Appendices

Appendix A

Proposed Legislation for Surrogate Decisions

Section

§ 1. 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 18 years of age or older or has married.

2. ***Attending physician*** means a physician, selected by or assigned to a patient, 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. ***Bioethics review committee*** means the interdisciplinary hospital committee. established in accordance with the requirements of section 11 of this article.

4. ***Close friend*** means any person, 18 years of age or older, who presents a signed, written statement to an attending physician stating that he or she is a close friend of the patient and that he or she has maintained such regular contact with the patient as to be familiar with the patient's activities, health, and religious or moral beliefs, and stating the facts and circumstances that demonstrate such familiarity.

5. ***Close relative*** means any person, 18 years of age or older, who presents a signed, written statement to an attending physician stating that he or she is a relative of the patient and that he or she 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.

6. ***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, any such proposed health care, and to reach an informed decision.

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

8. ***General hospital*** means a general hospital as defined in section 2801(10) of the public health law.

9. ***Guardian of a minor*** or ***guardian*** means a health care guardian or a legal guardian of the person of a minor.

10. ***Health care*** means any treatment, service, or procedure to diagnose or treat an individual's physical or mental condition.

11. ***Health care agent*** means a health care agent designated by an adult pursuant to article 29-C of the public health law.

12. ***Health care decision*** means any decision to consent or refuse to consent to health care.

13. ***Health care guardian*** means an individual appointed by a court, pursuant to section 16(3) of this article, as the guardian of a minor patient solely for the purpose of deciding about life-sustaining treatment pursuant to this article.

14. ***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.

15. ***Hospital*** means a general hospital as defined in section 2801(10) of the public health law, and a residential health care facility as defined in section 2801(3) of the public health law.

16. ***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.

17. ***Major medical treatment*** means any treatment, service or procedure to diagnose or treat an individual's physical or mental condition: where a general anesthetic is used; or, which involves any significant risk; or which involves any significant invasion of bodily integrity requiring an incision, producing substantial pain, discomfort, debilitation or having a significant recovery period; or, which involves a significant period of chemical or physical restraint.

18. ***Metal hygiene facility*** means a residential facility operated or licensed by the office of mental health or the office of mental retardation and developmental disabilities.

19. ***Mental illness*** means a mental illness as defined in section 1.03(20) of the mental hygiene law, provided, however, that mental illness shall not include dementia, such as Alzheimer's disease, or other disorders related to dementia.

20. ***Minor*** means any person who is not an adult.

21. ***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.

22. ***Patient*** means a person admitted to a hospital.

23. ***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 care professional who is or has been directly involved in the patient's care, and any duly authorized state agency.

24. ***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.

25. ***Residential health care facility*** means a residential health care facility as defined in section 2801(3) of the public health law.

26. ***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 that would be deemed routine if used on a temporary basis.

27. ***Surrogate*** means the person selected to make a health care decision on behalf of a patient pursuant to section 4 of this article.

28. ***Surrogate list*** means the list set forth in section 4(1) of this article.

§ 2. Priority of decision by health care agent; mental hygiene facility residents

1. A health care decision by a health care agent on a patient's behalf is governed by article 29-C of the public health law and shall have priority over decisions by any other person except the patient or as otherwise provided in the health care proxy. Health care providers shall make reasonable efforts to determine whether the patient has appointed a health care agent and to contact the agent before relying on a decision by a surrogate under this article.

2. This article shall not apply to residents of mental hygiene facilities, except for section 16(2) of this article governing court orders for decisions about life-sustaining treatment.

§ 3. 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 committee of the person has been appointed for the adult pursuant to article 78 of the mental hygiene law.

2. **Determination by attending physician.** A determination that an adult patient lacks decision-making capacity shall be made by an attending physician to a reasonable degree of certainty. The determination shall be included in the patient's chart and shall contain the physician's opinion regarding the cause and nature of the patient's incapacity, as well as its extent and the likelihood that the patient will regain decision-making capacity.

3. **Concurring opinion.**

   (a) At least one other health care professional must concur in the determination that an adult patient lacks decision-making capacity. Such concurring opinion shall also be included in the patient's chart. Hospitals shall adopt written policies identifying the training and credentials of health care professionals qualified to provide a concurring opinion of incapacity.

   (b) If an attending physician determines that a patient lacks decision-making capacity because of mental illness or developmental disability, an attending physician who makes the determination must have, or must consult with a health care professional who has specialized training or experience in diagnosing or treating mental illness or developmental disabilities of the same or similar nature. A record of such consultation shall be included in the patient's chart.

4. **Informing the patient and surrogate.** Notice of a determination that the 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; and

(b) to at least one person on the surrogate list highest in order of priority listed, when persons in prior subparagraphs are not reasonably available.

The manner of notice to the patient shall be included in the patient's chart. Nothing in this subdivision shall preclude or require notice to more than one person on the surrogate list.

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 a health care decision made by a surrogate or made pursuant to section 7 of this article, the patient's objection or decision shall prevail unless a court of competent jurisdiction determines that the patient lacks decision-making capacity or the patient is or has been adjudged incompetent for all purposes.

7. **Confirmation of lack of decision-making capacity.**

(a) 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 opinion 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.

(b) Any confirmation of continued lack of decision-making capacity, and concurring opinion thereof, shall be included in the patient's chart. Health care providers shall not be required to inform the patient or surrogate of the confirmation.

§ 4. Health care decisions for adult patients by surrogates

1. **Identifying the surrogate.** One person from the following list, chosen from the class highest in priority when persons in prior classes are not reasonably available, willing, and competent to act, shall be the surrogate for an adult patient without decision-making capacity:

(a) a committee or guardian of the person appointed pursuant to article 78 of the mental hygiene law or article 17-A of the surrogate's court procedure act;

(b) an individual, 18 years of age or older, designated by others on the surrogate list, provided that no person on the surrogate list objects to the designation;

(c) the spouse, if not legally separated from the patient;

(d) a son or daughter 18 years of age or older;

(e) a parent;

(f) a brother or sister 18 years of age or older;

(g) a close friend or close relative 18 years of age or older.

