court order, or unless a guardian is authorized to decide about health care for the adult pursuant to article eighty-one of the mental hygiene law.

2. Initial determination by attending physician. An attending physician shall make an initial determination that an adult patient lacks decision-making capacity to a reasonable degree of medical certainty. Such determination shall include an assessment of the cause and extent of the patient's incapacity and the likelihood that the patient will regain decision-making capacity.

3. Concurring determinations. (a) An initial determination that a patient lacks decision-making capacity shall be subject to a concurring determination, independently made, where required by this subdivision. A concurring determination shall include an assessment of the cause and extent of the patient's incapacity and the likelihood that the patient will regain decision-making capacity, and shall be included in the patient's medical record. Hospitals shall adopt written policies identifying the training and credentials of health or social services practitioners qualified to provide concurring determinations of incapacity.

(b) (i) In a residential health care facility, a health or social services practitioner employed by or otherwise formally affiliated with the facility must independently determine whether an adult patient lacks decision-making capacity.

(ii) In a general hospital a health or social services practitioner employed by or otherwise formally affiliated with the facility must independently determine whether an adult patient lacks decision-making capacity if the surrogate's decision concerns the withdrawal or withholding of life-sustaining treatment.

(c) (i) If the attending physician makes an initial determination that a patient lacks decision-making capacity because of mental illness, either such physician must have the following qualifications, or another physician with the following qualifications must independently determine whether the patient lacks decision-making capacity: a physician licensed to practice medicine in New York state, who is a diplomate or eligible to be certified by the American Board of Psychiatry and Neurology or who is certified by the American Osteopathic Board of Neurology and Psychiatry or is eligible to be certified by that board. A record of such consultation shall be included in the patient's medical record.

(ii) If the attending physician makes an initial determination that a patient lacks decision-making capacity because of mental retardation or a developmental disability, either such physician must have the following qualifications, or another professional with the following qualifications must independently determine whether the patient lacks decision-making capacity: a physician or clinical psychologist who either is

employed by a school named in section 13.17 of the mental hygiene law, or who has been employed for a minimum of two years to render care and service in a facility operated or licensed by the office of mental retardation and developmental disabilities, or who has been approved by the commissioner of mental retardation and developmental disabilities in accordance with regulations promulgated by such commissioner. Such regulations shall require that a physician or clinical psychologist possess specialized training or three years experience in treating developmental disabilities. A record of such consultation shall be included in the patient's medical record.

(d) If an attending physician has determined that the patient lacks decision-making capacity and if the health or social services practitioner consulted for a concurring determination disagrees with the attending physician's determination, the matter shall be referred to the ethics review committee if it cannot otherwise be resolved.

4. Informing the patient and surrogate. Notice of a determination that a surrogate will make health care decisions because the adult patient has been determined to lack decision-making capacity shall promptly be given:

(a) to the patient, where there is any indication of the patient's ability to comprehend the information;

(b) to at least one person on the surrogate list highest in order of priority listed when persons in prior classes are not reasonably available pursuant to subdivision one of section twenty-nine hundred ninety-four-d of this article;

(c) if the patient was transferred from a mental hygiene facility, to the director of the mental hygiene facility and to the mental hygiene legal service under article forty-seven of the mental hygiene law.

5. Limited purpose of determination. A determination made pursuant to this section that an adult patient lacks decision-making capacity shall not be construed as a finding that the patient lacks capacity for any other purpose.

6. Priority of patient's decision. Notwithstanding a determination pursuant to this section that an adult patient lacks decision-making capacity, if the patient objects to the determination of incapacity, or to the choice of a surrogate or to a health care decision made by a surrogate or made pursuant to section twenty-nine hundred ninety-four-g of this article, the patient's objection or decision shall prevail unless: (a) a court of competent jurisdiction has determined that the patient lacks decision-making capacity or the patient is or has been adjudged incompetent for all purposes and, in the case of a patient's objection to treatment, makes any other finding required by law to authorize the treatment, or (b) another legal basis exists for overriding the patient's decision.

7. Confirmation of continued lack of decision-making capacity. An attending physician shall confirm the adult patient's continued lack of decision-making capacity before complying with health care decisions made pursuant to this article, other than those decisions made at or about the time of the initial determination. A concurring determination of the patient's continued lack of decision-making capacity shall be required if the subsequent health care decision concerns the withholding or withdrawal of life-sustaining treatment. Health care providers shall not be required to inform the patient or surrogate of the confirmation.

§ 2994-d. Health care decisions for adult patients by surrogates. 1. Identifying the surrogate. One person from the following list from the class highest in priority when persons in prior classes are not reason-

ably available, willing, and competent to act, shall be the surrogate for an adult patient who lacks decision-making capacity. However, such person may designate any other person on the list to be surrogate, provided no one in a class higher in priority than the person designated objects:

(a) A guardian authorized to decide about health care pursuant to article eighty-one of the mental hygiene law;

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

(c) A son or daughter eighteen years of age or older;

(d) A parent;

(e) A brother or sister eighteen years of age or older;

(f) A close friend.

2. Restrictions on who may be a surrogate. An operator, administrator, or employee of a hospital or a mental hygiene facility from which the patient was transferred, or a physician who has privileges at the hospital or a health care provider under contract with the hospital may not serve as the surrogate for any adult who is a patient of such hospital, unless such individual is related to the patient by blood, marriage, domestic partnership, or adoption, or is a close friend of the patient whose friendship with the patient preceded the patient's admission to the facility. If a physician serves as surrogate, the physician shall not act as the patient's attending physician after his or her authority as surrogate begins.

3. Authority and duties of surrogate. (a) Scope of surrogate's authority.

(i) Subject to the standards and limitations of this article, the surrogate shall have the authority to make any and all health care decisions on the adult patient's behalf that the patient could make.

(ii) Nothing in this article shall obligate health care providers to seek the consent of a surrogate if an adult patient has already made a decision about the proposed health care, expressed orally or in writing or, with respect to a decision to withdraw or withhold life-sustaining treatment expressed either orally during hospitalization in the presence of two witnesses eighteen years of age or older, at least one of whom is a health or social services practitioner affiliated with the hospital, or in writing. If an attending physician relies on the patient's prior decision, the physician shall record the prior decision in the patient's medical record. If a surrogate has already been designated for the patient, the attending physician shall make reasonable efforts to notify the surrogate prior to implementing the decision; provided that in the case of a decision to withdraw or withhold life-sustaining treatment, the attending physician shall make diligent efforts to notify the surrogate and, if unable to notify the surrogate, shall document the efforts that were made to do so.

(b) Commencement of surrogate's authority. The surrogate's authority shall commence upon a determination, made pursuant to section twenty-nine hundred ninety-four-c of this article, that the adult patient lacks decision-making capacity and upon identification of a surrogate pursuant to subdivision one of this section. In the event an attending physician determines that the patient has regained decision-making capacity, the authority of the surrogate shall cease.

(c) Right and duty to be informed. Notwithstanding any law to the contrary, the surrogate shall have the right to receive medical information and medical records necessary to make informed decisions about the patient's health care. Health care providers shall provide and the

surrogate shall seek information necessary to make an informed decision, including information about the patient's diagnosis, prognosis, the nature and consequences of proposed health care, and the benefits and risks of and alternative to proposed health care.

