

Memorandum in Support

HEALTH LAW SECTION

Health # 4

June 6, 2014

S.7151 (Hannon) / A.9647 (Clark)	Relates to health care agents, decisions under the family care decisions act and non-hospital orders not to resuscitate
S.7152 (Hannon) / A.9548 (Gunther)	Relates to orders not to resuscitate; repealer
S.7153 (Hannon) / A.9671 (Pretlow)	Relates to conforming and improving the process for determining incapacity
S.7154 (Hannon) / A.9566-A (Rosenthal)	Relates to artificial nutrition and hydration standards
S.7155 (Hannon) / A.9670 (Pretlow)	Relates to disputes between a surrogate and a hospital or individual health care provider
S.7156 (Hannon) / A.9648 (Gottfried)	Authorizes the issuance of an order not to resuscitate in cases of medical futility
S.7157 (Hannon) / A.9549 (Gunther)	Relates to health care decisions for persons with developmental disabilities

THE HEALTH LAW SECTION SUPPORTS THIS LEGISLATION

This legislation taken together is informally known as “The Surrogate Decision-Making Improvement Acts (SDMIAs).”

Position: Support

The NYSBA Health Law Section has long supported changes in New York law to promote the rights and interests of patients. To that end, the Section was a strong supporter of the Family Health Care Decisions Act (Ch. 8, L. 2010)(“FHCDA”), which empowers a close family member or friend to make health care decisions for a patient who lacks capacity and did not previously appoint a health care agent.

Since enactment of the FHCDA, the Section has sought to ensure its successful implementation, and to identify ways to improve that law and other laws that govern health care decisions for patients who lack capacity.

The seven “Surrogate Decision-Making Improvement Acts” (SDMIAs) effect changes, small and large, that will improve, clarify and coordinate the FHCDA and other surrogate decision-makings laws. The SDMIAs include proposals advanced by a broad range of practitioners, organizations (including the Section), government agencies and others, and draw upon their day-to-day experience in carrying out and resolving issues under these laws.

In particular the SDMIAs will:

1. Replace PHL Article 29-B, Orders Not to Resuscitate for Mental Hygiene Facilities. (S.7152 (Hannon) / A.9548 (Gunther)).

PHL Article 29-B (“Orders Not to Resuscitate in Mental Hygiene Facilities”) governs DNR orders in OPWDD operated “schools” (an outdated term) and in OMH operated and licensed psychiatric hospitals and units. There is no longer a need for this article. DNR decisions in OPWDD operated developmental centers facilities (the successor to OMRDD “schools”) are already governed by SCPA 1750-b. DNR decisions in psychiatric hospitals and units could easily be made subject to the FHCDA, which has principles similar to those in PHL Art. 29-B. This would be particularly helpful for general hospitals, which now have to follow slightly different DNR rules in their medical units from those in their psychiatric units, with no policy rationale for the differences.

2. Reconcile the authority of agents and surrogates with respect to decisions about medically-provided nutrition and hydration S.7154 (Hannon) / A.9566-A (Rosenthal).

When strict clinical criteria are satisfied, the FHCDA allows a surrogate to make a decision to withhold or withdraw life-sustaining treatment, including medically-provided nutrition and hydration based on the patient’s wishes, if reasonably known, or else the patient’s best interests. But the Health Care Proxy Law authorizes an agent to decide to withhold or withdraw medically-provided nutrition and hydration based solely on the patient’s wishes, if reasonably known – and not the patient’s best interests if the patient’s wishes are not reasonably known. The SDMIA would amend the Health Care Proxy Law to allow an agent to make a decision about artificial nutrition and hydration based on the patient’s best interests. This is an appropriate amendment - a health care agent, specifically appointed by the patient, should be able to act in furtherance of a principal’s best interests when the patient’s wishes are not reasonably known.

3. Conform various provisions in the Health Care Proxy Law and the FHCDA. S.7151 (Hannon) /A.9647 (Clark); (S.7153 (Hannon) / A.9671 (Pretlow)).

The SDMIA eliminates many discrepancies in language between the health care proxy law and the FHCDA, mostly in the provisions about determining incapacity. Those discrepancies, though mostly non-substantive, are a source of confusion and other implementation complications.

4. Require a concurring determination of incapacity, and a determination of incapacity by specially qualified professionals, only for life-sustaining treatment decisions. S.7153 (Hannon) / A.9671 (Pretlow).

Currently, both the Health Care Proxy Law and the FHCDA require: (i) that the attending physician determine whether a patient lacks capacity; (ii) that if the decision relates to the withdrawal or withholding of life-sustaining treatment there must be a concurring determination of incapacity; and (iii) that if the basis for that determination is a developmental disability or mental illness, either the attending physician must have special qualifications or must secure a concurring opinion by another person with specified qualifications. Also, the FHCDA requires a concurring opinion of incapacity for all determinations involving nursing home residents. The SDMIA amendment would make the Health Care Proxy Law and FHCDA requirement of a determination by a person with specialized qualifications and the FHCDA requirement of a concurring opinion in nursing homes, applicable only to cases involving withdrawal or withholding life-sustaining treatment decisions, and not to cases involving consent to treatment. This change ensures that additional safeguards, and the additional time, effort and resources that those safeguards require, are mandated in the cases where they are most important - for decisions to withhold or withdraw life-sustaining treatment - and not where they could impede the delivery of treatment to a patient.