2. **Restrictions on who may be a surrogate.** An operator, administrator, or employee of a 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, or adoption.

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 a physician to provide a treatment, service, or procedure at the request of a surrogate that the physician would have no duty to provide at the request of a patient with decision-making capacity.

(iii) 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, including a decision about withdrawing or withholding life-sustaining treatment. If an attending physician relies on the patient's prior decision, the physician shall record the prior decision in the patient's chart.

(b) **Commencement of surrogate's authority.** The surrogate's authority shall commence upon a determination, made pursuant to section 3 of this article, that the adult patient lacks decision-making capacity. In the event an attending

physician determines that the patient has regained decision-making capacity, the authority of the surrogate shall cease, but shall recommence if the patient subsequently loses capacity as determined pursuant to section 3 of this article.

(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 and clinical records necessary to make informed decisions about the patient's health care. 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 alternatives to, proposed health care.

4. Decision-making standards.

(a) **General standard.** 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.

In either case, health care decisions shall reflect the values of the patient, including the patient's religious and moral beliefs, to the extent they are reasonably known or can with reasonable diligence be ascertained.

(b) **Assessment of 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 such other concerns and values as a reasonable person in the patient's circumstances would wish to consider.

5. Decisions to withhold or withdraw life-sustaining treatment.

(a) **Limited application of this subdivision.** This subdivision applies only to decisions to withhold or withdraw life-sustaining treatment. Nothing in this subdivision is intended to apply to other health care decisions for patients who lack decision-making capacity, including decisions about alternative treatments that are medically accepted therapies and

decisions about the course of routine or major medical treatment.

(b) **Standards for decisions.** A surrogate shall have the authority to decide to withhold or withdraw life-sustaining treatment, if the following two conditions are satisfied:

(i) Treatment would be an excessive burden to the patient in light of the standards set forth in subdivision (4) of this section. This determination shall be made on an individualized basis for each patient and shall include consideration of the patient's preferences, values, and personal circumstances, to the extent possible, as well as the likelihood that the patient will regain decision-making capacity.

(ii) At least one of the following circumstances is present:

(A) **Terminal condition.** An attending physician determines, with the concurrence of another physician, that, to a reasonable degree of medical certainty, the patient has an illness or injury from which there is no recovery, and which reasonably can be expected to cause death within six months.

(B) **Permanent unconsciousness.** An attending physician determines, with the concurrence of another physician that, to a reasonable degree of medical certainty, the patient is permanently unconscious.

(C) **Physician determination and bioethics review committee approval.** An attending physician and the bioethics review committee determine that the surrogate's decision complies with the standards set forth in subdivision (4) of this section and subparagraph (i) of this paragraph, and the bioethics review committee approves the decision.

(D) **Judicial approval.** A court of competent jurisdiction issues an order approving the decision, pursuant to section 16(2) of this article.

(c) **Patient's chart.** Determinations made pursuant to paragraph (b) of this subdivision shall be recorded in the patient's chart.

(d) **Expression of decisions.** The surrogate shall express a decision to withdraw or withhold life-sustaining treatment either in writing, dated and signed in the presence of one

witness, 18 years of age or older, who must sign the decision; or orally to two persons, 18 years of age or older, one of whom is a physician affiliated with the hospital in which the patient is being treated. The decision shall be recorded in the patient's chart.

§ 5. 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 decide to withhold or withdraw life-sustaining treatment, subject to the provisions of this section and the standards for surrogate decisions for adults.

2. **Decision-making standards and procedures for minor patient.**

   (a) 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, the minor must consent to withhold or withdraw life-sustaining treatment for decisions pursuant to this section.

   (b) Where an attending physician has reason to believe that a parent of a minor patient, including a noncustodial parent, has not been informed of a decision to withdraw or withhold life-sustaining treatment, an attending physician or someone acting on his or her behalf, shall make reasonable efforts to determine if the uninformed parent has maintained substantial and continuous contact with the minor and, if so, shall make diligent efforts to notify that parent 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, prior to implementing the decision, an attending physician and the bioethics review committee determine that the decision accords with the standards for surrogate decisions for adults,

and the bioethics review committee approves the decision. Such determinations shall be recorded in the patient's chart.

(b) If the hospital can readily 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.

§ 6. Obligations of attending physician

1. An attending physician provided with or 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 chart, review the medical bases 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 bioethics review committee.

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

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

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

   (c) a minor patient refuses consent to life-sustaining treatment, or consents to the withholding or withdrawal of 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.

§ 7. Health care decisions for adult patients without surrogates

1. **Identifying adult patients without surrogates.** Within a reasonable time after admission 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 if at least one individual is available to serve as the patient's surrogate in the event the patient loses decision-making capacity. If no such potential surrogate is identified, the hospital shall identify, to the extent reasonably possible, the patient's wishes, preferences, and values about pending health care decisions, and shall make a written record of its findings.

2. **Decision-making standards.** Any health care decision made pursuant to this section shall be made in accordance with the standards for surrogate decisions for adults and shall not be based on the financial interests of the hospital or any other health care provider.

3. **Routine medical treatment.** If no surrogate is available, willing, and competent to act, 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 3 of this article.

4. **Major medical treatment.** If no surrogate is available, willing, and competent to act, 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 3 this article:

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

   (b) Prior to implementing the recommendation in a general hospital, at least one other physician designated by the hospital must concur in the recommendation.

   (c) Prior to implementing the recommendation in a residential health care facility, the medical director of the facility, or a physician designated by the medical director, must concur in the recommendation; provided that if the medical director is the patient's attending physician, a different physician designated by the residential health care facility must concur in the recommendation.

5. **Decisions to withhold or withdraw life-sustaining treatment.** If no surrogate is available, willing, and competent to act, a decision to withhold or withdraw life-sustaining 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 3 of this article:

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

(b) Prior to implementing the recommendation in a general hospital:

(i) at least one other physician designated by the hospital must concur in the recommendation;

(ii) the bioethics review committee must determine that the recommendation accords with the standards for surrogate decisions for adults and must approve the recommendation; and

(iii) if the patient has been transferred from a residential health care facility, before the bioethics review committee approves or disapproves the recommendation, a representative of the committee must make reasonable efforts to consult with staff from the facility who were directly responsible for the patient's care.

