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NOTES

HEALTH CARE PROXIES: NEW YORK'S ATTEMPT TO RESOLVE THE RIGHT TO DIE DILEMMA

INTRODUCTION

It is uniformly accepted that competent adults have the right to make decisions regarding their own health care, including decisions that authorize termination of life-sustaining procedures.¹ Problems arise, however, when a patient becomes incompetent and thus no longer able to make such decisions.² Judicial opinions in New York³ and throughout the country⁴ have con-

¹ "No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law." *Union Pac. R.R. Co. v. Botsford*, 141 U.S. 250, 251 (1891). See also *Gray v. Romeo*, 697 F. Supp. 580, 584 (D.R.I. 1988) ("[t]he right to control medical decisions affecting one's body is deeply rooted in our country's history and tradition"); *In re Estate of Longeway*, 123 Ill. 2d 33, 549 N.E.2d 292 (1989) (a patient has a common law right to refuse life-saving or life-sustaining procedures); *In re Peter*, 103 N.J. 365, 529 A.2d 419 (1987) (all patients have the right to refuse life-sustaining medical treatment); *In re Colyer*, 99 Wash. 2d 114, 660 P.2d 738 (1983), modified on other grounds by *In re Hamlin*, 102 Wash.2d 810, 689 P.2d 1372 (1984) (right to refuse medical treatment encompasses the right to refuse life-sustaining treatment).

² "Competent" is defined as "possessing the requisite natural or legal qualifications"; "able; adequate; suitable; sufficient; capable; legally fit," while "capacity" is defined as an "ability to understand the nature and effects of one's acts." BLACK'S LAW DICTIONARY 188, 257 (5th ed. 1979). In this context, capacity to make health care decisions means the "ability to understand and appreciate the nature and consequences of health care decisions, including the benefits and risks of and alternatives to any proposed health care, and to reach an informed decision." N.Y. PUB. HEALTH LAW, § 2930(3) (McKinney Supp. 1991). Although there is a slight distinction between the meanings of competence and capacity, they have been used interchangeably for the purposes of this Note.

³ See, e.g., *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981) (cases involving discontinuance of life-sustaining treatment for incompetents call for substantive and procedural innovations in the law that are not for the courts to make); *A.B. v. C.*, 124 Misc. 2d 672, 477 N.Y.S.2d 281 (Sup. Ct., 1984) (the problem of withdrawing treatment from incompetent patients should be addressed by the legislature, rather than the courts).

⁴ See, e.g., *In re Estate of Longeway*, 123 Ill. 2d 33, 549 N.E.2d 292 (1989) (the

sistently recognized that the problem is one best suited for legislative initiative.⁵

The recent decision of the Supreme Court in *Cruzan v. Missouri Dep't of Health*⁶ underscores the vital importance of state legislative action on the complicated question of how to effectuate the wishes of terminally ill, incompetent individuals regarding their right to die. Although the Court did affirm that competent persons have a constitutional right to refuse life-sustaining procedures, it determined that where the patient is incompetent, it is constitutionally permissible for a state to require clear and convincing evidence of the patient's wishes to withdraw life-sustaining treatment before such wishes can be effectuated.⁷ The

legislature can better resolve the sensitive issues presented in cases involving the discontinuance of life-sustaining treatment); *In re Peter*, 108 N.J. 365, 385, 529 A.2d 419, 429 (1987) (the legislature is best suited to resolve the "fundamental societal questions" presented in withdrawal of treatment cases (quoting *In re Farrell*, 108 N.J. 335, 341, 529 A.2d 404, 407 (1987)); *In re Conroy*, 98 N.J. 321, 344, 486 A.2d 1209, 1220 (1985) (the legislature could more effectively formulate standards to follow in withdrawal of treatment cases); *In re Colyer*, 99 Wash. 2d 114, 139, 660 P.2d 738, 752 (1983) ("the [l]egislature is the body most capable of assessing the views of the people of th[e] state" on issues, such as withdrawing life-sustaining treatment, that "necessarily involve society's moral standards as well as legal and medical issues"), modified on other grounds by *In re Hamlin*, 102 Wash. 2d 810, 689 P.2d 1372 (1984).

⁵ However, despite the call for legislative initiative in this field, most courts, New York being an exception, have been willing to address questions dealing with the right to die. See, e.g., *In re Estate of Longeway*, 123 Ill. 2d 33, 549 N.E.2d 292 (1989) (faced with these cases, the court cannot wait for the legislature to act); *In re Peter*, 108 N.J. 365, 529 A.2d 419 (1987) (until the legislature acts, the court must involve itself in these cases and provide guidelines); *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985) (in the absence of specific legislation the courts may not properly avoid the issue merely because it is troubling or difficult).

⁶ 110 S. Ct. 2841 (1990).

⁷ It should be noted that on December 14, 1990, a Missouri county probate judge authorized the family of Nancy Cruzan to discontinue the artificial nutrition and hydration that had been sustaining Nancy's life since January 11, 1983. In the time since the Supreme Court decision, three more of Nancy's friends came forward, all describing conversations they had with Nancy in which she said she would have wanted her life-sustaining treatment stopped. This additional testimony provided the requisite clarity needed under the Missouri law. *Cruzan Granted the Right to Die*, *Newsday*, Dec. 15, 1990, at 3, col. 1. Nancy's feeding tube was removed hours after the decision was issued. *Feeding Tube Removed From Comatose Woman*, *Newsday*, Dec. 16, 1990, at 15, col. 3. Requests were made to resume giving food and water to Nancy, but the Missouri Supreme Court refused these pleas. *Request To Feed Cruzan is Rejected*, *Newsday*, Dec. 21, 1990, at 15, col. 1. Nancy Cruzan died on December 26, 1990, without ever showing any signs of discomfort or distress. *Death Ends Cruzan Family's Ordeal*, *Newsday*, Dec. 27, 1990, at 8, col. 1.

Supreme Court has thus permitted states to set up procedural roadblocks that effectively constitute an involuntary waiver of this right to be free of unwanted life-sustaining treatment. Six days after the Court announced its decision in *Cruzan*, the New York State Legislature passed an amendment to the Public Health Law that had been pending for years, Article 29-C: Health Care Agents and Proxies.⁸ This law promotes the right of individuals to decide about treatment in accordance with their own religious, moral and personal convictions. It enables family members or others chosen by the patient to ensure that the patient's wishes about treatment are honored after the patient has lost the capacity to express those wishes directly.

Part I of this Note follows the development of an individual's "right to die" in general, and in New York courts. As a matter of legal principle, adults have an expansive right to refuse life-sustaining treatment.⁹ However, as the New York case law demonstrates, this right is, as a practical matter, terribly constrained. Too often, an individual's wishes are not effectuated by the courts once the patient has lost the capacity to decide.¹⁰ Part II examines the development of the New York

⁸ N.Y. PUB. HEALTH LAW, §§ 2980-2994 (McKinney Supp. 1991) [hereinafter Proxy Law].

⁹ See, e.g., *Gray v. Romeo*, 697 F. Supp. 580 (D.R.I. 1988) (court authorized removal of feeding tube from patient in a permanent vegetative state); *McConnell v. Beverly Enter.-Conn., Inc.*, 209 Conn. 692, 553 A.2d 596 (1989) (court approved removal of nutrition and hydration from a patient in a terminal coma to implement patient's clearly expressed wishes); *In re Estate of Longeway*, 123 Ill. 2d 33, 549 N.E.2d 292 (1989) (guardian of an incompetent, irreversibly comatose patient permitted to exercise patient's right to refuse artificial nutrition and hydration); *In re Gardner*, 534 A.2d 947 (Me. 1987) (removal of feeding tubes allowed based on the personal intent of the then incompetent patient).

¹⁰ See, e.g., *In re O'Connor*, 72 N.Y.2d 517, 531 N.E.2d 607, 534 N.Y.S.2d 886 (1988) (patient's off-stated desire not to have her life artificially sustained held not to encompass a desire to decline medically provided food and water); *In re Wickel*, 159 A.D.2d 576, 552 N.Y.S.2d 437 (2d Dep't 1990) (petition to terminate life-sustaining treatment denied for failure to show that the patient "unequivocally demonstrated a firm and settled commitment" to such action); *Vogel v. Forman*, 134 Misc. 2d 395, 512 N.Y.S.2d 622 (Sup. Ct. Nassau 1986) (authorization to remove artificial nutrition and hydration from a permanently comatose patient denied, despite repeated testimony that such mechanical life support was against the wishes of the patient). This Note is not concerned with the rights of competent individuals to refuse life-sustaining treatment. The rights of these patients have not been terribly constrained by the courts. See, e.g., *Deel v. Syracuse Veterans Admin. Medical Center*, 729 F. Supp. 231 (N.D.N.Y. 1990) (competent, adult patient's decision to discontinue his use of artificial respiration was honored); *Fosmire v. Nicoleau*, 75 N.Y.2d 218, 551 N.E.2d 77, 551 N.Y.S.2d 876 (1990) (patient, as a compe-

Health Care Proxy Law. An analysis of the statute shows that, although the law is a dramatic step toward fulfilling the responsibility charged to the states by the *Cruzan* ruling, it does not go far enough. The law fails to address the broader issue of surrogate decision making for patients who lack capacity and who did not appoint an agent. Part III discusses various alternative procedures that could have been included in the statute so as to better ensure protection of an individual's right to refuse treatment.