4. Decision-making standards. (a) The surrogate shall make health care decisions:

(i) in accordance with the patient's wishes, including the patient's religious and moral beliefs; or

(ii) if the patient's wishes are not reasonably known and cannot with reasonable diligence be ascertained, in accordance with the patient's best interests. An assessment of the patient's best interests shall include: consideration of the dignity and uniqueness of every person; the possibility and extent of preserving the patient's life; the preservation, improvement or restoration of the patient's health or functioning; the relief of the patient's suffering; and any medical condition and such other concerns and values as a reasonable person in the patient's circumstances would wish to consider.

(b) In all cases, the surrogate's assessment of the patient's wishes and best interests shall be patient-centered; health care decisions shall be made on an individualized basis for each patient, and shall be consistent with the values of the patient, including the patient's religious and moral beliefs, to the extent reasonably possible.

5. Decisions to withhold or withdraw life-sustaining treatment. In addition to the standards set forth in subdivision four of this section, decisions by surrogates to withhold or withdraw life-sustaining treatment shall be authorized only if the following conditions are satisfied, as applicable:

(a)(i) Treatment would be an extraordinary burden to the patient and an attending physician determines, with the independent concurrence of another physician, that, to a reasonable degree of medical certainty and in accord with accepted medical standards, (A) the patient has an illness or injury which can be expected to cause death within six months, whether or not treatment is provided; or (B) the patient is permanently unconscious; or

(ii) The provision of treatment would involve such pain, suffering or other burden that it would reasonably be deemed inhumane or extraordinarily burdensome under the circumstances and the patient has an irreversible or incurable condition, as determined by an attending physician with the independent concurrence of another physician to a reasonable degree of medical certainty and in accord with accepted medical standards.

(b) In a residential health care facility, a surrogate shall have the authority to refuse life-sustaining treatment under subparagraph (ii) of paragraph (a) of this subdivision only if the ethics review committee, including at least one physician who is not directly responsible for the patient's care, or a court of competent jurisdiction, reviews the decision and determines that it meets the standards set forth in this article. This requirement shall not apply to a decision to withhold cardiopulmonary resuscitation.

(c) In a general hospital, if the attending physician objects to a surrogate's decision, under subparagraph (ii) of paragraph (a) of this subdivision, to withdraw or withhold nutrition and hydration provided by means of medical treatment, the decision shall not be implemented until the ethics review committee, including at least one physician who is not directly responsible for the patient's care, or a court of competent jurisdiction, reviews the decision and determines that it meets the

standards set forth in this subdivision and subdivision four of this section.

(d) Providing nutrition and hydration orally, without reliance on medical treatment, is not health care under this article and is not subject to this article.

(e) Expression of decisions. The surrogate shall express a decision to withdraw or withhold life-sustaining treatment either orally to an attending physician or in writing.

§ 2994-e. Decisions about life-sustaining treatment for minor patients. 1. Authority of parent or guardian. The parent or guardian of a minor patient shall have the authority to make decisions about life-sustaining treatment, including decisions to withhold or withdraw such treatment, subject to the provisions of this section and subdivision five of section twenty-nine hundred ninety-four-d of this article.

2. Decision-making standards and procedures for minor patient. (a) The parent or guardian of a minor patient shall make decisions in accordance with the minor's best interests, consistent with the standards set forth in subdivision four of section twenty-nine hundred ninety-four-d of this article, taking into account the minor's wishes as appropriate under the circumstances.

(b) An attending physician, in consultation with a minor's parent or guardian, shall determine whether a minor patient has decision-making capacity for a decision to withhold or withdraw life-sustaining treatment. If the minor has such capacity, a parent's or guardian's decision to withhold or withdraw life-sustaining treatment for the minor may not be implemented without the minor's consent.

(c) Where a parent or guardian of a minor patient has made a decision to withhold or withdraw life-sustaining treatment and an attending physician has reason to believe that the minor patient has a parent or guardian who has not been informed of the decision, including a non-custodial parent or guardian, an attending physician or someone acting on his or her behalf, shall make reasonable efforts to determine if the uninformed parent or guardian has maintained substantial and continuous contact with the minor and, if so, shall make diligent efforts to notify that parent or guardian prior to implementing the decision.

3. Decision-making standards and procedures for emancipated minor patient. (a) If an attending physician determines that a patient is an emancipated minor patient with decision-making capacity, the patient shall have the authority to decide about life-sustaining treatment. Such authority shall include a decision to withhold or withdraw life-sustaining treatment if an attending physician and the ethics review committee determine that the decision accords with the standards for surrogate decisions for adults, and the ethics review committee approves the decision.

(b) If the hospital can with reasonable efforts ascertain the identity of the parents or guardian of an emancipated minor patient, the hospital shall notify such persons prior to withholding or withdrawing life-sustaining treatment pursuant to this subdivision.

§ 2994-f. Obligations of attending physician. 1. An attending physician informed of a decision to withdraw or withhold life-sustaining treatment made pursuant to the standards of this article shall record the decision in the patient's medical record, review the medical basis for the decision, and shall either: (a) implement the decision, or (b) promptly make his or her objection to the decision and the reasons for the objection known to the decision-maker, 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 ethics review committee.

2. If an attending physician has actual notice of the following objections or disagreements, he or she shall promptly refer the matter to the ethics review committee if the objection or disagreement cannot otherwise be resolved:

(a) A health or social services practitioner consulted for a concurring determination that an adult patient lacks decision-making capacity disagrees with the attending physician's determination; or

(b) Any person on the surrogate list objects to the designation of the surrogate pursuant to subdivision one of section twenty-nine hundred ninety-four-d of this article; or

(c) Any person on the surrogate list objects to a surrogate's decision; or

(d) A parent or guardian of a minor patient objects to the decision by another parent or guardian of the minor; or

(e) A minor patient refuses life-sustaining treatment, and the minor's parent or guardian wishes the treatment to be provided, or the minor patient objects to an attending physician's determination about decision-making capacity or recommendation about life-sustaining treatment.

3. Notwithstanding the provisions of this section or subdivision one of section twenty-nine hundred ninety-four-q of this article, if a surrogate directs the provision of life-sustaining treatment, the denial of which in reasonable medical judgment would be likely to result in the death of the patient, a hospital or individual health care provider that does not wish to provide such treatment shall nonetheless comply with the surrogate's decision pending either transfer of the patient to a willing hospital or individual health care provider, or judicial review in accordance with section twenty-nine hundred ninety-four-r of this article.

§ 2994-g. Health care decisions for adult patients without surrogates. 1. Identifying adult patients without surrogates. Within a reasonable time after admission as an inpatient to the hospital of each adult patient, the hospital shall make reasonable efforts to determine if the patient has appointed a health care agent or has a guardian, or if at least one individual is available to serve as the patient's surrogate in the event the patient lacks or loses decision-making capacity. With respect to a patient who lacks capacity, if no such health care agent, guardian or potential surrogate is identified, the hospital shall identify, to the extent reasonably possible, the patient's wishes and preferences, including the patient's religious and moral beliefs, about pending health care decisions, and shall record its findings in the patient's medical record.

2. Decision-making standards and procedures. (a) The procedures specified in this and the following subdivisions of this section apply to health care decisions for adult patients who would qualify for surrogate decision-making under this article but for whom no surrogate is reasonably available, willing or competent to act.

(b) Any health care decision made pursuant to this section shall be made in accordance with the standards set forth in subdivision four of section twenty-nine hundred ninety-four-d of this article and shall not be based on the financial interests of the hospital or any other health care provider. The specific procedures to be followed depend on whether the decision involves routine medical treatment, major medical treatment, or the withholding or withdrawal of life-sustaining treatment, and the location where the treatment is provided.