(c) Prior to implementing the recommendation in a residential health care facility:

(i) the medical director of the facility, or a physician designated by the medical director, must concur in the recommendation; provided that if the medical director is the patient's attending physician, a different physician designated by the residential health care facility must concur in the recommendation; and

(ii) the bioethics review committee must determine that the recommendation accords with the standards for surrogate decisions for adults and must approve the recommendation.

6. **Health care without medical benefit.** If no surrogate is available, willing, and competent to act for a patient determined to lack decision-making capacity pursuant to section 3 of this article, a decision to withhold or withdraw life-sustaining treatment shall be authorized if:

(a) an attending physician determines, in accordance with accepted medical standards and to a reasonable degree of medical certainty, that the patient will die within a short time period despite the provision of treatment and that treatment should be withdrawn or withheld; and

(b) one other physician selected by the hospital concurs in this determination.

7. **Patient's chart; physician's obligations.**

(a) Recommendations and determinations made pursuant to this section shall be recorded in the patient's chart.

(b) If the following disputes cannot otherwise be resolved, they shall be referred by an attending physician to the bioethics review committee:

(i) the concurring physician objects to an attending physician's recommendation or determination;

(ii) a member of the hospital staff directly responsible for the patient's care objects to an attending physician's recommendation.

§ 8. 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 notifying a physician or member of the nursing staff of the revocation.

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

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

(b) cancel any orders or plans of care 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 nursing staff informed of a revocation made pursuant to this section shall immediately notify a physician of the revocation.

§ 9. Implementation and review of decisions

1. Hospitals shall adopt written policies requiring implementation and regular review of decisions to withhold or withdraw life-sustaining treatment, in accordance with accepted medical standards.

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 ap-

propriate 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 chart;

(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; and

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

§ 10. Interinstitutional transfers

1. If a patient with any order or plan of care to withhold or withdraw life-sustaining treatment is transferred 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:

   (a) 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

   (b) cancel such order or plan and immediately 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.

§ 11. Bioethics review committees

1. **Establishment of a bioethics review committee; written policy.** Each hospital shall establish at least one bioethics review committee or participate in a bioethics 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 section.

2. **Functions of bioethics review committee.**

   (a) The bioethics review committee shall consider any health care matter presented to it by a person connected with the case.

(b) The bioethics 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;

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

(iv) discussing a matter without making a recommendation.

(c) Recommendations and advice by the bioethics review committee shall be advisory and nonbinding, except for committee approvals or disapprovals of the withdrawal or withholding of life-sustaining treatment from an emancipated minor patient, from an adult patient without a surrogate, or from any patient who is neither terminally ill nor permanently unconscious.

(d) The bioethics review committee may undertake other functions, such as education and policy review and development, as authorized by the hospital or hospitals it serves.

(e) The bioethics review committee may review and approve or disapprove recommendations to withhold or withdraw particular treatments or recommendations about a patient's course of treatment.

3. Composition of bioethics review committee.

(a) The bioethics review committee shall consist of a minimum of five individuals. It shall include at least one physician, one registered nurse, one certified social worker or other person with training or expertise in providing psychosocial services to patients, one other individual with training or expertise in bioethics, moral philosophy or theology, and one individual who is not affiliated with the hospital.

(b) In addition to meeting the requirements of paragraph (a) of this subdivision, in a residential health care facility at least one committee member must be a member of the facility's residents' council; and at least one committee member must be a certified ombudsman with the New York State Long Term Care Ombudsman Program or a representative or member of a not-for-profit organization organized and operated to promote the interests or rights of the elderly or nursing home residents. Nothing in this paragraph shall require the bioethics review committee of a residential health care facility to consist of more than five individuals, so long

as the qualifications of the members satisfy the requirements of paragraphs (a) and (b) of this subdivision.

(c) The bioethics review committee may include other individuals as chosen by the hospital.

4. Procedures for bioethics review committee.

(a) A minimum of three bioethics review committee members, at least one of whom is a physician, must participate in the consideration of any matter presented to it by a person connected with the case, subject to the following exceptions:

(i) Any committee member may suffice for dispute mediation.

(ii) The consideration of withdrawing or withholding life-sustaining treatment from an emancipated minor patient, an adult patient without a surrogate, or any patient who is neither terminally ill nor permanently unconscious, shall require the participation of at least five committee members who meet the requirements of subdivision (3) of this section; and the proportion of committee members that constitute a quorum of the entire review committee. The hospital shall make reasonable efforts to notify all committee members of these pending cases.

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

(c) The bioethics review committee shall:

(i) establish the proportion of committee members that constitute a quorum of the entire committee;

(ii) respond promptly, as required by the circumstances, to any request for a case consideration made by a person connected with the case; and

(iii) 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.

(d) The bioethics 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 patient's care, any parent or guardian of a minor patient directly involved in the minor patient's care, an attending physician,

the hospital, and other persons the committee deems appropriate, with the following:

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

(ii) the committee's response to the case, including a written statement of the reasons for approving or disapproving the withholding or withdrawal life-sustaining treatment from an emancipated minor patient, an adult patient without a surrogate, or any patient who is neither terminally ill nor permanently unconscious.

(e) Following bioethics 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 paragraph (d) of this subdivision have been informed of the committee's response to the case.

(f) The bioethics review committee may act through subcommittees, use different members for different types of cases and functions, and seek the advice of consultants as necessary. Any subcommittee shall routinely report its activities to the entire committee.

(g) The written policy of the bioethics review committee shall contain procedures to implement the requirements of this subdivision.