I. DEVELOPMENT OF THE RIGHT TO DIE—AN OVERVIEW

In 1914, the New York Court of Appeals recognized that the common law confers on all competent adults the right to determine what shall be done with their own bodies.¹¹ At common law, the patient lost this right of self-determination if incompetent. Self-determination was viewed as a personal right that a surrogate could not exercise on behalf of an incompetent patient without clear evidence of the patient's preincompetence intent.¹² Where there was no statutory law dealing with this situation, the courts were forced to determine whether a person could exercise this right, through a surrogate or otherwise. The courts have extended, by varying degrees, the rights of the competent surrogate which may be applied on behalf of the incompetent by devising decision-making standards to guide the surrogate.

A. *The Substituted Judgment Approach*

Under the substituted judgment approach, the goal is to have a surrogate ascertain what the now incompetent patient would have done when faced with these circumstances, and then effectuate that decision.¹³ The first time a surrogate was allowed to exercise this right of self-determination for an incompetent

tent adult, had a right to decline life-saving blood transfusions).

¹¹ The common law rights of self-determination and bodily integrity are grounded in the law of trespass and battery. As Judge Cardozo stated in *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914), "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without the patient's consent commits an assault, for which he is liable in damages."

¹² See Note, *In re Storar: The Right to Die and Incompetent Patients*, 43 U. PITT. L. REV. 1087, 1097 (1982).

¹³ See *In re Estate of Longeway*, 133 Ill. 2d 33, 48-49, 549 N.E.2d 292, 299 (1989).

patient was in the case of Karen Ann Quinlan.¹⁴ In *In re Quinlan*, twenty-one-year-old Karen had, for unknown reasons, entered into a chronic, persistent vegetative state with no possible hope of recovery.¹⁵ The *Quinlan* court stated that "the only practical way to prevent destruction of the right [to terminate treatment] is to permit the guardian and family of Karen to render their best judgment . . . as to how she would exercise it in these circumstances."¹⁶

The concept of substituted judgment was expanded, arguably as far as possible, by a Massachusetts court in *Superintendent of Belchertown State School v. Saikewicz*.¹⁷ There, the court applied this approach to a patient who was profoundly mentally retarded, a person who was unable to understand his medical situation or to make informed decisions regarding treatment. The court accepted this approach because of its "straight-forward respect for the integrity and autonomy of the individual."¹⁸ The court reiterated that the primary goal of such an analysis is to determine the wants and needs of the individual

¹⁴ *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976).

¹⁵ Dr. Fred Plum, Professor and Chairman of the Department of Neurology at Cornell University invented the phrase "persistent vegetative state." He explains that: [V]egetative state describes a body which is functioning entirely in terms of its internal controls. It maintains temperature, heartbeat and pulmonary ventilation, digestive activity, and reflex activity of muscles and nerves for low-level conditioned responses. But there is no behavioral evidence of either self-awareness or awareness of the surroundings in a learned manner.

In re Jobes, 108 N.J. 394, 403, 529 A.2d 434, 438 (1987). See also Shapiro, *The Case of L.W.: An Argument for a Permanent Vegetative State Treatment Statute*, 51 OHIO ST. L.J. 439 (1990):

Persons in permanent vegetative state demonstrate a total loss of cerebral cortical functioning; they are permanently and irreversibly devoid of any awareness, thought, or feelings. Thus, for permanently vegetative patients, personality, memory, purposive action, social interaction, joy, satisfaction and pleasure are forever gone. Moreover, such patients do not and will never experience pain or suffering A diagnosis of the permanent vegetative state usually can be made with a reasonably high degree of reliability within weeks or months after the original injury by a physician skilled in neurological diagnosis.

Id. at 441-42. The author argues that a more "direct and intellectually honest approach to terminating treatment of such patients may be to define them as dead." *Id.* at 448.

¹⁶ *Quinlan*, 70 N.J. at 41, 355 A.2d at 664.

¹⁷ 373 Mass. 728, 370 N.E.2d 417 (1977).

¹⁸ *Id.* at 751, 370 N.E.2d at 431. "It does not advance the interests of the State or the ward to treat the ward as a person of lesser status or dignity than others." *Id.* at 746, 370 N.E.2d at 428.

involved.¹⁹

The evidentiary standard that purportedly must be met in showing the incompetent patient's intent or desire under the substituted judgment approach is one of clear and convincing evidence.²⁰ Courts vary, however, in determining what types of evidence will be admitted to make the determination. They often allow the surrogate to rely on general statements made long ago or even on knowledge of the patient's value system, which the surrogate then uses to interpret the incompetent's present preferences regarding treatment.²¹

B. *The Best Interests Approach*

Where no reliable evidence of a patient's intent exists, some courts have determined that the substituted judgment approach should be abandoned in favor of a best interests analysis.²² The New Jersey Supreme Court in *In re Conroy*²³ was the first to explicitly articulate this approach. Broken into two strands, the analysis was to apply in cases where there was less than clear and convincing evidence of a patient's preferences. Under the "limited-objective test," the court held that life-sustaining treatment may be withheld from the patient if there is some "trust-worthy" evidence, rather than clear and convincing evidence, that the patient would have refused the treatment, and the decision maker is clearly satisfied "that the burdens of the patient's

¹⁹ *Id.* at 750, 370 N.E.2d at 430.

²⁰ Evidence is 'clear and convincing' when it 'produce[s] in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations sought to be established, evidence so clear, direct and weighty and convincing as to enable [the factfinder] to come to a clear conviction without hesitancy of the precise facts in issue.'

In re Jobs, 108 N.J. 394, 407, 529 A.2d 434, 441 (1987) (quoting *State v. Hodge*, 95 N.J. 369, 376, 471 A.2d 389, 393 (1984) (citation omitted)).

²¹ See Note, *Someone Make Up My Mind: The Troubling Right to Die Issues Presented by Incompetent Patients with No Prior Expression of a Treatment Preference*, 64 NOTRE DAME L. REV. 394, 407 (1989). For criticism, see *In re Longeway*, 133 Ill. 2d 33, 59-61, 549 N.E.2d 292, 304-05 (1989) (Ward, J., dissenting). Judge Ward admitted that "the substituted judgment approach is appealing because it purports to preserve the incompetent patient's personal right of self-determination and bodily integrity." *Id.* at 61, 549 N.E.2d at 305. However, Judge Ward found that the "analysis is based upon a legal fiction: that the incompetent patient actually chooses to refuse life-sustaining treatment, and the court and litigants simply effectuate or carry out the patient's intent." *Id.*

²² See *Rasmussen v. Fleming*, 154 Ariz. 207, 741 P.2d 674 (1987).

²³ 98 N.J. 321, 486 A.2d 1209 (1985).

continued life with the treatment outweigh the benefits of that life for him."²⁴ Alternatively, in the absence of any proof of intent, the "pure-objective test" is to be followed. Here, a surrogate decision maker is to weigh the benefits and burdens of treatment. If the "net burdens of the patient's life with treatment clearly and markedly outweigh the benefits that the patient derives from life," and the treatment, if continued, would cause the patient "unavoidable and severe pain," then treatment may be discontinued.²⁵

The calculations under the best-interests approach generally involve consideration of factors relating to the treatment decision, including the patient's current condition, degree of pain, loss of dignity, prognosis, and the risks, side effects and benefits of each treatment option.²⁶ Courts may even allow consideration of the interests of the patient's family.²⁷ The problem with the best interests test is that the decision maker, in effect, becomes a judge on how worthwhile the patient's life is, which undermines the principle of self-determination.²⁸ As a result, few courts have explicitly adopted either strand of this standard.²⁹ However, as a practical matter, many versions of the substituted

²⁴ *Id.* at 365-66, 486 A.2d at 1232.

²⁵ *Id.*

²⁶ *Id.* at 365-66, 486 A.2d at 1232.

²⁷ See, e.g., *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983) (surrogate may consider how a decision to discontinue treatment will affect the patient's loved ones); *In re Jobes*, 108 N.J. 394, 415 n.10, 529 A.2d 434, 444 n.10 (1987) ("patient's likely attitude toward the impact of his or her choice of medical treatment on his or her loved ones" is a factor for the decision maker to consider).

²⁸ *In re Longeway*, 133 Ill. 2d 33, 48, 549 N.E.2d 292, 299 (1989).

²⁹ This standard was eventually rejected in New Jersey in favor of the subjective substituted judgment test, since, by definition, patients in permanent vegetative states do not experience any of the benefits and burdens that the objective balancing tests were intended or able to appraise. See *In re Peter*, 108 N.J. 365, 529 A.2d 419 (1987); *In re Jobes*, 108 N.J. 394, 529 A.2d 434 (1987). However, these courts, in applying the subjective test, considered an exceptionally broad range of evidence. As one author has stated, "[T]he point is that even someone critical of an objective standard is in the end unavoidably drawn to it." Dressler, *Relitigating Life and Death*, 51 OHIO ST. L.J. 425, 429 (1990). The author argues that the objective standard should first be expanded and then used by the courts in their determinations. The author argues that the permanently unconscious patient has no ability to experience life since, at minimum, some capacity for social interaction is needed. Without such interaction, the patient receives no benefit out of continued life, regardless of whether treatment is provided. Thus, a patient lacking any capacity to interact with others should, under this standard, have treatment stopped. *Id.* at 428-29. The author's proposed enriched objective standard would take into account the "absence of human cognition, love and awareness." *Id.* at 430.

judgment model incorporate the best interests standard by allowing evidence beyond the express wishes of the incompetent patient.³⁰

C. *The New York Position*

The New York Court of Appeals in *In re Storar* rejected the substituted judgment test as an unrealistic attempt to determine whether the terminally ill, incompetent patient would want to discontinue treatment.³¹ The court instead adopted an individualized subjective intent test with a clear and convincing evidentiary standard in order to ascertain, and then effectuate, the patient's clearly expressed wishes.³² The court reasoned that because the mentally retarded Storar had never been competent so as to be able to make reasoned decisions regarding medical treatment, a surrogate could not possibly determine what his preferences would be. Thus, the court would not allow Storar's mother, who concededly had her son's best interests in mind, to prevent the administration of painful life-sustaining blood transfusions.