3. Routine medical treatment. (a) For purposes of this subdivision, "routine medical treatment" means any treatment, service, or procedure to diagnose or treat an individual's physical or mental condition, such as the administration of medication, the extraction of bodily fluids for analysis, or dental care performed with a local anesthetic, for which health care providers ordinarily do not seek specific consent from the patient or authorized representative. It shall not include the long-term provision of treatment such as ventilator support or a nasogastric tube but shall include such treatment when provided as part of post-operative care or in response to an acute illness and recovery is reasonably expected within one month or less.

(b) An attending physician shall be authorized to decide about routine medical treatment for an adult patient who has been determined to lack decision-making capacity pursuant to section twenty-nine hundred ninety-four-c of this article. Nothing in this subdivision shall require health care providers to obtain specific consent for treatment where specific consent is not otherwise required by law.

4. Major medical treatment. (a) For purposes of this subdivision, "major medical treatment" means any treatment, service or procedure to diagnose or treat an individual's physical or mental condition: (i) where general anesthetic is used; or (ii) which involves any significant risk; or (iii) which involves any significant invasion of bodily integrity requiring an incision, producing substantial pain, discomfort, debilitation or having a significant recovery period; or (iv) which involves the use of physical restraints, as specified in regulations promulgated by the commissioner, except in an emergency; or (v) which involves the use of psychoactive medications, except when provided as part of post-operative care or in response to an acute illness and treatment is reasonably expected to be administered over a period of forty-eight hours or less, or when provided in an emergency.

(b) A decision to provide major medical treatment, made in accordance with the following requirements, shall be authorized for an adult patient who has been determined to lack decision-making capacity pursuant to section twenty-nine hundred ninety-four-c of this article.

(i) An attending physician shall make a recommendation in consultation with hospital staff directly responsible for the patient's care.

(ii) In a general hospital, at least one other physician designated by the hospital must independently determine that he or she concurs that the recommendation is appropriate.

(iii) In a residential health care facility the medical director of the facility, or a physician designated by the medical director, must independently determine that he or she concurs that the recommendation is appropriate; provided that if the medical director is the patient's attending physician, a different physician designated by the residential health care facility must make this independent determination. Any health or social services practitioner employed by or otherwise formally affiliated with the facility may provide a second opinion for decisions about physical restraints made pursuant to this subdivision.

5. Decisions to withhold or withdraw life-sustaining treatment. (a) A court of competent jurisdiction may make a decision to withhold or withdraw life-sustaining treatment for an adult patient who has been determined to lack decision-making capacity pursuant to section twenty-nine hundred ninety-four-c of this article if the court finds that the decision accords with standards for decisions for adults set forth in subdivisions four and five of section twenty-nine hundred ninety-four-d of this article.

(b) If the attending physician, with independent concurrence of a second physician designated by the hospital, determines to a reasonable degree of medical certainty that:

(i) life-sustaining treatment offers the patient no medical benefit because the patient will die imminently, even if the treatment is provided; and

(ii) the provision of life-sustaining treatment would violate accepted medical standards, then such treatment may be withdrawn or withheld from an adult patient who has been determined to lack decision-making capacity pursuant to section twenty-nine hundred ninety-four-c of this article, without judicial approval. This paragraph shall not apply to any treatment necessary to alleviate pain or discomfort.

6. Physician objection. If a physician consulted for a concurring opinion objects to an attending physician's recommendation or determination made pursuant to this section, or a member of the hospital staff directly responsible for the patient's care objects to an attending physician's recommendation about major medical treatment or treatment without medical benefit, the matter shall be referred to the ethics review committee if it cannot be otherwise resolved.

§ 2994-i. Specific policies for orders not to resuscitate. An order not to resuscitate shall be written in the patient's medical record. Consent to an order not to resuscitate shall not constitute consent to withhold or withdraw treatment other than cardiopulmonary resuscitation.

§ 2994-j. Revocation of consent. 1. A patient, surrogate, or parent or guardian of a minor patient may at any time revoke his or her consent to withhold or withdraw life-sustaining treatment by informing an attending physician or a member of the medical or nursing staff of the revocation.

2. An attending physician informed of a revocation of consent made pursuant to this section shall immediately:

(a) record the revocation in the patient's medical record;

(b) cancel any orders implementing the decision to withhold or withdraw treatment; and

(c) notify the hospital staff directly responsible for the patient's care of the revocation and any cancellations.

3. Any member of the medical or nursing staff informed of a revocation made pursuant to this section shall immediately notify an attending physician of the revocation.

§ 2994-k. Implementation and review of decisions. 1. Hospitals shall adopt written policies requiring implementation and regular review of decisions to withhold or withdrew life-sustaining treatment in accordance with accepted medical standards. Hospitals shall also develop policies in accord with accepted medical standards regarding documentation of clinical determinations and decisions by surrogates and health care providers pursuant to this article.

2. If a decision to withhold or withdraw life-sustaining treatment has been made pursuant to this article, and an attending physician determines at any time that the decision is no longer appropriate or authorized because the patient has regained decision-making capacity or because the patient's condition has otherwise improved, the physician shall immediately:

(a) include such determination in the patient's medical record;

(b) cancel any orders or plans of care implementing the decision to withhold or withdraw life-sustaining treatment;

(c) notify the person who made the decision to withhold or withdraw treatment, or, if that person is not reasonably available, to at least one person on the surrogate list highest in order of priority listed

when persons in prior classes are not reasonably available pursuant to subdivision one of section twenty-nine hundred ninety-four-d of this article; and

(d) notify the hospital staff directly responsible for the patient's care of any cancelled orders or plans of care.

§ 2994-l. Interinstitutional transfers. If a patient with an order to withhold or withdraw life-sustaining treatment is transferred from a mental hygiene facility to a hospital or from a hospital to a different hospital, any such order or plan shall remain effective until an attending physician first examines the transferred patient, whereupon an attending physician must either:

1. Issue appropriate orders to continue the prior order or plan. Such orders may be issued without obtaining another consent to withhold or withdraw life-sustaining treatment pursuant to this article; or

2. Cancel such order, if the attending physician determines that the order is no longer appropriate or authorized. Before canceling the order the attending physician shall make reasonable efforts to notify the person who made the decision to withhold or withdraw treatment and the hospital staff directly responsible for the patient's care of any such cancellation. If such notice cannot reasonably be made prior to canceling the order or plan, the attending physician shall make such notice as soon as reasonably practicable after cancellation.

§ 2994-m. Ethics review committees. 1. Establishment of an ethics review committee, written policy. Each hospital shall establish at least one ethics review committee or participate in an ethics review committee that serves more than one hospital, and shall adopt a written policy governing committee functions, composition, and procedure, in accordance with the requirements of this article. A hospital may designate an existing committee, or subcommittee thereof, to carry out the functions of the ethics review committee provided the requirements of this section are satisfied.

2. Functions of the ethics review committee. (a) The ethics review committee shall consider and respond to any health care matter presented to it by a person connected with the case.

(b) The ethics review committee response to a health care matter may include:

(i) providing advice on the ethical aspects of proposed health care;

(ii) making a recommendation about proposed health care; or

(iii) providing assistance in resolving disputes about proposed health care.

(c) Recommendations and advice by the ethics review committee shall be advisory and nonbinding, except as specified in subdivision five of section twenty-nine hundred ninety-four-d of this article and subdivision three of section twenty-nine hundred ninety-four-e of this article.