5. **Access to medical records and information; patient confidentiality.** Bioethics review committee members and consultants shall have access to medical information and medical and clinical records necessary to perform their function under this article. Notwithstanding any other provision of 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. **Bioethics review committee confidentiality.** Notwithstanding any other provisions of law, the proceedings and records of a bioethics 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 a bioethics review committee shall not be subject to disclosure or inspection in any manner, including under article 6 of the public officers law or article 31 of the civil practice law and rules; and, no person shall testify as to the proceedings or records of a bioethics 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) bioethics review committee proceedings and records, in cases where a committee approves or disapproves of the withholding or withdrawal of life-sustaining treatment from an emancipated minor patient, an adult patient without a surrogate, or any patient who is neither terminally ill nor permanently unconscious, shall be subject to review by the department of health; and

(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.

§ 12. 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.

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 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 convictions; 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.

§ 13. Immunity

1. **Bioethics review committees.** No person shall be subjected to criminal or civil liability, or be deemed to have engaged in unprofessional conduct, for acts performed in good faith pursuant to this article as a member of or consultant to a bioethics review committee or a participant in a bioethics 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 in good faith a health care decision made pursuant to this article or for other actions taken in good faith pursuant to this article.
3. **Surrogates, parents and guardians.** No person shall be subjected to criminal or civil liability for making a health care decision in good faith pursuant to this article or for other actions taken in good faith pursuant to this article.

§ 14. 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.

§ 15. 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.

§ 16. 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 bioethics review committee may commence a special proceeding in a court of competent jurisdiction with respect to any dispute arising under this article.

2. **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 section 4(4) of this article.

3. **Health care guardian for a minor patient.**

   (a) 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 383-b of the social services law; or

      (iv) an individual, 18 years of age or older, who has assumed care of the minor for a substantial and continuous period of time.

   (b) Notice of the proceeding shall be given to the persons identified in section 1705 of the surrogate's court procedure act.

   (c) 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.

(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.

§ 17. Remedy

1. Any hospital or attending physician that refuses to honor a health care decision made by a person authorized to make such decision pursuant to this article shall not be entitled to compensation for treatment, services, or procedures provided in violation of this article.

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 29-C of the public health law, or a person authorized to make health care decisions pursuant to this article, including injunctive and declaratory relief, and any other provisions of the public health law governing fines, penalties, or forfeitures.

§ 18. Regulations

1. The commissioner of health shall establish such regulations as may be necessary to implement this article.

2. The commissioner of health, 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 a concurring opinion, pursuant to section 3(3) of this article, that a patient lacks decision-making capacity because of mental illness or developmental disability.

§ 19. Rights to be publicized

1. The commissioner of health 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 a hospital, or within a reasonable time thereafter, and to each member of the hospital's staff.

Appendix B

Policies for DNR Orders: Existing Law

The Task Force recommends that the basic policies of Article 29-B of the New York Public Health Law, governing orders not to resuscitate (DNR orders), should be merged with its legislative proposal for surrogate decisions. However, certain policies specific to decisions about cardiopulmonary resuscitation (CPR) should still be contained in legislation or New York State Department of Health regulation. This appendix sets forth these provisions from Article 29-B. Chapter 16 discusses the Task Force's recommendations for integrating Article 29-B with the proposed legislation.

Definitions

To clarify legislative provisions on DNR orders, certain defined terms set forth in Section 2961 of Article 29-B should be retained. They are as follows:

1. ***Cardiopulmonary resuscitation*** means measures, as specified in regulations promulgated by the Commissioner of the Department of Health, to restore cardiac function or to support ventilation in the event of a cardiac or respiratory arrest. CPR shall not include measures to improve ventilation and cardiac functions in the absence of an arrest.

2. ***Emergency medical services personnel*** means the personnel of a service engaged in providing initial emergency medical assistance, including but not limited to first responders, emergency medical technicians, and advanced emergency medical technicians.

3. ***Hospital*** means a general hospital as defined in Section 2801(10) of the Public Health Law or a residential health care facility as defined in Section 2801(3) of the Public Health Law or a hospital as defined in Section 1.03(10) of the New York Mental Hygiene Law or a school named in Section 13.17 of the Mental Hygiene Law.

4. ***Hospital emergency service personnel*** means the personnel of the emergency service of a general hospital, as defined in Section 2801(10) of the Public Health Law, including but not limited to

emergency services attending physicians, emergency services registered professional nurses, and registered professional nurses, nursing staff and registered physicians assistants assigned to the general hospital's emergency service.

5. ***Hospitalization*** means the period during which a person is a patient in, or a resident of, a hospital.

6. ***Medically futile*** means that CPR 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.

7. ***Nonhospital order not to resuscitate*** means an order, issued in accordance with Section 2977 of the Public Health Law, that directs emergency medical services personnel and hospital emergency service personnel not to attempt CPR in the event a patient suffers cardiac or respiratory arrest.

8. ***Patient*** means a person admitted to a hospital or, for the purpose of provisions in the Public Health Law governing nonhospital DNR orders, a person who has or may be issued a nonhospital DNR order.

Decisions by Patients with Capacity — The Therapeutic Exception (Section 2964(3))

In general, Article 29-B requires physicians to seek the consent of an adult patient before entering a DNR order if the patient has the capacity to decide. Section 2964(3) of Article 29-B allows physicians to seek consent from a family member or other surrogate if two physicians determine that the discussion about a DNR order would cause the patient severe, immediate injury, and other requirements are met. This provision, as set forth below, should remain in effect, and should apply only to decisions about CPR.

Section 2964(3).

(a) In the event that the attending physician determines, in writing, that, to a reasonable degree of medical certainty, an adult patient who has capacity would suffer immediate and severe injury from a discussion of CPR, the attending physician may issue a DNR order without obtaining the patient's consent, but only after:

(i) consulting with and obtaining the written concurrence of another physician selected by a person authorized by the hospital to make such selection, given after personal examination of the patient, concerning the assessment of immediate and severe injury to the patient from a discussion of CPR;

(ii) ascertaining the wishes of the patient to the extent possible without subjecting the patient to a risk of immediate and severe injury;

(iii) including the reasons for not consulting the patient in the patient's chart; and

(iv) obtaining the consent of a health care agent who is available and would be authorized to make a decision regarding CPR if the patient lacked capacity or, if there is no such agent, a surrogate pursuant to Section 2965 of Article 29-B, provided, however, that the consent of an agent or surrogate should not be required if the patient has previously consented to a DNR order pursuant to Section 2964(2).