In the companion case to *Storar*, *In re Eichner*,³³ the court held that the wishes of the patient, Brother Joseph Fox, were to be respected. The court based this decision on "solemn pronouncements" by Brother Fox that he did not want to be maintained in a vegetative coma by use of a respirator. The court apparently considered that Brother Fox's religious beliefs supported his views regarding treatment and that he was clearly old enough to realize or feel the consequences of his statements.³⁴

³⁰ See, e.g., *Brophy v. New England Sinai Hosp., Inc.*, 398 Mass. 417, 497 N.E.2d 626 (1986); *In re Colyer*, 99 Wash. 2d 114, 660 P.2d 738 (1983), modified on other grounds by *In re Hamlin*, 102 Wash. 2d 810, 689 P.2d 1372 (1984). Justice Stevens's dissent in the *Cruzan* case seems to support the inclusion of such evidence when making determinations as to whether life support should be withdrawn or withheld. In his view, the best interests of the individual must not be ignored by state policy. See *Cruzan v. Missouri*, 110 S. Ct. 2841, 2878 (1990) (Stevens, J., dissenting).

³¹ *In re Storar*, 52 N.Y.2d 363, 380, 420 N.E.2d 64, 72, 438 N.Y.S.2d 266, 275 (1981).

³² *Id.*

³³ 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981).

³⁴ *Id.* at 380, 420 N.E.2d at 72, 438 N.Y.S.2d at 274. The patient in this case, Brother Joseph Fox, was a member of the Society of Mary, a Catholic religious order. At the age of 83 years, Brother Fox suffered a hernia and agreed to undergo an operation to correct the condition. It was during this operation that Brother Fox "suffered cardiac arrest, with resulting loss of oxygen to the brain and substantial brain damage." *Id.* at 370-71, 420 N.E.2d at 67, 438 N.Y.S.2d at 269. Brother Fox fell into a permanent vegeta-

The court emphasized that it was merely giving effect to the decisions regarding treatment that Brother Fox had made for himself before he became incompetent, that is, to his subjective intent.³⁵

Viewed together, these two cases authorize the withdrawal or withholding of life-sustaining treatment from an incompetent patient only if there is clear and convincing evidence that the patient had subjectively expressed the desire not to receive life-sustaining treatment.³⁶ The New York Court of Appeals in the 1988 decision of *In re O'Connor*,³⁷ advanced an even stricter approach for effectuating the treatment preferences of incompetent patients than the approach articulated in *Storar*. Rather than accepting general evidence of the patient's subjective intent regarding life-sustaining treatment, the court required findings of a specific subjective intent as to the exact procedure in question involved before allowing it to be withdrawn.

O'Connor involved an elderly hospital patient who, as a result of several major strokes, was left mentally incompetent and physically disabled. Her two daughters sought to prevent the insertion of a nasogastric tube to provide nutrition and hydration. The daughters stated that such treatment was against their mother's expressed wishes because, before becoming incompetent, she had repeatedly stated that she did not want her life

tive state, requiring a respirator to survive. *Id.* at 370-71, 420 N.E.2d at 67, 438 N.Y.S.2d at 269.

³⁵ *Id.* at 378, 420 N.E.2d at 72, 438 N.Y.S.2d at 274.

³⁶ New York cases decided after *Storar*, however, appeared to be leaning toward a substituted judgment analysis in determining whether life-sustaining treatment should be withdrawn or withheld from incompetent patients. See, e.g., *In re Beth Israel Hosp.*, 136 Misc. 2d 931, 931, 519 N.Y.S.2d 511, 514 (N.Y. Sup. Ct. 1987) (holding that the right to refuse treatment does not absolutely require that the patient have manifested his or her exact preferences prior to becoming incompetent). The *Beth Israel* court articulated objective, rather than solely subjective, factors that should be considered in making such determinations. Included among these factors were the patients age, his or her life expectancy with or without the treatment, the degree of pain or suffering with or without treatment, and the possible risks or side effects of the treatment. *Id.* at 940, 519 N.Y.S.2d at 517. The articulation of such factors followed the approach suggested in *In re Conroy*, that is, a weighing of the benefits and burdens of continued treatment, 93 N.J. 321, 486 A.2d 1209 (1985). See also *Delio v. Westchester County Medical Center*, 129 A.D.2d 1, 516 N.Y.S.2d 677 (2d Dep't 1987) (inference that a patient's wishes not to be artificially maintained in a chronic vegetative state with no hope of recovery encompassed a desire not to be provided with artificial nutrition and hydration).

³⁷ 72 N.Y.2d 517, 531 N.E.2d 607, 534 N.Y.S.2d 886 (1988).

prolonged by artificial means.³⁸ However, both daughters, as well as a third witness, conceded that O'Connor had never discussed providing food or water with medical assistance, nor had she ever said that she would decline artificial life-support, if to do so would cause her pain.³⁹

The court again explicitly rejected the substituted judgment approach for asserting an incompetent patient's right to refuse medical treatment, holding that it is "inconsistent with our fundamental commitment to the notion that no person or court should substitute its judgment as to what would be an acceptable quality of life for another."⁴⁰ The court therefore refused to accept less than the clearly expressed wishes of a patient as to the specific treatment involved before permitting the exercise of the right to refuse treatment by a surrogate decision maker.

Statements made by the patient prior to becoming incompetent could not be relied on as an expression of intent if they were merely "immediate reactions to the unsettling experience of seeing or hearing of another's unnecessarily prolonged death"⁴¹ or if they were so general in nature as to fail to indicate what the patient's precise intent was at the time the pronouncements were made.⁴² However, this is the manner by which most ordinary, nonmedically oriented individuals express their preferences. It was surprisingly relevant to the court "whether the infirmities [O'Connor] was concerned with and the procedures she eschewed" at the time the statements were made were "qualitatively different" from those presented at the time of her incompetence.⁴³ In so evaluating, the court took a view opposite to that taken by most other courts which do not distinguish between the type of treatment administered. These courts accept artificial nutrition and hydration as being equivalent to artificial respiration and other forms of life-sustaining procedures.⁴⁴

³⁸ *Id.* at 523, 531 N.E.2d at 609, 534 N.Y.S.2d at 888.

³⁹ *Id.* at 527, 531 N.E.2d at 611, 534 N.Y.S.2d at 890.

⁴⁰ *Id.* at 530, 531 N.E.2d at 613, 534 N.Y.S.2d at 892.

⁴¹ *Id.* at 532, 531 N.E.2d at 614, 534 N.Y.S.2d at 893.

⁴² *Id.* The court reasoned that the patient's statement that she "would not want to be a burden to anyone" was of such too general a nature. The court indicated that elderly people "frequently, almost invariably" make statements of this type. The court decided that "the aged and infirm would be placed at a grave risk if the law treated such statements as a calm and deliberate resolve to decline all treatment." *Id.*

⁴³ *Id.* at 533, 531 N.E.2d at 614, 534 N.Y.S.2d at 893.

⁴⁴ See, e.g., *Gray v. Romeo*, 697 F. Supp. 580, 587 (D.R.I. 1988) (there is "no legal

Courts have adopted the O'Connor standard in cases where an individual attempts to exercise an incompetent patient's right to refuse medical treatment;⁴⁵ this, despite the fact that the O'Connor case involved a patient who was alert, able to follow simple commands and respond to simple questions.⁴⁶ As this case demonstrates, the specific subjective intent standard is unrealistic, unworkable and inhumane for almost everyone involved in the treatment decision. Contrary to cases such as *Quinlan* and *Saikewicz*, the *O'Connor* decision refuses to allow the termination of life-sustaining treatment in situations where the incompetent patient's wishes as to such treatment in general are clearly and convincingly known, but the patient's feelings about specific life-sustaining procedures are not known.⁴⁷ This

difference exists between a mechanical device that allows a person to breathe artificially and a mechanical device that artificially allows a person nourishment"); *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983) (no rational difference exists between the administration of food and water and the use of a respirator or other life support); *McConnell v. Beverly Enter.-Conn., Inc.*, 209 Conn. 692, 553 A.2d 596 (1989) (although applicable statute excluded the provision of artificial nutrition and hydration from the definition of "life support systems," court held there was no logical distinction between that and removal of a respirator and thus, allowed removal of a terminally ill patient's gastrostomy tube); *Brophy v. New England Sinai Hosp.*, 398 Mass. 417, 497 N.E.2d 626 (1986) (the primary focus should not be the type of treatment involved); *In re Gardner*, 534 A.2d 947 (Me. 1987) (the fact that artificial nutrition and hydration is involved does not mandate a different result). See also note 101 *infra* and accompanying text.

⁴⁵ See *Elbaum v. Grace Plaza*, 148 A.D.2d 244, 544 N.Y.S.2d 840 (2d Dep't 1989), where the court applied the *O'Connor* specific-subjective-intent test and held that a gastrointestinal feeding tube could be removed from the patient, Mrs. Elbaum. Removal was allowed because she had, prior to becoming incompetent, repeatedly stated that she would not want the use of feeding tubes if she were in an irreversible vegetative state. The court emphasized that its task was to determine what the patient would specifically have decided, if competent, under the present circumstances.