3. Committee membership. The membership of ethics review committees must be interdisciplinary and must include at least five members who have demonstrated an interest in or commitment to patient's rights or to the medical, public health, or social needs of those who are ill. At least three ethics review committee members must be health or social services practitioners, at least one of whom must be a registered nurse and one of whom must be a physician. At least one member must be a person without any governance, employment or contractual relationship with the hospital. In a residential health care facility the facility must offer the residents' council of the facility (or of another facility that participates in the committee) the opportunity to appoint up to two persons to the ethics review committee, none of whom may be a resi-

dent of or a family member of a resident of such facility, and both of whom shall be persons who have expertise in or a demonstrated commitment to patient rights or to the care and treatment of the elderly or nursing home residents through professional or community activities, other than activities performed as a health care provider.

4. Procedures for ethics review committee. (a) These procedures are required only when: (i) the ethics review committee is convened to review a decision by a surrogate to withhold or withdraw life-sustaining treatment for: (A) a patient in a residential health care facility pursuant to paragraph (b) of subdivision five of section twenty-nine hundred ninety-four-d of this article; (B) a patient in a general hospital pursuant to paragraph (c) of subdivision five of section twenty-nine hundred ninety-four-d of this article; or (C) an emancipated minor patient pursuant to subdivision three of section twenty-nine hundred ninety-four-e of this article; or (ii) when a person connected with the case requests the ethics review committee to provide assistance in resolving a dispute about proposed care. Nothing in this section shall bar health care providers from first striving to resolve disputes through less formal means, including the informal solicitation of ethical advice from any source.

(b)(i) A person connected with the case may not participate as an ethics review committee member in the consideration of that case.

(ii) The ethics review committee shall respond promptly, as required by the circumstances, to any request for assistance in resolving a dispute or consideration of a decision to withhold or withdraw life-sustaining treatment pursuant to paragraphs (b) and (c) of subdivision five of section twenty-nine hundred ninety-four-d of this article made by a person connected with the case. The committee shall permit persons connected with the case to present their views to the committee, and to have the option of being accompanied by an advisor when participating in a committee meeting.

(iii) The ethics review committee shall promptly provide the patient, where there is any indication of the patient's ability to comprehend the information, the surrogate, other persons on the surrogate list directly involved in the decision or dispute regarding the patient's care, any parent or guardian of a minor patient directly involved in the decision or dispute regarding the minor patient's care, an attending physician, the hospital, and other persons the committee deems appropriate, with the following:

(A) notice of any pending case consideration concerning the patient, including, for patients, persons on the surrogate list, parents and guardians, information about the ethics review committee's procedures, composition and function; and

(B) the committee's response to the case, including a written statement of the reasons for approving or disapproving the withholding or withdrawal of life-sustaining treatment for decisions considered pursuant to subparagraph (ii) of paragraph (a) of subdivision five of section twenty-nine hundred ninety-four-d of this article. The committee's response to the case shall be included in the patient's medical record.

(iv) Following ethics review committee consideration of a case concerning the withdrawal or withholding of life-sustaining treatment, treatment shall not be withdrawn or withheld until the persons identified in subparagraph (iii) of this paragraph have been informed of the committee's response to the case.

5. Access to medical records and information; patient confidentiality. Ethics review committee members and consultants shall have access to

medical information and medical records necessary to perform their function under this article. Any such information or records disclosed to committee members, consultants, or others shall be kept confidential except to the extent necessary to accomplish the purposes of this article or as otherwise provided by law.

6. Ethics review committee confidentiality. Notwithstanding any other provisions of law, the proceedings and records of an ethics review committee shall be kept confidential and shall not be released by committee members, committee consultants, or other persons privy to such proceedings and records; the proceedings and records of an ethics review committee shall not be subject to disclosure or inspection in any manner, including under article six of the public officers law or article thirty-one of the civil practice law and rules; and, no person shall testify as to the proceedings or records of an ethics review committee, nor shall such proceedings and records otherwise be admissible as evidence in any action or proceeding of any kind in any court or before any other tribunal, board, agency or person, except that:

(a) Ethics review committee proceedings and records, in cases where a committee approves or disapproves of the withholding or withdrawal of life-sustaining treatment pursuant to subdivision five of section twenty-nine hundred ninety-four-d of this article, or subdivision three of section twenty-nine hundred ninety-four-e of this article, may be obtained by or released to the department;

(b) Nothing in this subdivision shall prohibit the patient, the surrogate, other persons on the surrogate list, or a parent or guardian of a minor patient from voluntarily disclosing, releasing or testifying about committee proceedings or records; and

(c) Nothing in this subdivision shall prohibit the state commission on quality of care and advocacy for persons with disabilities or any agency or person within or under contract with the commission which provides protection and advocacy services from requiring any information, report or record from a hospital in accordance with the provisions of section 45.09 of the mental hygiene law.

§ 2994-n. Conscience objections. 1. Private hospitals. Nothing in this article shall be construed to require a private hospital to honor a health care decision made pursuant to this article if:

(a) The decision is contrary to a formally adopted policy of the hospital that is expressly based on sincerely held religious beliefs or sincerely held moral convictions central to the facility's operating principles;

(b) The hospital has informed the patient, family, or surrogate of such policy prior to or upon admission, if reasonably possible; and

(c) The patient is transferred promptly to another hospital that is reasonably accessible under the circumstances and willing to honor the decision and pending transfer the hospital complies with subdivision three of section twenty-nine hundred ninety-four-f of this article. If the patient's family or surrogate is unable or unwilling to arrange such a transfer, the hospital may intervene to facilitate such a transfer. If such a transfer is not effected, the hospital shall seek judicial relief in accordance with section twenty-nine hundred ninety-four-r of this article or honor the decision.

2. Individual health care providers. Nothing in this article shall be construed to require an individual as a health care provider to honor a health care decision made pursuant to this article if:

(a) the decision is contrary to the individual's sincerely held religious beliefs or sincerely held moral conviction; and

(b) the individual health care provider promptly informs the person who made the decision and the hospital of his or her refusal to honor the decision. In such event, the hospital shall promptly transfer responsibility for the patient to another individual health care provider willing to honor the decision. The individual health care provider shall cooperate in facilitating such transfer and comply with subdivision three of section twenty-nine hundred ninety-four-f of this article.

§ 2994-o. Immunity. 1. Ethics review committee. No person shall be subject to criminal or civil liability, or be deemed to have engaged in unprofessional conduct, for acts performed reasonably and in good faith pursuant to this article as a member of or as a consultant to an ethics review committee or as a participant in an ethics review committee meeting.

2. Providers. No health care provider or employee thereof shall be subjected to criminal or civil liability, or be deemed to have engaged in unprofessional conduct, for honoring reasonably and in good faith a health care decision made pursuant to this article or for other actions taken reasonably and in good faith pursuant to this article.

3. Surrogates and guardians. No person shall be subjected to criminal or civil liability for making a health care decision reasonably and in good faith pursuant to this article or for other actions taken reasonably and in good faith pursuant to this article.

§ 2994-p. Liability for health care costs. Liability for the cost of health care provided to an adult patient pursuant to this article shall be the same as if the health care were provided pursuant to the patient's decision. No person shall become liable for the cost of health care for a minor solely by virtue of making a decision as a guardian of a minor pursuant to this article.