5. Clarify that the duties that arise when a surrogate insists upon treatment do not apply when the hospital or physician is carrying out an adult patient's prior decision. S.7155 (Hannon) / A.9670 (Pretlow).

Currently, both the Health Care Proxy Law and FHCDA state that if a health care agent or surrogate directs the provision of life-sustaining treatment, but the hospital or individual health care provider "does not wish to provide such treatment," the hospital or individual provider nevertheless must either comply with the agent's decision, transfer the patient or seek court review. §§2984.5 and 2994-f.3. The SDMIA would amend this requirement to clarify that it does not apply:

in the case of a health care agent, when the hospital or individual health care provider is carrying out a prior decision by the patient. (§7), and

in the case of a surrogate, when the hospital or individual health care provider is carrying out a prior decision by the patient made in accord with the FHCDA provisions.

The obligation to honor the clear prior instructions of an adult patient is firmly supported by the United States and New York State Constitutions, as well as numerous federal and New York State statutes, regulations and caselaw. Sections 2984.5 and 2994-f.3 should not be read to override that obligation. Moreover, under the FHCDA, if a provider has adequate prior instructions from a patient, there is no need to seek an agent's or surrogate's consent. See §2994-d.3(ii).

7. Clarify medical futility as a basis for a DNR order. S.7156 (Hannon) /A.9648 (Gottfried).

The FHCDA establishes that two physicians can consent to a DNR order if the treatment “offers the patient no medical benefit and the patient will die imminently even if treatment is provided, and the provision of treatment would violate accepted medical standards...” The proposed amendment in Section 19 clarifies the meaning of medical futility in the context of a DNR order. The amendments also clarify that physicians can enter a DNR order on the basis of medical futility even if the patient is eligible for decision-making by an article 80 surrogate decision-making committee, since the decision about futility, as defined in the statute, is strictly a medical determination. Under the former DNR law (PHL Art 29-B), a surrogate could consent to a DNR order if the patient met any one of four clinical criteria, including a finding by two physicians that resuscitation would be “medically futile,” defined to mean that resuscitation “will be unsuccessful in restoring cardiac and respiratory function or that the patient will experience repeated arrest in a short time period before death occurs.” The former DNR law also allowed two physicians to write a DNR order on medical futility grounds for a patient who did not have a surrogate.

For decisions by family members and other surrogates, the FHCDA established standards for the withdrawal or withholding of a broader range of life-sustaining treatment, including resuscitation. The FHCDA does not specify medical futility as a basis for a DNR order or for other treatments. However, medical futility would clearly be encompassed by the existing standards for decision-making under the FHCDA. The Section members have different views on the value of including the medical futility standard as a basis for a surrogate consent for a DNR order. However, we support explicitly clarifying the manner in which the medical futility standard applies as a basis for approval of a DNR order for patient who does not have a surrogate (or for whom a MHL Art 80 surrogate decision-making panel would be the surrogate).

8. Clarify the right of developmentally disabled persons who have capacity to make decisions. S.7157 (Hannon) /A.9549 (Gunther).

Currently, SCPA §1750-b only authorizes life-sustaining treatment decisions when made by SCPA 1750-b guardians. This amendment clarifies that if the developmentally disabled person is found to have capacity can make his or her own decisions relating to life-sustaining treatment.(§31). It also provides that if the developmentally disabled person created a health care proxy, then such decisions can be made pursuant to the health care proxy law.

9. Modify the roles of Surrogate Decision Making Committees and Mental Hygiene Legal Services with respect to DNR orders. S.7157 (Hannon) /A.9549 (Gunther).

Surrogate Decision Making Committees - Under the former DNR law, the MHL Article 80 Surrogate Decision Making Committee (SDMC) had no role in reviewing DNR orders. The FHCDA, by making SCPA 1750-b applicable to DNR orders for developmentally disabled

persons, indirectly required SDMC review of DNR orders for such persons. This bill removes the SDMC's role in the review of DNR orders entered on the basis of medical futility. (§35) *Mental Hygiene Legal Services*. Under the former DNR law, for patients in or transferred from a mental hygiene facility, notice of a DNR order had to be given to the facility director, but not to the mental hygiene legal services (MHLS) prior to entry of the order. By making SCPA§1750-b applicable to most such patients, the FHCDA requires notice to MHLS of all decisions to withhold or withdraw life-sustaining treatment, including DNR orders. Moreover, if MHLS objects to the order, it must be stayed.

Notice to MHLS of all DNR orders for developmentally disabled persons in hospitals or nursing homes is not supported by identified problems or poor decisions and delays what may be urgent treatment decisions for these patients. Restoring the previous procedure, and eliminating both the notice to MHLS and its authority to object would reduce a burden on hospitals and nursing homes, and prevent unnecessary and sometimes harmful delays in the issuance of appropriate DNR orders while MHLS investigates each case.

The proposed amendment preserves the safeguard of notice to MHLS, but provides that an objection by MHLS will not stay the DNR order unless MHLS provides a basis for its objection, including clinical support. This approach strikes a reasonable balance.

Conclusion

The Surrogate Decision-Making Improvement Acts make a series of valuable clarifications and adjustments to the FHCDA and related laws. The Health Law Section urges passage of these bills to further realize the intention of New York's laws on treatment decisions.

For the reasons stated above, the Health Law Section of the New York State Bar Association **SUPPORTS** this legislation.

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