⁴⁶ *O'Connor*, 72 N.Y.2d 517, 525, 531 N.E.2d 607, 609, 534 N.Y.S.2d 886, 889. These facts were especially significant to Judge Hancock who concurred in the judgment that treatment should not be withdrawn. He found that the "particular circumstances here — e.g., the patient is neither terminal, comatose nor vegetative; she is awake, responsive and experiencing no pain; and the prescribed procedure is relatively simple and routine — would weigh heavily in favor of continuing the medically assisted feeding under any of the approaches . . ." *Id.* at 535, 531 N.E.2d at 616, 534 N.Y.S.2d at 895 (Hancock, J., concurring). Judge Hancock did, however, sharply criticize the majority's approach as unrealistic and unworkable. He proposed an approach that would require the court to consider a wide range of factors, both medical and personal, before making a decision in a particular case. *Id.* at 537, 531 N.E.2d at 617, 534 N.Y.S.2d at 896.

⁴⁷ See Nankivell, *This Far and No Further: Is There a Constitutional Right to Die?*, 76 A.B.A. J. 66 (Apr. 1990).

position has been criticized as inflexible by both commentators⁴⁸ and courts in other jurisdictions.⁴⁹

If the specific-subjective-intent rule is applied literally there is no realistic possibility that a patient, once rendered incompetent, will have his or her wishes regarding treatment effectuated by the courts.⁵⁰ This is so because the rule in fact demands an impossibility. It requires a factual determination of the incompetent patient's actual desire at the time of the decision to terminate treatment, that is, "what the patient would say if asked

⁴⁸ See, e.g., Weir & Gostin, *Decisions to Abate Life-Sustaining Treatment for Non-autonomous Patients; Ethical Standards and Legal Liability for Physicians after Cruzan*, 264 J. A.M.A. 1846, 1847 (1990); see also Spencer, *Health Care Proxy Bill Gains New Life*, N.Y.L.J., June 29, 1990, at 1, col. 3.

⁴⁹ See, e.g., *In re Estate of Longeway*, 133 Ill. 2d 33, 549 N.E.2d 292 (1989).

⁵⁰ Practically, this statement applies only in instances where patients have left no advance directives, and disagreement occurs regarding the decisions, since this is when resort to the judicial system becomes necessary. Although the case law demonstrates that the typical disagreement arises when the family or friends of the incompetent patient wish to discontinue life support in contravention of the health care provider's policies, the situation can be reversed, as evidenced by the case of Helga Wanglie. Wanglie, 87, had been in a vegetative state with no possible hope of recovery since May 1990. Wanglie's family had refused to permit her to die. Therefore, authorities at Hennepin County Medical Center in Minneapolis, Minnesota, where Wanglie is a patient, asked a state court to grant the hospital permission to disconnect Wanglie's life-support systems which they contended are inappropriate because they cannot advance Wanglie's personal interests. See *Life and Death After Cruzan*, TIME, Jan. 21, 1991, at 67; *Fight Over Life*, Newsday, Jan. 29, 1991, at 63, col. 2. The court eventually ruled that the physicians could not overrule the wishes of Wanglie's family. See *Hospital Can't Pull Plug*, Newsday, July 2, 1991, at 15, col. 1. Many cases, however, never reach the courts. Hospitals do frequently discontinue treatment, based on clear and convincing evidence, in accord with the family's wishes. A survey commissioned by the American Association of Critical-Care Nurses (AACN) found that "sixty-five percent of the [critical care] nurses participate in decisions about withdrawing or withholding life support at least several times each month, with twenty-four percent taking part in such discussions at least several times each week." AACN, *Frequent Life Support Decisions Confirm Expertise of Critical Care Nursing, Survey Reveals*, Press Release (May 23, 1990). The American Hospital Association has estimated that 70% of the 6,000 deaths that occur in the United States on an average day occur as a result of privately made decisions concerning withdrawal or withholding of life-sustaining treatment. Malcolm, *Judge Allows Feeding-Tube Removal*, N.Y. Times, Dec. 15, 1990, at 10, col. 1. Despite the apparent frequency of such decisions, it is estimated that, nationwide, 10,000 to 15,000 patients are being kept alive by artificial means, at an annual cost of \$1.3 billion. See Wagner, *Right-to-Die Ruling Begs the Question: Who Will Decide*, MODERN HEALTHCARE, Oct. 29, 1990, at 34. It has even been said that the enormous amounts of money spent on caring for the hopelessly ill should be limited so more money could be available to treat the poor. See Thornton, *Survey Says Elderly Overwhelm Healthcare System*, Proprietary to the United Press Int'l (June 25, 1990).

today whether the treatment in issue should be terminated.”⁵¹ In answering this question, the court has refused to examine any evidence other than the patient’s express statements regarding treatment. It is simply unrealistic to expect ordinary individuals, with no extensive medical knowledge, to be able to accurately forecast what their future condition will be and what medical technology will be available to save their lives under those circumstances. Not knowing what life-sustaining procedures might be applied at some point in the future, incompetent patients who desire not to have their lives artificially prolonged are forced to have divined the unforeseeable.

Arguably, the *O'Connor* case was decided correctly based on previously established law in New York. The *Eichner* and *Storar* cases established that, in New York, only when a patient had expressly indicated his or her preferences regarding the withdrawal or withholding of life-sustaining treatment could such decisions be authorized. In that respect, New York law already differed from the case law in most other jurisdictions that recognized, in certain circumstances, the authority of a patient’s family or others to discontinue treatment.⁵² The *O'Connor* court did adopt the reasoning of earlier decisions. Indeed, the court stated that the present decision “simply demonstrates that the *Eichner* standard is a meaningful one.”⁵³ However, the court then proceeded to require even further that the individual’s express preferences must specifically relate to the type of treatment involved.

Unfortunately, as the dissenting judge in *O'Connor* stated, this decision “substantially rewrites the law of self-determination.”⁵⁴ There will be relatively few individuals who can meet the demanding standard imposed by the court. In these instances, the court itself will decide that life-sustaining treatment should be started or continued. This will occur regardless of the

⁵¹ *O'Connor*, 72 N.Y.2d at 530, 531 N.E.2d at 613, 534 N.Y.S.2d at 892.

⁵² See, e.g., *Longeway*, 133 Ill.2d 33, 549 N.E.2d 292 (1989) (guardian may exercise the incompetent patient’s right to refuse treatment); *Jobes*, 108 N.J. 394, 529 A.D.2d 434 (1987) (a family member is the most appropriate decision maker); *Colyer*, 99 Wash.2d 114, 660 P.2d 738 (1983) (family member may use his best judgment to exercise the rights of the incompetent patient), modified on other grounds by *In re Hamlin*, 102 Wash.2d 810, 689 P.2d 1372 (1984).

⁵³ *O'Connor*, 72 N.Y.2d at 534 n.5, 531 N.E.2d at 616 n.5, 534 N.Y.S.2d at 894 n.5.

⁵⁴ *Id.* at 539, 531 N.E.2d at 619, 534 N.Y.S.2d at 898 (Simons, J., dissenting).

existence of other relevant factors that demonstrate the true desire of the patient. Such a result is evident in the *O'Connor* decision where the majority dismissed the factual findings and inferences made in both lower courts that O'Connor had clearly and convincingly expressed her wishes, on many occasions, not to have her life prolonged by *any* artificial means.⁵⁵

The court refuses to accept the substituted judgment of the incompetent patient's family or friends, professing only to accept the specific subjective intent of the patient. However, it is practically impossible to determine accurately what the patient would decide regarding treatment in the precise circumstances presented. Even if an individual had, while competent, predicted the exact circumstances he would later be faced with and had repeatedly voiced his preferences regarding treatment, there always remains the possibility that prior to becoming incompetent, the person changed his mind without informing anyone. If the court is to allow decisions to be made regardless of this possibility, it should permit the choice to be made by people who knew the patient intimately. Such a stance by the New York courts would be more consistent with that taken by the New York legislature, as evidenced by its enactment of Article 29-B of the Public Health Law in 1987.⁵⁶ The legislature has recognized that the patient's spouse, children, relatives or close friends are the ones in the best position to know the patient's moral, ethical and religious beliefs regarding such treatment.

⁵⁵ *Id.* at 545, 531 N.E.2d at 622, 534 N.Y.S.2d at 901 (emphasis in original). Here, the court's review should have been limited solely to determining whether there was any valid line of reasoning that could lead a rational person to the same conclusion reached on the basis of the evidence. *See, e.g.,* *People v. Bleakley*, 69 N.Y.2d 490, 508 N.E.2d 672, 515 N.Y.S.2d 761 (1987) (with few exceptions, the court of appeals, unlike an intermediate appellate court, passes on questions of law only, not questions of fact); *Humphrey v. State*, 60 N.Y.2d 742, 457 N.E.2d 767, 469 N.Y.S.2d 661 (1983) (the court of appeals is without power to review lower court findings of fact if such findings are supported by evidence in the record); *Le Roux v. State*, 307 N.Y. 397, 405, 121 N.E.2d 386, 391 (1954) (lower court findings of fact, if supported by substantial evidence of record, are conclusive in the court of appeals). In the lower courts, the proper clear and convincing evidentiary standard was used and the conclusions reached by the lower courts were amply supported by the evidence.

⁵⁶ N.Y. PUB. HEALTH LAW § 2965(4)(a) (McKinney & Supp. 1991) provides that if a patient has not designated a surrogate, or if a designated surrogate is unavailable, certain other people may serve as a substitute surrogate. The list of individuals authorized in this situation to make decisions regarding issuance of an order not to resuscitate include the patient's spouse, children over the age of eighteen, parents, brothers or sisters over the age of eighteen and close friends. *See* notes 125-26 and accompanying text *infra*.