§ 2994-q. Effect on other rights. 1. Nothing in this article creates, expands, diminishes, impairs, or supersedes any authority that an individual may have under law to make or express decisions, wishes, or instructions regarding health care on his or her own behalf, including decisions about life-sustaining treatment.

2. Nothing in this article shall affect existing law concerning implied consent to health care in an emergency.

3. Nothing in this article is intended to permit or promote suicide, assisted suicide, or euthanasia.

4. This article shall not affect existing law with respect to sterilization.

5. Nothing in this article diminishes the duty of parents and legal guardians under existing law to consent to treatment for minors.

§ 2994-r. Special proceeding authorized; court orders; health care guardian for minor patient. 1. Special proceeding. Any person connected with the case and any member of the hospital ethics review committee may commence a special proceeding pursuant to article four of the civil practice law and rules in a court of competent jurisdiction with respect to any matter arising under this article.

2. Court orders designating surrogate. A court of competent jurisdiction may designate any individual from the surrogate list to act as surrogate, regardless of that individual's priority on the list, if the court determines that such appointment would best accord with the patient's wishes or, if the patient's wishes are not reasonably known, with the patient's best interests. Unless otherwise determined by a court, no surrogate decision made prior to an order designating a surrogate shall be deemed to have been invalid because of the issuance of a designating order.

3. Court orders to withhold or withdraw life-sustaining treatment. A court of competent jurisdiction may authorize the withholding or withdrawal of life-sustaining treatment from a person if the court determines that the person lacks decision-making capacity, and withdrawing or withholding the treatment would accord with the standards set forth in subdivision five of section twenty-nine hundred ninety-four-d of this article.

4. Health care guardian for a minor patient. (a) No appointment shall be made pursuant to this subdivision if a parent or legal guardian of the person is available, willing, and competent to decide about treatment for the minor.

(b) The following persons may commence a special proceeding in a court of competent jurisdiction to seek appointment as the health care guardian of a minor patient solely for the purpose of deciding about life-sustaining treatment pursuant to this article:

(i) the hospital administrator;

(ii) an attending physician;

(iii) the local commissioner of social services or the local commissioner of health, authorized to make medical treatment decisions for the minor pursuant to section three hundred eighty-three-b of the social services law; or

(iv) an individual, eighteen years of age or older, who has assumed care of the minor for a substantial and continuous period of time.

(c) Notice of the proceeding shall be given to the persons identified in section seventeen hundred five of the surrogate's court procedure act.

(d) Notwithstanding any other provision of law, seeking appointment or being appointed as a health care guardian shall not otherwise affect the legal status or rights of the individual seeking or obtaining such appointment.

§ 2994-s. Remedy. 1. Any hospital or attending physician that refuses to honor a health care decision by a surrogate made pursuant to this article and in accord with the standards set forth in this article shall not be entitled to compensation for treatment, services, or procedures refused by the surrogate, except that this subdivision shall not apply:

(a) when a hospital or physician exercises the rights granted by section twenty-nine hundred ninety-four-n of this article, provided that the physician or hospital promptly fulfills the obligations set forth in section twenty-nine hundred ninety-four-n of this article;

(b) while a matter is under consideration by the ethics review committee, provided that the matter is promptly referred to and considered by the committee;

(c) in the event of a dispute between individuals on the surrogate list; or

(d) if the physician or hospital prevails in any litigation concerning the surrogate's decision to refuse the treatment, services or procedure. Nothing in this section shall determine or affect how disputes among individuals on the surrogate list are resolved.

2. The remedy provided in this section is in addition to and cumulative with any other remedies available at law or in equity or by administrative proceedings to a patient, a health care agent appointed pursuant to article twenty-nine-C of this chapter, or a person authorized to make health care decisions pursuant to this article, including injunctive and declaratory relief, and any other provisions of this chapter governing fines, penalties, or forfeitures.

§ 2994-t. Regulations. 1. The commissioner shall establish such regulations as may be necessary to implement this article.

2. The commissioner, in consultation with the commissioners of the office of mental health and the office of mental retardation and developmental disabilities, shall promulgate regulations identifying the credentials of health care professionals qualified to provide an independent determination, pursuant to subdivision three of section twenty-nine hundred ninety-four-c of this article, that a patient lacks decision-making capacity because of mental illness or developmental disability.

§ 2994-u. Rights to be publicized. The commissioner shall prepare a statement summarizing the rights, duties, and requirements of this article and shall require that a copy of such statement be furnished to patients or to persons on the surrogate list known to the hospital, or to the parents or guardians of minor patients, at or prior to admission to the hospital, or within a reasonable time thereafter, and to each member of the hospital's staff directly involved with patient care.

ARTICLE 29-CCC
NONHOSPITAL ORDERS NOT TO RESUSCITATE

§ 2994-aa. Definitions. 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 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 a nonhospital 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. Such term shall not include measures to improve ventilation and cardiac function in the absence of an arrest.

5. "Emergency medical services personnel" means the personnel of a service or agency engaged in providing initial emergency medical assistance, including but not limited to first responders, emergency medical technicians, advanced emergency medical technicians and 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. "Health care agent" means a health care agent of the patient designated pursuant to article twenty-nine-C of this chapter.

7. "Health or social services practitioner" means a registered professional nurse, nurse practitioner, physician, physician assistant, psychologist or certified, licensed master social worker or licensed

clinical social worker, licensed or certified pursuant to the education law, acting within his or her scope of practice.

8. "Home care services agency" means an entity certified, licensed or exempt under article thirty-six of this chapter.

9. "Hospice" means a hospice as defined in article forty of this chapter.

10. "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.

11. "Hospital emergency services 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 physician assistants assigned to the general hospital's emergency service.

12. "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.

13. "Nonhospital order not to resuscitate" means an order that directs emergency medical services personnel and hospital emergency services personnel not to attempt cardiopulmonary resuscitation in the event a patient suffers cardiac or respiratory arrest.

14. "Patient" means a person who has been or who may be issued a nonhospital order not to resuscitate.

15. "Surrogate" means a person authorized to make a health care decision on behalf of a patient pursuant to article twenty-nine-CC of this chapter.

§ 2994-bb. General provisions. 1. (a) Emergency medical services personnel, home care services agency personnel, hospice personnel, and hospital emergency services personnel shall honor nonhospital orders not to resuscitate, except as provided in section twenty-nine hundred ninety-four-ee of this article.

(b) A nonhospital order not to resuscitate shall not constitute an order to withhold or withdraw treatment other than cardiopulmonary resuscitation.

2. A nonhospital 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.

§ 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 correctional services 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.

§ 2994-dd. Managing a nonhospital order not to resuscitate. 1. The attending physician shall record the issuance of a nonhospital order not to resuscitate in the patient's medical record.

2. A nonhospital 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 nonhospital 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 nonhospital order not to resuscitate or for providing health care services.

3. An attending physician who has issued a nonhospital order not to resuscitate, and who transfers care of the patient to another physician, shall inform the physician of the order.

4. For each patient for whom a nonhospital 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 record provided, however, that a registered nurse who provides direct care to the patient may record the review in the medical 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 record within fourteen days of such review. Failure to comply with this subdivision shall not render a nonhospital order not to resuscitate ineffective.

5. A person who has consented to a nonhospital 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 nonhospital order not to resuscitate shall notify the attending physician of the revocation. An attending physician who is informed that a nonhospital order not to resuscitate has been revoked shall record the revocation in the patient's medical record, cancel the order and make diligent efforts to retrieve the form issuing the order, and the standard bracelet, if any.