(b) Where the provisions of this subdivision have been invoked, the attending physician shall reassess the patient's risk of injury from a discussion of CPR on a regular basis, and shall consult the patient regarding CPR as soon as the medical basis for not consulting the patient no longer exists.

Effect of DNR Order on Other Treatment (Section 2968)

Section 2968 of the DNR law expressly states that "Consent to the issuance of a DNR order shall not constitute consent to withhold or withdraw medical treatment other than CPR." This provision should remain in effect.

DNR Orders in Community Settings (Section 2977)

In 1991, Article 29-B was amended to establish a system for honoring DNR orders for patients cared for at home or in other community settings. The amendments create a "nonhospital order not to resuscitate" and require emergency medical services personnel and hospital emergency service personnel to honor nonhospital DNR orders, except under narrow circumstances as described below in Section

2977(10). The Task Force proposes that these provisions should be retained.

Section 2977(2) extends policies for DNR orders in hospitals, nursing homes, and mental health facilities to nonhospital orders, except as otherwise provided in Section 2977. Under Section 2977(3), a nonhospital DNR order may be issued for patients in a health care facility to take effect after the patient leaves the facility, or it may be issued for a person who is not a patient or resident of a health care facility. Section 2977(4) establishes that consent to a nonhospital DNR order is given in the same manner as consent to a DNR order in a health care facility, except that a surrogate may only consent to a nonhospital order for a patient at a hospital, nursing home, or mental health facility. (This limitation expires on September 1, 1992, allowing surrogate decisions in other health care settings after that date.) Also, in any health care or community setting, an adult with capacity or a health care agent may consent to a nonhospital DNR order orally to the attending physician. A third person acting as a witness is not necessary for this consent.

Section 2977(2) specifies that requirements for dispute mediation established by Article 29-B apply only to patients at a hospital or nursing home. This is because a similar dispute mediation system is not available for home care patients or other patients in the community. Similarly, if the proposed legislation is enacted, the provisions for a bioethics review committee would apply only to patients in a general hospital or residential health care facility. The remaining provisions of Section 2977 are as follows:

Section 2977(6). A nonhospital DNR order shall be issued upon a standard form prescribed by the commissioner of health. The commissioner shall also develop a standard bracelet that may be worn by a patient with a nonhospital DNR order 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 DNR order or providing health care services.

Section 2977(7). An attending physician who has issued a nonhospital DNR order, and who transfers care of the patient to another physician, shall inform the physician of the order.

Section 2977(8). For each patient for whom a nonhospital DNR order 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 90 days, provided that the review need not occur more than once every 7 days. The attending physician shall record the review in the patient's chart or record provided, however, that a registered nurse who provides direct care to the patient may record the review in the chart or record at the direction of the physician. In such case, the attending physician shall include a confirmation of the review in the patient's chart or record within 14 days of such review. Failure to comply with this subdivision shall not render a nonhospital DNR order ineffective.

Section 2977(9). A person who has consented to a nonhospital DNR order 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 DNR order shall notify the attending physician of the revocation. An attending physician who is informed that consent to a nonhospital DNR order has been revoked shall record the revocation in the patient's chart or record, cancel the order, and make diligent efforts to retrieve the form issuing the order and the standard bracelet, if any.

Section 2977(10). Emergency medical services personnel or hospital emergency service personnel who are provided with a nonhospital DNR order, or who identify the standard bracelet on the patient's body, shall comply with the terms of such order; provided, however, that:

(a) emergency medical services personnel or hospital emergency service personnel may disregard the order if:

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

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

(b) hospital emergency service physicians may direct that the order be disregarded if other significant and exceptional medical circumstances warrant disregarding the order.

Section 2977(11). If a patient with a nonhospital DNR order is admitted to a hospital, the order shall be treated as a DNR order for a patient transferred from another hospital, and shall be governed by Section 2971 of Article 29-B ("Interinstitutional Transfers").

Section 2977(12). No person shall be subjected to criminal prosecution or civil liability, or be deemed to have engaged in unprofessional conduct, for honoring reasonably and in good faith pursuant to this

Section 2977 a nonhospital DNR order, for disregarding a nonhospital DNR order pursuant to Section 2977(10), or for other actions taken reasonably and in good faith pursuant to this Section 2977.

Residents of Mental Hygiene Facilities

Pending the development of comprehensive policies on surrogate decisions for residents of mental hygiene facilities, existing Article 29-B should apply to decisions about CPR for residents at such facilities and for those who have been transferred to a general hospital.

Medically Futile CPR

The Department of Health has clarified that Article 29-B creates no duty to provide medically futile CPR. The law defines futile CPR as CPR that will be unsuccessful in restoring cardiac and respiratory function or that will result in the patient experiencing repeated arrest in a short time period before death occurs. Under guidelines from the Department of Health, before a physician enters a DNR order because CPR would be futile, he or she must inform the patient, where there is any indication of the patient's ability to comprehend the information, or inform the person authorized to decide on the patient's behalf — a parent or legal guardian of a minor patient, a health care agent, or a surrogate for an adult patient without decision-making capacity.

This clarification about the intent and requirements of Article 29-B is important. The Task Force recommends that it should be set forth in legislation or regulation.

Appendix C

New York State Department of Health Patient Self-Determination Act Statement

PLANNING IN ADVANCE FOR YOUR MEDICAL TREATMENT

Your Right to Decide About Treatment

Adults in New York State have the right to accept or refuse medical treatment, including life-sustaining treatment. Our Constitution and state laws protect this right. This means that you have the right to request or consent to treatment, to refuse treatment before it has started, and to have treatment stopped once it has begun.

Planning in Advance

Sometimes because of illness or injury people are unable to talk to a doctor and decide about treatment for themselves. You may wish to plan in advance to make sure that your wishes about treatment will be followed if you become unable to decide for yourself for a short or long time period. If you don't plan ahead, family members or other people close to you may not be allowed to make decisions for you and follow your wishes.