This knowledge enables them to make most accurately the choice that the patient would have made were he or she competent.

New York courts have not adopted the substitute judgment approach, and so an incompetent patient's family or surrogate remains legally powerless to enforce the wishes of the patient regarding life-sustaining treatment absent specific evidence provided by the patient before becoming incompetent. A patient's statements may be completely disregarded by the court if they were made in general terms, in casual circumstances, as a spontaneous reaction to another person's medical treatment or while the patient was young and in excellent health.⁵⁷ The *Cruzan* decision legitimizes such an approach, thereby giving judicial protection only to those individuals who expressed their views regarding life-sustaining treatment in a manner sufficient to meet the rigorous standards imposed by the New York courts. A legislative determination recognizing an individual's right to refuse life-sustaining treatment and providing a method for implementing that right thus became vitally important in New York.

II. THE NEW YORK HEALTH CARE PROXY LAW

A. *Development*

In March 1985, Governor Cuomo convened the New York State Task Force on Life and the Law (Task Force). He asked the Task Force to develop recommendations on issues arising from recent advances in medical technology, including the withdrawal and withholding of life-sustaining treatment.⁵⁸ The Task Force realized that under current New York law, following the loss of capacity, a person's intensely held feelings about treatment may be subverted by "the emotional needs of family members, the professional ethos of health care providers, or the policies of medical facilities."⁵⁹ Without some procedure to allow individuals to express their wishes prior to losing capacity, the course their medical treatment takes would be decided by

⁵⁷ See *O'Connor*, 72 N.Y.2d 517, 532, 531 N.E.2d 607, 614, 534 N.Y.S.2d 886, 893 (1988); see also Orentlicher, *Advance Medical Directives*, 263 J. A.M.A. 2365 (1990).

⁵⁸ N.Y. STATE TASK FORCE ON LIFE AND THE LAW, *LIFE-SUSTAINING TREATMENT: MAKING DECISIONS AND APPOINTING A HEALTH CARE AGENT 1* (July 1987) [hereinafter *TASK FORCE REPORT*].

⁵⁹ *Id.* at 14.

others, rather than themselves.⁶⁰ The Task Force thus concluded that there was a "compelling need" for legislation in New York State to ensure that individuals' wishes dictate what treatment they receive, if any.⁶¹ The Task Force proceeded to examine the different types of legislation that could be utilized in New York to accomplish this objective.

1. Living Will Legislation

The purpose of a living will is to provide a written directive to the family, physicians and hospital that life-prolonging treatment should not be administered in the event the person becomes incompetent. Forty-two states and the District of Columbia have enacted legislation recognizing the validity of such prior written directives.⁶² New York has not enacted a living will

⁶⁰ *Id.*

⁶¹ *Id.* at 16.

⁶² See Alabama Natural Death Act, ALA. CODE §§ 22-8A-1 to -10 (1990); Alaska Rights of Terminally Ill Act, ALASKA STAT. §§ 18.12.010-100 (1986); Arizona Medical Treatment Decision Act, ARIZ. REV. STAT. ANN. §§ 36-3201 to -3210 (1986); Arkansas Rights of the Terminally Ill or Permanently Unconscious Act, ARK. STAT. ANN. §§ 20-17-201 to -218 (Supp. 1989); California Natural Death Act, CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1991); Colorado Medical Treatment Decision Act, COLO. REV. STAT. §§ 15-18-101 to -113 (1987 & Supp. 1990); Connecticut Removal of Life Support Systems Act, CONN. GEN. STAT. §§ 19a-570 to -575 (Supp. 1991); Delaware Death with Dignity Act, DEL. CODE ANN. tit. 16, §§ 2501-2509 (1983); District of Columbia Natural Death Act of 1981, D.C. CODE ANN. §§ 6-2421 to -2430 (1989); Florida Life-Prolonging Procedure Act, FLA. STAT. ANN. §§ 765.01 to -.17 (West 1986 & Supp. 1991); Georgia Living Will Act, GA. CODE ANN. §§ 31-32-1 to -12 (1991); Hawaii Medical Treatment Decisions Act, HAW. REV. STAT. §§ 327D-1 to -27 (Supp. 1989); Idaho Natural Death Act, IDAHO CODE §§ 39-4501 to -4509 (1985 & Supp. 1991); Illinois Living Will Act, ILL. ANN. STAT. ch. 110 ½, §§ 701-710 (Smith-Hurd Supp. 1991); Indiana Living Wills and Life-Prolonging Procedures Act, IND. CODE ANN. §§ 16-8-11-1 to -22 (Burns 1990); Iowa Life-Sustaining Procedures Act, IOWA CODE ANN. §§ 144A.1 -.11 (West 1989); Kansas Natural Death Act, KAN. STAT. ANN. §§ 65-28.101 to -28.109 (1985); Kentucky Living Will Act, 1990, KY. REV. STAT. ANN. §§ 311.622-.644 (Michie/Bobbs-Merrill 1991); Louisiana Life-Sustaining Procedures Act, LA. REV. STAT. ANN. §§ 40:1299.58.1-.10 (West Supp. 1991); Maine Uniform Rights of the Terminally Ill Act, ME. REV. STAT. ANN. tit. 18a, §§ 5-701 to -714 (Supp. 1990); Maryland Life-Sustaining Procedures Act, MD. HEALTH-GEN. CODE ANN. §§ 5-601 to -614 (1990); Minnesota Adult Health Care Decisions Act, MINN. STAT. ANN. §§ 145B.01-.17 (West Supp. 1991); Mississippi Withdrawal of Life-Saving Mechanisms Act, MISS. CODE ANN. §§ 41-41-101 to -121 (Supp. 1990); Missouri Uniform Rights of the Terminally Ill Act, MO. ANN. STAT. §§ 459.010 -.055 (Vernon Supp. 1991); Montana Living Will Act, MONT. CODE ANN. §§ 50-9-101 to -104, -11, -201 to -206 (1989); Nevada Withholding or Withdrawal of Life-Sustaining Procedures Act, NEV. REV. STAT. ANN. §§ 449.540 -.690 (Michie 1986 & Supp. 1989); New Hampshire Terminal Care Document, N.H. REV. STAT. ANN. §§ 137-H:1 to -H:16 (1990); New Mexico Right to Die Act, N.M.

law. Therefore a living will is only enforceable in New York on a case-by-case basis, where it can be offered as clear and convincing evidence of the incompetent patient's intent.⁶³

There are significant drawbacks inherent in living wills. A living will is written in advance of the time when treatment decisions must be made. It therefore cannot represent an informed decision among different alternatives under the present circumstances.⁶⁴ If a living will is drafted in specific language it cannot provide guidance in unanticipated circumstances. If, on the other hand, the will is written in general language, then its terms may be held too ambiguous and vague to apply to any particular treatment.⁶⁵ Furthermore, most statutes restrict the types of treatment that an individual may designate in the living will to be withdrawn or withheld.⁶⁶ It is also often specified that the

STAT. ANN. §§ 24-7-1 to -11 (1986); North Carolina Right to Natural Death Act, N.C. GEN. STAT. §§ 90-320 to -323 (1990); North Dakota Uniform Rights of the Terminally Ill Act, N.D. CENT. CODE §§ 23-06.4-01 to -14 (Supp. 1989); Oklahoma Natural Death Act, OKLA. STAT. ANN. tit. 63, §§ 3101-3111 (West 1991); Oregon Rights with Respect to Terminal Illness Act, OR. REV. STAT. §§ 127.605-.650 (1989); South Carolina Death with Dignity Act, S.C. CODE ANN. §§ 44-77-10 to -160 (Law. Co-op. Supp. 1990); South Dakota Living Will Act, S.D. CODIFIED LAWS ANN. §§ 34-12D-1 to -22 (Supp. 1991); Tennessee Right to Natural Death Act, TENN. CODE ANN. §§ 32-11-101 to -110 (Supp. 1990); Texas Natural Death Act, TEX. HEALTH & SAFETY CODE ANN. §§ 672.001-.021 (Vernon Supp. 1991); Utah Personal Choice and Living Will Act, UTAH CODE ANN. §§ 75-2-1101 to -1118 (Supp. 1991); Vermont Terminal Care Document Act, VT. STAT. ANN. tit. 18, §§ 5251-5262 & tit. 13, Forgery & Counterfeiting, § 1801 (1987 & Supp. 1990); Virginia Natural Death Act, VA. CODE ANN. §§ 54.1-2981 to -2992 (1990); Washington Natural Death Act, WASH. REV. CODE ANN. §§ 70.122.010-.905 (Supp. 1991); West Virginia Natural Death Act, W.VA. CODE §§ 16-30-1 to -10 (1991 & Supp. 1991); Wisconsin Natural Death Act, WIS. STAT. ANN. §§ 154.01-.15 (West 1989); Wyoming Living Will Act, WYO. STAT. §§ 35-22-101 to -109 (Supp. 1991). See also Uniform Rights of the Terminally Ill Act, §§ 1-18, 9A U.L.A. 456 (Supp. 1990).

⁶³ Note, *Living Wills in New York: Are They Valid?*, 38 SYRACUSE L. REV. 1369, 1384 (1987). See also *Saunders v. State*, 129 Misc. 2d 45, 492 N.Y.S.2d 510 (N.Y. Sup. Ct. 1985) (wishes expressed in a living will could serve as informed medical consent for withholding of life-sustaining treatment in the event the patient became incapacitated); but see TASK FORCE REPORT, *supra* note 58, at 77 (Task Force survey indicates that despite clear legal support, many hospitals and nursing homes are reluctant to enforce a patient's living will unless a variety of circumstances are met).