6. The commissioner may authorize the use of one or more alternative forms for issuing a nonhospital order not to resuscitate (in place of the standard form prescribed by the commissioner under subdivision two of this section). Such alternative form or forms may also be used to issue a non-hospital do not intubate order. Any such alternative forms intended for use for persons with mental retardation or developmental disabilities or persons with mental illness who are incapable of making their own health care decisions or who have a guardian of the person appointed pursuant to article eighty-one of the mental hygiene law or article seventeen-A of the surrogate's court procedure act must also be approved by the commissioner of mental retardation and developmental disabilities or the commissioner of mental health, as appropriate. An alternative form under this subdivision shall otherwise conform with applicable federal and state law. This subdivision does not limit, restrict or impair the use of an alternative form for issuing an order not to resuscitate in a general hospital or residential health care facility under article twenty-eight of this chapter or a hospital under subdivision ten of section 1.03 of the mental hygiene law or a school under section 13.17 of the mental hygiene law.

§ 2994-ee. Obligation to honor a nonhospital order not to resuscitate. Emergency medical services personnel, home care services agency personnel, hospice personnel, or hospital emergency services personnel who are provided with a nonhospital 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:

1. Emergency medical services personnel, home care services agency personnel, hospice personnel, or hospital emergency services personnel may disregard the order if:

(a) They believe in good faith that consent to the order has been revoked, or that the order has been cancelled; or

(b) Family members or others on the scene, excluding such personnel, object to the order and physical confrontation appears likely; and

2. Hospital emergency services physicians may direct that the order be disregarded if other significant and exceptional medical circumstances warrant disregarding the order.

§ 2994-ff. Interinstitutional transfer. If a patient with a nonhospital 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 article twenty-nine-CC of this chapter, except that any such order for a patient admitted to a mental hygiene facility shall be governed by article twenty-nine-B of this chapter.

§ 2994-gg. Immunity. 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 nonhospital order not to resuscitate, for disregarding a nonhospital order pursuant to section twenty-nine hundred ninety-four-ee of this article, or for other actions taken reasonably and in good faith pursuant to this section.

§ 3. Subdivision 1 of section 2805-q of the public health law, as added by chapter 471 of the laws of 2004, is amended to read as follows:

1. No domestic partner **or surrogate as defined by subdivision twenty-nine of section twenty-nine hundred ninety-four-a of this chapter** shall be denied any rights of visitation of his or her domestic partner **or of the patient or resident for whom he or she is the surrogate,** when such

rights are accorded to spouses and next-of-kin at any hospital, nursing home or health care facility.

§ 4. The article heading of article 29-B of the public health law, as added by chapter 818 of the laws of 1987, is amended to read as follows:

ORDERS NOT TO RESUSCITATE **FOR RESIDENTS OF MENTAL HYGIENE FACILITIES**

§ 5. Subdivisions 7, 10, 13 and 16 of section 2961 of the public health law are REPEALED.

§ 6. Subdivisions 2, 4, 5, 9 and 19 of section 2961 of the public health law, subdivisions 2 and 19 as amended and subdivision 9 as renumbered by chapter 370 of the laws of 1991 and subdivisions 4, 5 and 9 as added by chapter 818 of the laws of 1987, are amended to read as follows:

2. "Attending physician" means the physician selected by or assigned to a patient in a hospital [~~or, for the purpose of provisions herein governing nonhospital 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.

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~~], **or relative of the patient (other than a spouse, adult child, parent, brother or sister) who** 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~~] **and who presents a signed statement to that effect to the attending physician.**

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.

19. "Patient" means a person admitted to a hospital [~~or, for the purpose of provisions herein governing nonhospital orders not to resuscitate, a person who has or may be issued a nonhospital order not to resuscitate~~].

§ 7. Section 2961 of the public health law is amended by adding a new subdivision 6-a to read as follows:

6-a. "Domestic partner" means a person who, with respect to another person:

(a) is formally a party in a domestic partnership or similar relationship with the other person, entered into pursuant to the laws of the United States or of any state, local or foreign jurisdiction, or registered as the domestic partner of the other person with any registry maintained by the employer of either party or any state, municipality, or foreign jurisdiction; or

(b) is formally recognized as a beneficiary or covered person under the other person's employment benefits or health insurance; or

(c) is dependent or mutually interdependent on the other person for support, as evidenced by the totality of the circumstances indicating a mutual intent to be domestic partners including but not limited to: common ownership or joint leasing of real or personal property; common householding, shared income or shared expenses; children in common; signs of intent to marry or become domestic partners under paragraph (a) or (b) of this subdivision; or the length of the personal relationship of the persons.

Each party to a domestic partnership shall be considered to be the domestic partner of the other party. "Domestic partner" shall not include a person who is related to the other person by blood in a manner that would bar marriage to the other person in New York state. "Domestic partner" also shall not include any person who is less than eighteen years of age or who is the adopted child of the other person or who is related by blood in a manner that would bar marriage in New York state to a person who is the lawful spouse of the other person.

§ 8. Subdivision 1, paragraph (b) of subdivision 3 and subdivision 4 of section 2963 of the public health law, subdivisions 1 and 4 as added by chapter 818 of the laws of 1987 and paragraph (b) of subdivision 3 as amended by chapter 23 of the laws of 1994, are amended to read as follows:

1. Every adult shall be presumed to have the capacity to make a decision regarding cardiopulmonary resuscitation unless determined otherwise pursuant to this section or pursuant to a court order[~~. A lack of capacity shall not be presumed from the fact that a committee of the property or conservator has been appointed for the adult pursuant to article seventy seven or seventy eight of the mental hygiene law, or that a guardian has been appointed pursuant to article seventeen-A of the surrogate's court procedure act~~] or unless a guardian is authorized to decide about health care for the adult pursuant to article eighty-one of the mental hygiene law or article seventeen-A of the surrogate's court procedure act. The attending physician shall not rely on the presumption stated in this subdivision if clinical indicia of incapacity are present.

(b) If the attending physician [~~of a patient in a general hospital~~] determines that a patient lacks capacity because of mental illness, the concurring determination required by paragraph (a) of this subdivision shall be provided by a physician licensed to practice medicine in New York state, who is a diplomate or eligible to be certified by the American Board of Psychiatry and Neurology or who is certified by the American Osteopathic Board of Neurology and Psychiatry or is eligible to be certified by that board.

4. Notice of a determination that the patient lacks capacity shall promptly be given (a) to the patient, where there is any indication of the patient's ability to comprehend such notice, together with a copy of a statement prepared in accordance with section twenty-nine hundred seventy-eight of this article, and (b) to the person on the surrogate list highest in order of priority listed, when persons in prior subparagraphs are not reasonably available[~~, and (c) if the patient is in or is transferred from a mental hygiene facility, to the facility director~~]. Nothing in this subdivision shall preclude or require notice to more than one person on the surrogate list.

§ 9. Subdivisions 3 and 4 of section 2964 of the public health law are REPEALED.

§ 10. Paragraph (a) of subdivision 2 of section 2965 of the public health law, as added by chapter 818 of the laws of 1987 and subpara-

graphs (i), (ii), (iii), (iv), (v) and (vi) as redesignated and such subdivision as renumbered by chapter 370 of the laws of 1991, is amended to read as follows:

(a) One person from the following list, to be chosen in order of priority listed, when persons in the prior [~~subparagaphs~~] **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 [~~committee of the person or~~] **guardian authorized to decide about health care pursuant to article eighty-one of the mental hygiene law or** a guardian **of a person** appointed [~~pursuant to~~] **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 [~~committee of the person or~~] 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.