In New York State, appointing someone you can trust to decide about treatment if you become unable to decide for yourself is the best way to protect your treatment wishes and concerns. You have the right to appoint someone by filling out a form called a Health Care Proxy. A copy of the form and information about the Health Care Proxy are available from your health care provider.

If you have no one you can appoint to decide for you, or do not want to appoint someone, you can also give specific instructions about treatment in advance. Those instructions can be written, and are often referred to as a Living Will.

You should understand that general instructions about refusing treatment, even if written down, may not be effective. Your instructions must clearly cover the treatment decisions that must be made. For example, if you just write down that you do not want "heroic measures," the instructions may not be specific enough. You should say the kind of treatment that you do not want, such as a respirator or chemotherapy, and describe the medical condition

when you would refuse the treatment, such as when you are terminally ill or permanently unconscious with no hope of recovering. You can also give instructions orally by discussing your treatment wishes with your doctor, family members or others close to you.

Putting things in writing is safer than simply speaking to people, but neither method is as effective as appointing someone to decide for you. It is often hard for people to know in advance what will happen to them or what their medical needs will be in the future. If you choose someone to make decisions for you, that person can talk to your doctor and make decisions that they believe you would have wanted or that are best for you, when needed. If you appoint someone and also leave instructions about treatment in a Living Will, in the space provided on the Health Care Proxy form itself, or in some other manner, the person you select can use these instructions as guidance to make the right decision for you.

Deciding About Cardiopulmonary Resuscitation

Your right to decide about treatment also includes the right to decide about cardiopulmonary resuscitation (CPR). CPR is emergency treatment to restart the heart and lungs when your breathing or circulation stops.

Sometimes doctors and patients decide in advance that CPR should not be provided, and the doctor gives the medical staff an order not to resuscitate (DNR order). If your physical or mental condition prevents you from deciding about CPR, someone you appoint, your family members, or others close to you can decide. A brochure on CPR and your rights under New York law is available from your health care provider.

Appendix D

Health Care Proxy Form

Health Care Proxy

(1) I, _____

hereby appoint _____
(name, home address and telephone number)
_____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect when and if I become unable to make my own health care decisions.

(2) Optional instructions: I direct my agent to make health care decisions in accord with my wishes and limitations as stated below, or as he or she otherwise knows. (Attach additional pages if necessary.)

_____

_____

_____

(Unless your agent knows your wishes about artificial nutrition and hydration [feeding tubes], your agent will not be allowed to make decisions about artificial nutrition and hydration. See instructions on reverse for samples of language you could use.)

(3) Name of substitute or fill-in agent if the person I appoint above is unable, unwilling or unavailable to act as my health care agent.

_____
(name, home address and telephone number)
_____

(4) Unless I revoke it, this proxy shall remain in effect indefinitely, or until the date or conditions stated below. This proxy shall expire (specific date or conditions, if desired):

_____

(5) Signature _____

Address _____

Date _____

Statement by Witnesses (must be 18 or older)

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1 _____

Address _____

Witness 2 _____

Address _____

Appendix E

Hospital and Nursing Home Policies on Life-Sustaining Treatment 1988/89 Survey Results

Introduction

In 1986 the Task Force conducted a survey of hospitals and nursing homes in New York State to learn about practices and policies for decisions about life-sustaining treatment.[1] In the winter of 1988-89 the Task Force conducted a second survey. The surveys covered four basic areas: (i) the existence and scope of institutional policies about withdrawing and withholding life-sustaining treatment, (ii) the procedures to determine whether patients have decision-making capacity, (iii) the prevalence of and functions served by committees that resolve conflicts or offer guidance to decision-making parties about the withholding and withdrawing of life-sustaining treatment, and (iv) the prevalence of religious or moral objections to forgoing life-sustaining treatment. The survey results are presented in tables A through E and are summarized below.

Table A: Response Rate and Profile of Respondents

In November 1988 the Task Force distributed a written questionnaire to administrators of 554 nursing homes. The questionnaire was sent to all nursing homes with only skilled beds and those with both skilled and health related beds listed in the directory of health care facilities maintained by the New York State Department of Health.

A similar survey was sent to the administrators of New York State hospitals in January 1989. The Hospital Association of New York State (HANYS) provided the Task Force with its member mailing list of 229 hospitals. The Health and Hospital Corporation of New York City hospitals were added to the list. Overall, the Task Force sent the

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[1]Results of the 1986 survey are presented in New York State Task Force on Life and the Law, *Life-Sustaining Treatment: Making Decisions and Appointing a Health Care Agent,* (New York, 1987), 161-80.

questionnaire to 243 hospitals – over 85 percent of the hospitals in New York State.

Two hundred and twelve of 554 nursing homes (38 percent) and 140 of 243 hospitals (58 percent) returned the questionnaire. Administrators completed a majority of the questionnaires: 69 percent of the nursing home responses and 64 percent of the hospital survey.

The distribution of the nursing home respondent population did not differ significantly from the actual nursing home population when analyzed by type of facility, number of beds, and whether the facility was hospital based. The sample, however, was not representative of the population by sponsorship; proprietary nursing homes were underrepresented.

The hospital respondents were representative of the HANYS hospital population in terms of geographic region and hospital size (number of beds); a breakdown for the entire hospital population was not available for the other characteristics – type of facility and medical school association. Community hospitals and hospitals affiliated with medical schools made up a majority of the respondents.

Table B: Institutional Policies for Withholding/ Withdrawing Life-Sustaining Treatment

To determine the number of facilities with institutional policies, the survey asked respondents whether they have a policy for decisions to withdraw or withhold life-sustaining measures other than CPR. Among hospitals, approximately one third had developed institutional policies. Hospitals with larger patient capacity (over 100 beds) were more likely to have an institutional policy. Geographic region, medical school affiliation, and type of hospital did not have a significant impact on whether the hospital had developed a policy.

Only 26 percent of the nursing homes had an institutional policy on life-sustaining treatment. A majority of nursing home institutional policies addressed artificial respiration and artificial nutrition and hydration. In addition, 89 percent of the nursing home policies covered decisions to transfer residents to other facilities for treatment.

Almost all survey respondents with policies (both hospital and nursing home) indicated that the policies were written.