⁶⁴ TASK FORCE REPORT, *supra* note 58, at 75.

⁶⁵ See Orentlicher, *supra* note 57. Even assuming an individual could write in a living will that he or she desires no life-sustaining treatment whatsoever, the possibility remains that such a statement could be interpreted as barring administration of only those types of treatment in existence at the time that the living will was executed. Advancements in technology made after such a time would not be considered under such a result.

⁶⁶ See, e.g., Georgia Living Will Act, GA. CODE ANN. § 3132 (1989) ("Life-sustaining

living will is not effective unless the patient is diagnosed to be in a terminal condition,⁶⁷ which by definition, often does not apply to patients in persistent vegetative states.

For these reasons, the Task Force concluded that, for purposes of legislative action, living wills have value only in providing evidence of a patient's wishes in the event a healthcare agent has not been appointed.⁶⁸

2. Durable Powers of Attorney

Various states have either enacted durable power of attorney statutes for health care⁶⁹ or interpreted existing legislation to include powers to delegate decision-making authority for health care.⁷⁰ The New York durable power of attorney statute does not refer to health care decisions.⁷¹ In 1984, the New York Attorney General stated that a durable power of attorney, under the existing statute, is an "uncertain vehicle" for delegation of authority generally for an agent to make health care decisions on behalf of an incompetent person.⁷² He did acknowledge, however, that such a power could be used to authorize another person to communicate specific decisions made by the principal regarding health care decisions.⁷³ The principal's instructions,

procedures shall not include nourishment or anything deemed necessary to alleviate pain."); Missouri Life Support Declarations Act, Mo. ANN. STAT. § 459.010 (Vernon Supp. 1991) ("Death-prolonging procedure shall not include . . . the performance of any procedure to provide nutrition or hydration.").

⁶⁷ See, e.g., Alabama Natural Death Act, ALA. CODE § 22-8A (1990) (act applies only to a patient whose death is "imminent or whose condition is hopeless unless he or she is artificially supported through the use of life-sustaining procedures"); Missouri Life Support Declarations Act, Mo. ANN. STAT. § 459.010 (Vernon Supp. 1991) (terminal condition defined as an "irreversible or incurable condition which in the opinion of the attending physician is such that death will occur within a short time regardless of the application of medical procedures").

⁶⁸ TASK FORCE REPORT, *supra*, note 58, at 81. There is legislation in other states that combines a recognition of living wills with a process for surrogate decision making when a living will is not available. See *id.*

⁶⁹ See, e.g., Illinois Power of Attorney for Health Care, ILL. REV. STAT. ch. 110 ½, para. 804 (1988).

⁷⁰ See, e.g., *In re Peter*, 108 N.J. 365, 529 A.2d 419 (1987) (interpreting New Jersey's Power of Attorney Statute, N.J. STAT. ANN. § 46:2B-8 (West Supp. 1989), as authorizing conveyance of durable authority to make medical decisions).

⁷¹ N.Y. GEN. OBLIG. LAW § 5-1601 (McKinney 1990).

⁷² See TASK FORCE REPORT, *supra* note 58, at 80 (citing 84 Op. N.Y. Att'y Gen. F16 (1984)).

⁷³ *Id.*

rather than the delegation of decision-making power, are afforded legal recognition under this interpretation. Practically, therefore, under New York's existing legislation, executing a durable power of attorney is equivalent to executing a living will, accompanied by all the inherent disadvantages. In addition, powers concerning health care decisions would seem to be more sensitive than property matters that are generally delegated under power of attorney statutes. Particular rules and forms are desirable and necessary for health care agencies to ensure their validity and efficacy and to protect health care providers so that they will honor the authority of the agent at all times. The New York durable power of attorney statute, which does not contain such safeguards, therefore is not a viable vehicle for delegating general authority for medical decisions.

3. Appointing an Agent

The Task Force concluded that designing a separate statute which would enable an individual to designate an agent specifically for making health care decisions was the optimal choice for New York.⁷⁴ On July 22, 1990, the Health Care Agent and Proxy Proposal 6176-A was signed by Governor Cuomo.⁷⁵ This law, according to Governor Cuomo, was intended to give "adults in New York an effective means to ensure that their treatment wishes and interests will be protected if they lose the capacity to speak for themselves."⁷⁶ This method has received the most positive attention, by both courts and commentators, of any of the alternatives.⁷⁷

The advantages of such a legislative scheme are apparent. Appointing an agent to make health care decisions avoids the difficulties that are inherent in living wills. Most importantly, an

⁷⁴ TASK FORCE REPORT, *supra* note 58, at 80-83.

⁷⁵ N.Y. PUB. HEALTH LAW §§ 2980-2994 (McKinney Supp. 1991).

⁷⁶ Governor's Memorandum on the Approval of L. 1990, ch. 752, N.Y. Laws 2742 (McKinney).

⁷⁷ See, e.g., Note, *Living Wills in New York: Are They Valid?*, 38 SYRACUSE L. REV. 1369 (1987); Note, *Appointing An Agent to Make Medical Treatment Choices*, 84 COLUM. L. REV. 985 (1984); *Filling the Gap Where a Living Will Won't Do*, N.Y. Times, Jan. 17, 1991, at 39, col. 1 (discussing the advantages of a proxy over living wills); see also Justice O'Connor's concurrence in *Cruzan* that "failures might be avoided if the state considered an equally probative source of evidence: the patient's appointment of a proxy to make health care decisions on her behalf." 110 S. Ct. 2841, 2857 (1990).

individual is not required under such legislation to predict accurately the medical circumstances he or she will later face. If the individual becomes incompetent, an agent will be able to engage in the same decision-making process that the patient would himself have undertaken. The agent will be able to confer with physicians regarding the type of treatment involved and the accompanying risks and benefits. Thus the agent will be able to make the same type of informed decision that the patient would have made if competent. If a patient has left instructions regarding medical treatment, his agent will be available to interpret these statements and resolve any ambiguities in the event the patient becomes incompetent. Since the patient will have presumably chosen a person he trusts to represent his interests there is no substantial risk that the agent will disregard the patient's preferences.

Health care proxy legislation benefits health care providers as well as the individual patient. Although some courts have indicated that, where all parties are in agreement, prior court approval is not necessary in order to withhold or withdraw life-sustaining treatment from patients in irreversible vegetative comas,⁷⁸ as a practical matter, there is no way that physicians who withdraw treatment from patients can be sure that they will not later be subjected to liability unless the physicians have obtained prior approval.⁷⁹ The presence of an appointed agent, rec-

⁷⁸ See, e.g., *In re Colyer*, 99 Wash. 2d 114, 139, 660 P.2d 738, 752 (1983), modified on other grounds by *In re Hamlin*, 102 Wash. 2d 810, 689 P.2d 1372 (1984); *In re Storer*, 52 N.Y.2d 363, 378-80, 420 N.E.2d 64, 72, 438 N.Y.S.2d 266, 274, (1981).

⁷⁹ Note, *Discontinuing Treatment of Comatose Patients Who Have Not Executed Living Wills*, 19 Loy. L.A.L. Rev. 61 (1985). See *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983), where a physician was criminally prosecuted for withdrawing life-sustaining treatment even though he had obtained the consent of the family. Although the charges were eventually dismissed, the fear of criminal prosecution remains in the hearts of physicians. This concern can be attributed, in part, to the perceived "willingness of local prosecutors to aggressively pursue cases involving the withdrawal of life-sustaining treatment" and to the arguments advanced by pro-life advocates. TASK FORCE REPORT, *supra* note 58, at 10. But see *Weir & Gostin*, *supra* note 48 (arguing that the threat of liability for abating life-sustaining treatment has been greatly exaggerated). The threat of physician liability can also apply in the opposite situation. At least two courts have recognized that physicians may be sued for imposing life-sustaining treatment against the wishes of the patient or the patient's surrogates. See *Leach v. Shapiro*, 13 Ohio App. 3d 393, 469 N.E.2d 1047 (1984) (physicians failure to obtain family's consent before placing patient on a respirator, in the absence of an emergency, gives rise to a cause of action for battery); *Bartling v. Glendale Adventist Medical Center*, 184 Cal. App. 3d 961, 229 Cal. Rptr. 360 (1986) (physicians continued efforts to sustain the pa-

ognized by the law to have the power to give such approval, would afford doctors and hospitals greater legal protection. As a result, decisions could be made by physicians and agents without resorting to the court system with its inherent costs and delay.

B. *The New York State Law*

1. Specific Provisions

As enacted, the Proxy Law specifically authorizes any competent adult (the "principal") to appoint a health care agent by executing a form that, once signed and witnessed, delegates the principal's power to make health care decisions.⁸⁰ It is only upon a determination that the principal lacks capacity that the agent's power becomes effective.⁸¹ The agent has power to make health care decisions on behalf of the principal only to the extent that such decisions are consistent with the known wishes, as well as the religious and moral beliefs, of the principal.⁸² In the event that the principal's wishes are not reasonably known and cannot reasonably be determined, the agent may act in accordance with the principal's best interests.⁸³

tient's life could have given rise to causes of action for battery, violation of the patient's constitutional right to privacy and breach of fiduciary duty had the patient's death not extinguished the right to claim damages for pain and suffering). The *Bartling* court, in a separate decision, also recognized that a hospital could be ordered to pay legal fees incurred by a patient's wife in enforcing her husband's right to have life-sustaining treatment withdrawn. *Bartling v. Glendale Adventist Medical Center*, 184 Cal. App. 3d 97, 228 Cal. Rptr. 847 (1986). In addition, a recent court decision held that a nursing home may not bill for medical treatment provided against the patient's wishes. *N.Y. Times*, Jan. 16, 1990, at B1, col. 5.