§ 11. Paragraph (c) of subdivision 4 and subdivision 5 of section 2965 of the public health law are REPEALED.

§ 12. Paragraph (d) of subdivision 4 of section 2965 of the public health law, as added by chapter 818 of the laws of 1987 and such subdivision as renumbered by chapter 370 of the laws of 1991, is amended to read as follows:

[~~(d)~~] **(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[~~, or, if the patient is in or is transferred from a mental hygiene facility, by the facility director~~], the [~~phsyician~~] **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.

§ 13. Subdivision 2 of section 2966 of the public health law is REPEALED.

§ 14. Subdivision 3 of section 2966 of the public health law, as added by chapter 818 of the laws of 1987, is amended to read as follows:

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.

§ 15. Paragraph (c) of subdivision 2 of section 2967 of the public health law is REPEALED.

§ 16. Subdivision 1 of section 2970 of the public health law, as amended by chapter 370 of the laws of 1991, is amended to read as follows:

1. For each patient for whom an order not to resuscitate has been issued, the attending physician shall review the patient's chart to

determine if the order is still appropriate in light of the patient's condition and shall indicate on the patient's chart that the order has been reviewed[~~:~~

~~(a) for a patient, excluding outpatients described in paragraph (b) of this subdivision and alternate level of care patients, in a hospital, other than a residential health care facility, at least every seven days;~~

~~(b) for an outpatient whose order not to resuscitate is effective while the patient receives care in a hospital, each time the attending physician examines the patient, whether in the hospital or elsewhere, provided that the review need not occur more than once every seven days; and~~

~~(c) for a patient in a residential health care facility or an alternate level of care patient in a hospital,~~] each time the patient is required to be seen by a physician but at least every sixty days.

Failure to comply with this subdivision shall not render an order not to resuscitate ineffective.

§ 17. Section 2971 of the public health law is amended by adding a new subdivision 3 to read as follows:

3. For purposes of this section, an order not to resuscitate issued by a general hospital as defined in subdivision ten of section twenty-eight hundred one of this chapter, or by a residential health care facility as defined in subdivision three of section twenty-eight hundred one of this chapter, shall be deemed a hospital order not to resuscitate.

§ 18. Subdivision 2 of section 2972 of the public health law, as amended by chapter 370 of the laws of 1991, is amended to read as follows:

2. The dispute mediation system shall be authorized to mediate any dispute, including disputes regarding the determination of the patient's capacity, arising under this article between the patient and an attending physician or the hospital that is caring for the patient and, if the patient is a minor, the patient's parent, or among an attending physician, a parent, non-custodial parent, or legal guardian of a minor patient, any person on the surrogate list, **and** the hospital that is caring for the patient [~~and, where the dispute involves a patient who is in or is transferred from a mental hygiene facility, the facility director~~].

§ 19. Subdivision 1 of section 2973 of the public health law, as amended by chapter 577 of the laws of 1993, is amended to read as follows:

1. The patient, an attending physician, a parent, non-custodial parent, or legal guardian of a minor patient, any person on the surrogate list, the hospital that is caring for the patient and[~~, in disputes involving a patient who is in or is transferred from a mental hygiene or correctional facility,~~] the facility director, may commence a special proceeding pursuant to article four of the civil practice law and rules, in a court of competent jurisdiction, with respect to any dispute arising under this article, except that the decision of a patient not to consent to issuance of an order not to resuscitate may not be subjected to judicial review. In any proceeding brought pursuant to this subdivision challenging a decision regarding issuance of an order not to resuscitate on the ground that the decision is contrary to the patient's wishes or best interests, the person or entity challenging the decision must show, by clear and convincing evidence, that the decision is contrary to the patient's wishes including consideration of the patient's religious and moral beliefs, or, in the absence of evidence of

the patient's wishes, that the decision is contrary to the patient's best interests. In any other proceeding brought pursuant to this subdivision, the court shall make its determination based upon the applicable substantive standards and procedures set forth in this article.

§ 20. Section 2977 of the public health law is REPEALED.

§ 21. Subdivision 1 of section 2978 of the public health law is REPEALED and subdivision 2, as added by chapter 818 of the laws of 1987, such section as renumbered by chapter 370 of the laws of 1991, is amended to read as follows:

[~~2.~~] The commissioners of mental health and mental retardation and developmental disabilities[~~, in consultation with the commissioner of health,~~] shall establish such regulations as may be necessary for implementation of this article with respect to those persons in mental hygiene facilities.

§ 22. The opening paragraph of subdivision 1 of section 2979 of the public health law, as added by chapter 818 of the laws of 1987, such section as renumbered by chapter 370 of the laws of 1991, is amended to read as follows:

The [~~commissioner of health, after consultation with the~~] commissioners of mental health and mental retardation and developmental disabilities[~~,~~] shall prepare a statement summarizing the rights, duties, and requirements of this article and shall require that a copy of such statement:

§ 23. Subdivisions 3 and 4 of section 2984 of the public health law, as added by chapter 752 of the laws of 1990, are amended and a new subdivision 5 is added to read as follows:

3. Notwithstanding subdivision two of this section, nothing in this article shall be construed to require a private hospital to honor an agent's health care decision that the hospital would not honor if the decision had been made by the principal because the decision is contrary to a formally adopted policy of the hospital that is expressly based on religious beliefs or sincerely held moral convictions central to the facility's operating principles and the hospital would be permitted by law to refuse to honor the decision if made by the principal, provided:

(a) the hospital has informed the patient or the health care agent of such policy prior to or upon admission, if reasonably possible; and

(b) the patient is transferred promptly to another hospital that is reasonably accessible under the circumstances and is willing to honor the agent's decision **and pending transfer the hospital complies with subdivision five of this section**. If the agent is unable or unwilling to arrange such a transfer, the hospital may intervene to facilitate such a transfer. If such a transfer is not effected, the hospital shall seek judicial relief **in accordance with section twenty-nine hundred ninety-two of this article** or honor the agent's decision.

4. Notwithstanding subdivision two of this section, nothing in this article shall be construed to require an individual as a health care provider to honor an agent's health care decision that the individual would not honor if the decision had been made by the principal because the decision is contrary to the individual's religious beliefs or sincerely held moral convictions, provided the individual health care provider promptly informs the health care agent and the hospital of his or her refusal to honor the agent's decision. In such event, the hospital shall promptly transfer responsibility for the patient to another individual health care provider willing to honor the agent's decision. The individual health care provider shall cooperate in facilitating such

transfer of the patient and comply with subdivision five of this section.

5. Notwithstanding the provisions of this section or subdivision two of section twenty-nine hundred eighty-nine of this article, if an agent directs the provision of life-sustaining treatment, the denial of which in reasonable medical judgment would be likely to result in the death of the patient, a hospital or individual health care provider that does not wish to provide such treatment shall nonetheless comply with the agent's decision pending either transfer of the patient to a willing hospital or individual health care provider, or judicial review in accordance with section twenty-nine hundred ninety-two of this article.

§ 24. Section 2980 of the public health law is amended by adding a new subdivision 9-a to read as follows:

9-a. "Life-sustaining treatment" means any medical treatment or procedure without which the patient will die within a relatively short time, as determined by an attending physician to a reasonable degree of medical certainty. For purposes of this article, cardiopulmonary resuscitation is presumed to be a life sustaining treatment without the necessity of a determination by an attending physician.