Table C: Determining Decision-Making Capacity

Despite the importance of the determination of capacity, only 36 percent of the hospitals had a policy for the procedure to determine that a patient lacks capacity to make decisions. Tertiary care facilities, large hospitals, and hospitals affiliated with a medical school were significantly more likely to have a policy. A majority of these policies were written.

Close to one half of the nursing home respondents had written guidelines to determine capacity (a significant increase from the previous Task Force survey when only 12 percent of nursing homes had written policies[2]). Differences among nursing homes by facility characteristics such as size or sponsorship were insignificant.

The nursing home questionnaire also asked facilities to identify the person(s) responsible for determining that residents lack the capacity to decide about life-sustaining treatment. Facilities reported that the attending physician was involved in virtually all cases.

Table D: Institutional Committees

The Task Force questionnaire asked respondents whether the facility had a "committee that considers ethical issues, resolves conflicts, or offers guidance to decision-making parties regarding the withholding or withdrawal of life-sustaining or life-saving medical treatment." The question did not inquire specifically about an "ethics committee" since some facilities do not use that term but may have a committee that serves similar functions.

Twenty-seven percent of the nursing homes surveyed indicated they had a committee to address ethical issues. Size, sponsorship, type of facility, and whether the nursing home was hospital based were not significant variables. In addition, nursing homes with committees were more likely to have established institutional policies for withholding and withdrawing life-sustaining treatments than facilities without committees: 49 percent (28) of the 57 nursing homes with committees had institutional policies compared with 18 percent (29) of the 155 facilities without committees.

A majority of hospital respondents indicated that the facility had a committee. Tertiary care hospitals and hospitals affiliated with a medi-

[2]For an analysis and comparison of the 1986 and 1988 nursing home survey data see T. Miller and A. M. Cugliari, "Withdrawing and Withholding Treatment: Policies in Long-Term Care Facilities," *Gerontologist* 30 (1990): 462-68.

cal school were more likely to have formed a committee. However, hospitals with committees were not more likely to have an institutional policy about life-sustaining treatment.

Committees at both facilities most frequently addressed ethical issues in patient care generally and decisions about life-sustaining treatment. A majority of the committees provided consultation and a forum for discussing ethical issues. In addition, a majority of the committees engaged in dispute resolution.

The committees in New York State hospitals and nursing homes were multidisciplinary. Almost all the committees included physicians, nurses, social workers, and lawyers. Members of the clergy and administrators participated on approximately half the committees. Thirty-eight percent of the hospital committees included an ethicist in contrast to 12 percent of the nursing home committees.

Table E: Institutional Conscience Objections to Treatment Decisions

In order to understand the nature and prevalence of institutional conscience objections at hospitals and nursing homes, the questionnaire sought information about facilities that refuse to honor, on religious or moral grounds, decisions to withhold or withdraw life-sustaining treatment by competent patients or patients who left clear evidence of their wishes. The questionnaire instructed respondents to exclude concerns about liability as a basis for refusing to honor decisions to forgo treatment when answering the questions.

The questionnaire asked respondents whether their facility would object on religious or moral grounds to decisions to withhold artificial respiration or artificial nutrition and hydration for patients facing three different medical conditions: (i) terminal illness, (ii) permanent unconsciousness, and (iii) severe debilitation in the absence of terminal illness and permanent unconsciousness. The questionnaire also asked for responses about withdrawing treatment in each of these circumstances.

The survey results revealed four important findings: (i) overall, 29 percent of the hospitals and 40 percent of the nursing home respondents indicated an institutional objection based on either religious or moral beliefs to at least one of the 12 treatment decisions posed; (ii) a majority of the hospitals and nursing homes with conscience objections had not expressed their policy in writing – 90 percent of the hospitals and 70 percent of the nursing homes; (iii) a higher percentage of

hospital and nursing home respondents opposed or had no policies for decisions to forgo artificial nutrition and hydration than opposed or had no policies for artificial respiration; and (iv) facilities were more likely to have "no policy" for withdrawing treatment than for withholding treatment.

Although a substantial number of nursing homes and hospitals expressed conscience objections, the study did not examine surrogate decisions for incompetent adults who left no clear guidance; the study inquired solely about objections to decisions by patients to forgo treatment. Since facilities may be more likely to raise conscience objections when surrogates decide than when competent patients choose for themselves, the actual number of facilities that opposed decisions to forgo life-sustaining treatment may have been higher than was indicated by the survey.

Table A
Response Rate and Profile of Respondents

Response Rate

	Hospital	Nursing Home
Questionnaires	243	554
Responses	140	212
Overall Response Rate*	58%	38%

Profile of Respondents

1989 Hospital Survey

Type	n=140	
Community	113	81%
Tertiary	24	17%
Region		
Nassau/Suffolk	11	8%
Northeast	16	11%
Central	24	17%
Buffalo	21	15%
Greater New York	28	20%
Northern Metropolitan	23	16%
Rochester	14	10%

Affiliation	n=140	
Medical school	56	40%
Independent	83	59%
Number of Bed		
under 100	29	21%
100-250	46	33%
250-500	43	31%
over 500	22	16%
Position of Respondent		
Administrator	90	64%
Medical director	16	11%
Director of nursing	10	7%
Counsel	6	4%
Other	2	1%
No response	16	11%

1988 Nursing Home Survey

Type	n=212	
Skilled	120	57%
Combined	92	44%
Number of Beds		
under 50	16	8%
50-99	54	25%
100-199	79	37%
over 200	63	30%

Sponsorship	n=212	
Voluntary	89	42%
Public	33	16%
Proprietary	85	40%
Association		
Hospital based	40	19%
Not hospital based	172	81%
Position of Respondent		
Administrator	146	69%
Director of nursing	27	13%
Medical director	15	7%
Other	17	8%

* The response rate for particular questions may be lower.