⁸⁰ PROXY LAW, *supra* note 8, § 2981(2).

⁸¹ *Id.* § 2981(4). Section 2983 sets forth that a "determination that a principal lacks capacity to make health care decisions shall be made by the attending physician to a reasonable degree of medical certainty" *Id.* §2983(1)(a). The physician must set forth, in writing, any opinions regarding the cause, nature, extent and probable duration of the principal's incapacity. *Id.* Another physician must confirm such a designation of incapacity in cases involving decisions to withdraw or withhold life-sustaining treatment. *Id.*

⁸² *Id.* § 2982(2)(a).

⁸³ *Id.* §2982(2)(b). By mandating that the surrogate act in the patient's best-interests, the legislature in effect places more restrictions on the decision than if the patient were to personally make the determination. If a competent individual unequivocally expresses an intent to decline life support, the decision will be honored, even when clearly contradicted by the existing circumstances. An objective best interests approach allows the surrogate to consider not only the patient's past expressions of intent but also the facts involved in the particular instance. The results of such evaluations would protect

The law effectively eliminates some of the risks inherent in appointing an agent to make medical decisions. Special proceedings are authorized for determining the validity of a health care proxy.⁸⁴ An agent may be removed on grounds that he or she is not reasonably available, willing or competent to fulfill his or her obligations or that he or she is acting in bad faith.⁸⁵ Furthermore the agent's decision can be overridden.⁸⁶ The possibilities that an agent will make an irrational or uninformed decision are thus significantly minimized.⁸⁷ The law also confers upon the principal the right to revoke the proxy at any time.⁸⁸ This power eliminates the dangers that the principal's preferences regarding treatment will significantly change in the period between the execution of the proxy and when the agent's services are actually required, a period that could span many years. Furthermore, in specifically providing immunity for health care providers and agents for honoring and making good faith determinations regarding withdrawal or removal of life-sustaining procedures,⁸⁹ the law ensures that such decisions will be made.

2. Barriers to Effectiveness

The drafters of the Proxy Law attempted to make the process of appointing a medical agent as simple as possible for the principal. In doing so, they included within the statute a model form for individuals to follow when drafting their proxies.⁹⁰ Specialized proxy forms designed by attorneys for their clients, however, may contain superfluous legal terms that a health care pro-

incompetent patients who retain significant interests in continued life as well as prevent unwarranted treatment. See Dresser, *supra* note 29, at 431-34 (discussing this problem in the context of living wills).

⁸⁴ PROXY LAW, *supra* note 8, § 2992(1). The special proceeding may be commenced pursuant to article four of the N.Y. CIV. PRAC. L. & R. *Id.*

⁸⁵ *Id.* § 2992(2)(a), (b).

⁸⁶ *Id.* § 2992(3). This provision which provides for a special proceeding in court is problematic in that it makes no exceptions for emergency situations. By the time a court resolves the conflict between the surrogate and those challenging his decision, the condition of the patient may have irreversibly deteriorated or the patient may have already died.

⁸⁷ See Note, *supra* note 77, at 1005-06 (advocating the safeguards the PROXY LAW has adopted).

⁸⁸ PROXY LAW, *supra* note 8, § 2985.

⁸⁹ *Id.* § 2986.

⁹⁰ *Id.* § 2981(5)(d).

vider might not understand.⁹¹ Furthermore, individuals who want to appoint an agent to make medical decisions for them might not have access to the model form, or even to an attorney. In such cases, the proxies they draft might be so vague or generalized as to prevent health care providers from following them for fear of subsequent liability.

The statute also requires that the proxy be signed in front of two witnesses.⁹² Unlike a last will and testament, the principal may not merely acknowledge his or her signature to the witnesses, but must also sign the proxy in the presence of these witnesses.⁹³ The person appointed as agent is not permitted to attest to the proxy.⁹⁴ As one commentator suggests, this prohibition also seems to run counter to the policy behind easy execution.⁹⁵ A health care agent appointed by the principal because of a special, trusting relationship, is less like a will beneficiary than a fiduciary, who is permitted to witness a will in which he or she is named.⁹⁶

One of the most significant barriers to enforcement of an incompetent's wishes through the proxy mechanism is the requirement that the principal's preferences regarding artificial nutrition and hydration must be specified before his or her agent is deemed to have the authority to decide these questions.⁹⁷ This limitation on artificial nutrition and hydration was not included in the original legislation proposed by the Task Force.⁹⁸

The Task Force believed "that competent adults should be free to determine the extent of the authority they wish to delegate . . . [since] such a policy recognizes the individual's interest in self-determination and enhances the individual's ability to di-

⁹¹ See Miller, *New York State's Health Care Proxy Law*, N.Y.L.J., Aug. 16, 1990, at 1, col. 1.

⁹² PROXY LAW, *supra* note 8, § 2981(2)(a).

⁹³ *Id.* In New York, a Testator has the choice of affixing his signature to his will in the presence of each of the attesting witnesses or acknowledging to each of them that his signature was affixed by him or at his direction. See N.Y. EST. POWERS & TRUSTS LAW § 3-2.1(a)(2) (McKinney 1990).

⁹⁴ PROXY LAW, *supra* note 8, § 2981(2)(a).

⁹⁵ Angell, *Health Care Proxies: Practical Considerations*, N.Y.L.J., Aug. 27, 1990, at 1, col. 1.

⁹⁶ N.Y. EST. POWERS & TRUSTS LAW § 3-3.2 (McKinney 1990).

⁹⁷ PROXY LAW, *supra* note 8, § 2982(2)(b).

⁹⁸ TASK FORCE REPORT, *supra* note 57, at 152 (§ 3.1 Scope of Authority).

rect health care matters in accordance with personal concerns, values and life goals."⁹⁹ Only when an agent can exercise those same powers that the patient could have exercised if competent is the goal of preserving patient self-determination achieved. With this consideration in mind, the Task Force provision concerning the agent's powers provided that the agent must be given the power to make any decisions on behalf of the principal, even those regarding artificial nutrition and hydration, unless the principal has expressly indicated otherwise.¹⁰⁰ The enacted statute takes the opposite approach, which, as one commentator observed, appears to be the product of an unfortunate, last minute legislative compromise.¹⁰¹ The view of the New York State Legislature, as expressed in the provision regarding artificial nutrition and hydration, thus contravenes the widely accepted view that such a procedure should not be singled out from other forms of life-sustaining medical procedures.¹⁰²

⁹⁹ *Id.* at 90.

¹⁰⁰ *Id.* at 152 (§ 3.1 Scope of Agent's Authority).

¹⁰¹ Angell, *supra*, note 95.

¹⁰² It may be difficult to regard the termination of nutrients as merely allowing natural causes to operate. The removal of a respirator does not, in every instance, result in death whereas terminating artificial nutrition and hydration is generally fatal. Death resulting from the termination of artificial nutrition and hydration is also sometimes thought to be extremely painful. See, e.g., *Brophy v. New England Sinai Hosp.*, 398 Mass. 417, 444, 497 N.E.2d 626, 641 (1986) (Lynch, J., dissenting in part)(describing in detail the likely results when nutrition and hydration are withdrawn). However, death by suffocation, that is, from the removal of a respirator, is also not painless; it just occurs in a shorter period of time. In addition, such "tube feeding" may cause serious complications such as pneumonia. Patients often react adversely to the insertion of these tubes and have to be restrained to prevent them from dislodging them. Realistically, artificial nutrition and hydration is not akin to natural feeding, it is mechanical medical treatment. See Note, *A Necessary Compromise: The Right to Forego Artificial Nutrition and Hydration Under Maryland's Life-Sustaining Procedures Act*, 47 Md. L. Rev. 1188, 1191-92 (1988) (arguing that legislatures should distinguish between artificial and natural forms of nutrition and hydration). The American Medical Association's Council on Ethical and Judicial Affairs has concluded that artificially provided nutrition and hydration constitute medical treatment. See *Rasmussen v. Fleming*, 154 Ariz. 207, 217, 741 P.2d 674, 684 (1987). The Council's statement, issued March 15, 1986, stated:

Even if death is not imminent but a patient's coma is beyond doubt irreversible and there are adequate safeguards to confirm the accuracy of the diagnosis and with the concurrence of those who have responsibility for the care of the patient it is not unethical to discontinue *all* means of life prolonging medical treatment. Life prolonging treatment includes medication and artificially or technologically supplied respiration, nutrition or hydration.