§ 25. Paragraph 8 of subdivision (a) of section 81.22 of the mental hygiene law, as amended by chapter 438 of the laws of 2004, is amended to read as follows:

8. [~~consent to or refuse generally accepted routine or major medical or dental treatment subject to the provisions of subdivision (e) of section 81.29 of this article dealing with life sustaining treatment, the guardian shall make treatment decisions consistent with the findings under section 81.15 of this article and in accordance with the patient's wishes, including the patient's religious and moral beliefs, or if the patient's wishes are not known and cannot be ascertained with reasonable diligence, in accordance with the person's best interests, including a consideration of the dignity and uniqueness of every person, the possibility and extent of preserving the person's life, the preservation, improvement or restoration of the person's health or functioning, the relief of the person's suffering, the adverse side effects associated with the treatment, any less intrusive alternative treatments, and such other concerns and values as a reasonable person in the incapacitated person's circumstances would wish to consider~~] (i) for decisions in hospitals as defined by subdivision eighteen of section twenty-nine hundred ninety-four-a of the public health law, act as the patient's surrogate pursuant to and subject to article twenty-nine-CC of the public health law, and (ii) in all other circumstances, to consent to or refuse generally accepted routine or major medical or dental treatment, subject to the decision-making standard in subdivision four of section twenty-nine hundred ninety-four-d of the public health law;

§ 26. Subdivision (e) of section 81.29 of the mental hygiene law is REPEALED.

§ 27. The opening paragraph and paragraphs (a) and (b) of subdivision 1 and the opening paragraph of subdivision 4 of section 1750-b of the surrogate's court procedure act, the opening paragraph of subdivision 1 as amended and paragraphs (a) and (b) of subdivision 1 as added by chapter 105 of the laws of 2007, the closing paragraph of paragraph (a) of subdivision 1 as amended by chapter 12 of the laws of 2009 and the opening paragraph of subdivision 4 as added by chapter 500 of the laws of 2002, are amended to read as follows:

Unless specifically prohibited by the court after consideration of the determination, if any, regarding a mentally retarded person's capacity

to make health care decisions, which is required by section seventeen hundred fifty of this article, the guardian of such person appointed pursuant to section seventeen hundred fifty of this article shall have the authority to make any and all health care decisions, as defined by subdivision six of section twenty-nine hundred eighty of the public health law, on behalf of the mentally retarded person that such person could make if such person had capacity. Such decisions may include decisions to withhold or withdraw life-sustaining treatment[~~, as defined in subdivision (e) of section 81.29 of the mental hygiene law~~]. **For purposes of this section, "life-sustaining treatment" means medical treatment, including cardiopulmonary resuscitation and nutrition and hydration provided by means of medical treatment, which is sustaining life functions and without which, according to reasonable medical judgment, the patient will die within a relatively short time period. Cardiopulmonary resuscitation is presumed to be life-sustaining treatment without the necessity of a medical judgment by an attending physician.** The provisions of this article are not intended to permit or promote suicide, assisted suicide or euthanasia; accordingly, nothing in this section shall be construed to permit a guardian to consent to any act or omission to which the mentally retarded person could not consent if such person had capacity.

(a) For the purposes of making a decision to withhold or withdraw life-sustaining treatment pursuant to this section, in the case of a person for whom no guardian has been appointed pursuant to section seventeen hundred fifty or seventeen hundred fifty-a of this article, a "guardian" shall also mean a family member of a person who (i) has mental retardation, or (ii) has a developmental disability, as defined in section 1.03 of the mental hygiene law, which (A) includes mental retardation, or (B) results in a similar impairment of general intellectual functioning or adaptive behavior so that such person is incapable of managing himself or herself, and/or his or her affairs by reason of such developmental disability. Qualified family members shall be included in a prioritized list **of said family members** pursuant to regulations established by the commissioner of mental retardation and developmental disabilities. Such family members must have a significant and ongoing involvement in a person's life so as to have sufficient knowledge of their needs and, when reasonably known or ascertainable, the person's wishes, including moral and religious beliefs. **In the case of a person who was a resident of the former Willowbrook state school on March seventeenth, nineteen hundred seventy-two and those individuals who were in community care status on that date and subsequently returned to Willowbrook or a related facility, who are fully represented by the consumer advisory board and who have no guardians appointed pursuant to this article or have no qualified family members to make such a decision, then a "guardian" shall also mean the Willowbrook consumer advisory board.** A decision of such family member **or the Willowbrook consumer advisory board** to withhold or withdraw life-sustaining treatment shall be subject to all of the protections, procedures and safeguards which apply to the decision of a guardian to withhold or withdraw life-sustaining treatment pursuant to this section.

In the case of a person for whom no guardian has been appointed pursuant to this article or for whom there is no qualified family member **or the Willowbrook consumer advisory board** available to make such a decision, a "guardian" shall also mean, notwithstanding the definitions in section 80.03 of the mental hygiene law, a surrogate decision-making committee, as defined in article eighty of the mental hygiene law. All

declarations and procedures, including expedited procedures, to comply with this section shall be established by regulations promulgated by the commission on quality of care and advocacy for persons with disabilities.

(b) Regulations establishing the prioritized list **of qualified family members** required by paragraph (a) of this subdivision shall be developed by the commissioner of mental retardation and developmental disabilities in conjunction with parents, advocates and family members of persons who are mentally retarded. **Regulations to implement the authority of the Willowbrook consumer advisory board pursuant to paragraph (a) of this subdivision may be promulgated by the commissioner of the office of mental retardation and developmental disabilities with advice from the Willowbrook consumer advisory board.**

The guardian shall have the affirmative obligation to advocate for the full and efficacious provision of health care, including life-sustaining treatment [~~**as defined in subdivision (e) of section 81.29 of the mental hygiene law**~~]. In the event that a guardian makes a decision to withdraw or withhold life-sustaining treatment from a mentally retarded person:

§ 28. Issues to be considered by the task force on life and the law; special advisory committee. The New York state task force on life and the law (referred to in this section as the "task force"), a body created by executive order number 56 (issued December 20, 1984), shall consider and make regulatory and statutory recommendations relating to the family health care decisions act (article 29-CC of the public health law, referred to in this section as the "FHCDA"), including the following:

1. The task force shall consider whether the FHCDA should be amended to incorporate procedures, standards and practices for decisions about the withdrawal or withholding of life-sustaining treatment from patients with mental illness or mental retardation or developmental disabilities, and from patients residing in mental health facilities. The task force shall form a special advisory committee to advise the task force in its work under this subdivision. The special advisory committee shall consist of six task force members, selected by the chair of the task force, three persons selected by the commissioner of the office of mental health, and three persons selected by the commissioner of the office of mental retardation and developmental disabilities. The special advisory committee shall solicit comments from a broader range of interested persons.

2. The task force shall consider whether the FHCDA should be amended to apply to health care decisions in settings other than general hospitals and residential health care facilities.

§ 29. This act shall take effect immediately; provided that sections one through twenty-six of this act shall take effect on the first of June next succeeding the date on which this act shall have become a law; and provided further that effective immediately it shall be lawful for a hospital, as defined in subdivision 18 of section 2994-a of the public health law, as added by this act to adopt a policy that is consistent with the requirements of article 29-CC of the public health law as added by section two of this act or the mental hygiene law as amended by sections twenty-five and twenty-six of this act and for a health care provider to accept and carry out a health care decision in accordance with such requirements for a patient in a hospital that has adopted such policy.