Table B
Institutional Policies

Hospitals/nursing homes with institutional policies for withholding or withdrawing life-sustaining treatment (other than CPR)

	Hospital n=138		Nursing Home n=206	
Yes	50	36%	56	27%
No	78	57%	131	64%
In progress	10	7%	19	9%

Hospitals/nursing homes with institutional policies in writing

	n=50		n=56	
Yes	43	86%	52	93%
No	7	14%	4	7%

Treatments included in institutional policies

	n=50		n=56	
Artificial respiration	28	56%	30	54%
Dialysis	8	16%	12	21%
Surgery	8	16%	18	32%
Antibiotics	9	18%	22	39%
Artificial nutrition & hydration	10	20%	33	59%

Table C
Determining Capacity

Hospitals/nursing homes with a procedure or policy for determining capacity

	Hospital n=140		Nursing Home* n=212	
Yes	51	36%	102	48%
No	81	58%	68	32%
In progress	6	4%	14	7%
No response	2	1%	28	13%

Hospitals with policies that are written

	n=51	
Yes	37	73%
No	14	27%

Professional who determines capacity**

	n=212	
Attending physician	38	18%
Attending physician with one health care professional	128	60%
No response	46	22%

* Nursing home survey asked if facility had a *written* policy for determining capacity.
** Nursing home survey only.

Table D
Institutional Committees

Hospitals/nursing homes that have a committee to consider ethical issues, resolve conflicts, or offer guidance to decision-making parties about the withholding or withdrawal of life-sustaining medical treatment (excluding committees that address only CPR)

	Hospital n=140		Nursing Home n=212	
Yes	71	51%	57	27%
No	54	38%	135	64%
In progress	8	6%	20	10%
No response	7	5%		
Issue(s) committees address	n=71		n=57	
Ethical issues in patient care generally	64	90%	32	56%
Life-sustaining treatment decisions *			36	63%
Only issues in neonatal and infant care **	6	8%		
Other	10	14%	5	9%
Frequency of committee meetings	n=71		n=57	
Monthly	22	31%	8	14%
Bi-monthly	4	6%	1	2%
Quarterly	4	6%		
When necessary	36	51%	48	84%
Function of the committees	n=71		n=57	
Prognosis determination	9	13%		
Dispute resolution	47	66%	45	79%
Retrospective case review	25	35%	13	23%
Prospective case review	14	20%	18	32%
Consultation	48	68%	36	63%
Education	49	69%	25	44%
Policy development	47	66%	27	47%
Discussing ethical issues	61	86%	33	58%
Other	9	13%		
Composition of the committees	n=71		n=57	
Physicians	71	100%	54	95%
Nurses	68	96%	55	96%
Social workers	53	75%	55	96%
Lawyers	43	61%	17	30%
Ethicists	27	38%	7	12%
Members of the outside community	29	41%	15	26%
Clergy	38	54%	26	46%
Administrators	30	42%	27	47%
Other ***	27	38%	21	37%

* Nursing home survey only.

** Hospital survey only.

*** "Other" included board members, psychologists, patient representatives, and risk managers.

Table E
Institutional Conscience Objections to Treatment Decisions*

Hospitals/nursing homes that would object on religious or moral grounds to the following:

A. **Withholding artificial respiration** for patients facing the following medical conditions:**

	Terminally Ill		Permanently Unconscious		Severely Debilitated	
	Hospital	Nursing Home	Hospital	Nursing Home	Hospital	Nursing Home
	n = 132	n = 151	n = 131	n = 149	n = 129	n = 150
Yes	1 1%	11 7%	5 4%	12 8%	18 14%	27 18%
No	105 80%	108 72%	98 75%	103 69%	73 57%	88 59%
No policy	26 20%	32 21%	28 21%	34 23%	38 29%	35 23%

B. **Withdrawing artificial respiration** for patients facing the following medical conditions:**

	Terminally Ill		Permanently Unconscious		Severely Debilitated	
	Hospital	Nursing Home	Hospital	Nursing Home	Hospital	Nursing Home
	n = 132	n = 143	n = 131	n = 142	n = 129	n = 140
Yes	7 5%	17 12%	14 11%	17 12%	19 15%	29 21%
No	88 67%	82 57%	80 61%	79 56%	61 47%	64 46%
No policy	37 28%	44 31%	37 28%	46 32%	49 38%	47 34%

C. **Withholding artificial nutrition and hydration** for patients facing the following medical conditions:

	Terminally Ill		Permanently Unconscious		Severely Debilitated	
	Hospital	Nursing Home	Hospital	Nursing Home	Hospital	Nursing Home
	n = 133	n = 193	n = 131	n = 191	n = 130	n = 190
Yes	20 15%	51 26%	22 17%	55 29%	31 24%	72 38%
No	67 51%	103 53%	62 47%	94 49%	43 33%	75 40%
No policy	46 35%	39 20%	47 36%	42 22%	56 43%	43 23%

D. **Withdrawing artificial nutrition and hydration** for patients facing the following medical conditions:

	Terminally Ill		Permanently Unconscious		Severely Debilitated	
	Hospital	Nursing Home	Hospital	Nursing Home	Hospital	Nursing Home
	n = 133	n = 186	n = 131	n = 186	n = 130	n = 186
Yes	21 16%	54 29%	26 20%	62 33%	31 24%	73 39%
No	60 45%	83 45%	53 40%	74 40%	38 29%	62 33%
No policy	52 39%	49 26%	53 40%	50 27%	61 47%	51 27%

* Percentages may not add up to 100% because of rounding.

** Some nursing home respondents indicated that the treatment is not provided at their facility.

Other Reports by the Task Force

- Surrogate Parenting: Analysis and Recommendations for Public Policy, May 1988 (143 pp.)
- Transplantation in New York State: The Procurement and Distribution of Organs and Tissues, January 1988 (164 pp.)
- Fetal Extrauterine Survivability, January 1988 (13 pp.)
- Life-Sustaining Treatment: Making Decisions and Appointing a Health Care Agent, July 1987 (180 pp.)
- The Determination of Death, July 1986 (48 pp.)
- Do Not Resuscitate Orders, April 1986 (113 pp.)
- The Required Request Law, March 1986 (16 pp.)

Copies of Task Force reports may be obtained by writing or calling:

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The New York State Task Force on Life and the Law

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