Id. (emphasis in original). This position is consistent with the views of other prominent organizations and commissions. See *Orentlicher, Cruzan v. Director of Missouri Dep't of*

3. Limitations of the Proxy Law

The New York statute articulates a means for its citizens to choose a natural death under certain circumstances. In addition, the statute specifically provides that the failure to appoint a health care agent does not create a presumption that a patient wishes continued medical treatment.¹⁰³ The statute also adopts a relatively relaxed standard, as compared to that articulated under New York case law, for allowing an agent to determine the preferences of the principal. Under the statute, an agent is expressly bound to follow a substituted judgment/best interests procedure.¹⁰⁴ This standard is consistent with the New York Legislature's stance, which allows individuals to die with dignity. Unfortunately, the statute only provides a means for effectuating this right for competent adults who follow its requirements. The legislature's decision affords little protection to children, to victims of unexpected accidents, to people who neglect to designate an agent, or to the many individuals who may not know of, or have, anyone sufficiently close to them to whom they can entrust such critical decisions.¹⁰⁵

Furthermore, although the statute creates a duty on the

Health: *An Ethical and Legal Perspective*, 262 J. A.M.A. 2928 (1989). The Supreme Court in *Cruzan* found that the constitutional right to refuse medical treatment encompasses the right to refuse technologically delivered food and water. *Cruzan v. Missouri Dep't of Health*, 110 S. Ct. 2841, 2856 (1990) (O'Connor, J., concurring). The New York courts have even taken a similar approach. In *Delio v. Westchester County Medical Center*, 129 A.D.2d 1, 516 N.Y.S.2d 677 (2d Dep't 1987), the court held that the common law right to refuse medical treatment included the right to forego artificial nutrition and hydration, and consequently, the patient's wife was entitled to act in accordance with the patient's prior, clearly expressed, wishes and have his feeding and hydration tubes disconnected.

¹⁰³ PROXY LAW, *supra* note 8, § 2989.

¹⁰⁴ *Id.* § 2982(2). Under this dual standard, the agent is bound to conform his or her decisions to the patient's expressed wishes, values, preferences or beliefs. The agent should also evaluate all of the available alternatives and decide which course of treatment is in the best interest of the patient in the event the patient's wishes are unclear. TASK FORCE REPORT, *supra* note 58, at 91-92.

¹⁰⁵ This lack of protection is especially evident when dealing with nursing home patients. Many of these individuals have no family, and the law does not permit them to designate hospital employees, which may extend to members of the nursing home staff, often the only people they know or feel close to, as their surrogates. PROXY LAW, *supra* note 8, § 2981(3)(a). A physician may act as an agent provided he relinquishes his role as attending physician after the authority under the health care proxy commences *Id.* § 2981(3)(c). Under this limitation, nursing home staff should be entitled to act as agents as well.

part of the Commissioner of Health to prepare a statement summarizing the rights the statute creates and to furnish such statement to patients upon admission to hospitals,¹⁰⁶ the fact remains that many people will remain unaware of this legislation. Of those who do know of the opportunity to appoint an agent, many will delay execution of a proxy until it is too late. Whatever the reason, be it lack of knowledge, fear, or even laziness, the health care proxy will all too often go unused by those who could benefit from it.¹⁰⁷ In view of the current state of New York case law on this subject, individuals who either fail to or are not permitted to appoint an agent run the risk of having their treatment preferences ignored. Without a proxy appointment, family members or others will have no legal authority to forego life-sustaining treatment on the incompetent's behalf. Instead, clear and convincing evidence of the specific, express wishes of the incompetent will be the sole legal basis for discontinuing treatment.¹⁰⁸

III. POSSIBLE ALTERNATIVES

For many individuals, lack of physical control and an inability to maintain even minimal intellectual functions would engender an unacceptable loss of dignity; few would welcome such utter dependence on machines, as well as on other persons, for survival.¹⁰⁹ These individuals would want to lessen the suffering of those closest to them and to be remembered as they once were.¹¹⁰ Such sentiments are felt by many, not just those who utilize the statutory methods to prevent this situation, nor simply those who are, by law, permitted to do so. Procedures should be implemented to ensure that *all* individuals may have their wishes effectuated.

¹⁰⁶ *Id.* § 2994.

¹⁰⁷ *Cruzan*, 110 S. Ct. at 2875 (Brennan, J., dissenting) (citing *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 1015, 194 Cal. Rptr. 484, 489 (1983)). The results of an empirical study conducted by one commentator suggest that advance directives, under the current state of the law, have not had a significant impact on the way physicians treat incompetent patients. Too few patients have executed advance directives to cause physicians to become familiar with either the instruments themselves, or the laws governing them. See Zinberg, *Decisions for the Dying: An Empirical Study of Physicians' Responses to Advance Directives*, 13 Vt. L. Rev. 445, 452 (1989).

¹⁰⁸ See Miller, *supra* note 91.

¹⁰⁹ Orentlicher, *supra* note 102, at 2928-30.

¹¹⁰ *Id.* at 2929.

At the present time in New York, inevitably the courts are involved whenever an incompetent has failed to execute a health care proxy and health care providers cannot agree with the patient's family regarding decisions to withhold or suspend life-sustaining treatment. Arguably, the ultimate decision-making responsibility should not be shifted away from the courts, which presumably provide a detached but searching investigation in deciding such questions of life and death.¹¹¹ However, many courts take the opposite view.¹¹² These courts realize that the judiciary is not the proper forum for resolving these types of cases, as these cases necessarily have serious time-constraints, and involve complex issues, both medical and social, that are better left to those with more expertise in the area.¹¹³

To prevent resort to the judicial system, it might be beneficial to require an individual's physician to initiate discussion and advise patients of the availability of advance directives and the possible decisions that making them would entail.¹¹⁴ Studies have shown that patients want to discuss the use of life-sustaining treatment with their physicians.¹¹⁵ The physician can describe to the patient what terminal illnesses and conditions of permanent unconsciousness encompass, while, at the same time, recording the patient's reactions in the patient's medical records. This can provide the clear and convincing evidence required in the event the patient becomes incompetent without

¹¹¹ See *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977) (courts should be entrusted with decisions whether to continue artificial life support, rather than the patient's family, or any others).

¹¹² See, e.g. *Cruzan*, 110 S. Ct. at 2859 (Scalia, J., concurring); *Rasmussen v. Fleming*, 154 Ariz. 207, 741 P.2d 674 (1987); *In re Longeway*, 123 Ill. 2d 33, 549 N.E.2d 292 (1989); *In re Jobes*, 108 N.J. 394, 529 A.2d at 434 (1987).

¹¹³ See *Longeway*, 123 Ill. 2d at 39, 549 N.E.2d at 295. See also Vitiello, *On Letting Seriously Ill Minors Die: A Review of Louisiana's Natural Death Act*, 31 Loy. L. Rev. 67, 82 (1985) (Judicial review is expensive and time-consuming; "it can disrupt the process of providing care for the patient . . . it can create unnecessary strains in the relationship between the surrogate decisionmaker and others, such as the health care providers, who may be forced into the role of formal adversaries in the litigation; and it exposes ordinarily quite private matters to the scrutiny of the courtroom and sometimes even to the . . . media.") (quoting Report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (1983)).

¹¹⁴ See Orentlicher, *supra* note 57, at 2365; Ruark, Raffin & Stanford Univ. Med. Center Comm. on Ethics, *Initiating and Withdrawing Life Support, Principles and Practice in Adult Medicine*, 318 N. Eng. J. Med. 25, 28 (1988).

¹¹⁵ Orentlicher, *The Right to Die After Cruzan*, 264 J. A.M.A. 2444, 2445 (1990) (citations omitted).

having appointed a proxy decision maker.¹¹⁶ However, the physician alone should not be permitted to exercise the incompetent patient's right of self-determination.¹¹⁷ As one commentator notes, physicians can pose a significant threat to patient self-determination because "the possibility of medical malpractice litigation or even criminal sanctions could greatly affect a physician's judgment in a treatment situation."¹¹⁸ Furthermore, informed consent and refusal, important premises underlying health care decision making, would be undermined were the provider of the information, that is the physician, also deemed the decision maker.¹¹⁹

The *Quinlan* court suggested that it would be more appropriate to establish a regular forum, in the form of a hospital ethics committee, which would provide input and dialogue in individual situations and allow the responsibility for these judgments to be shared.¹²⁰ Such committees, composed of physicians, social workers, attorneys, and theologians,¹²¹ have been espoused by commentators as a viable alternative to judicial involvement.¹²² However, committee members, in seeking acceptance by the group, may inadvertently avoid controversial issues or alternatives that would prevent quick agreement.¹²³ Specific guidelines could be implemented to prevent such results, but the fact remains that these ethics committees may still

¹¹⁶ Orentlicher, *Advance Medical Directives*, *supra* note 57, at 2367 (discussing the physician's role in ascertaining treatment preferences). See McMillon, *The Right to Terminate Care*, A.B.A. J., Oct. 1990, at 134, for a discussion of federal patient's rights legislation which would require Medicare and Medicaid providers to inform their patients of the options, in the applicable state, for advance directives. Under this measure, the patients must receive written information regarding their rights at the time of their admission to a hospital or nursing home. Commentators have referred to this new law as a medical "Miranda warning." *'91 Law Says Failing Patients Must be Told of Their Options*, N.Y. Times, Dec. 8, 1990, at A50, col. 1.

¹¹⁷ Note, *Do Not Resuscitate: The Failure to Protect the Incompetent Patient's Right of Self-Determination*, 75 CORNELL L. REV. 218, 237 (1989) (expressing concern that "the physician may rely on his or her traditional expertise and preempt patient authority").

¹¹⁸ *Id.*

¹¹⁹ Weir & Gostin, *supra* note 48, at 1848.

¹²⁰ *In re Quinlan*, 70 N.J. 10, 49, 355 A.2d 647, 668 (1976).

¹²¹ *Id.*

¹²² See *Ethical Principles in Critical Care*, 263 J. A.M.A. 696, 697 (1990); Note, *supra* note 21, at 418; Weir & Gostin, *supra* note 48, at 1846.

¹²³ Lo, *Behind Closed Doors, Promises and Pitfalls of Ethics Committees*, 317 N. ENG. J. MED. 46, 48 (1987).

fall victim to "groupthink."¹²⁴ Rather than permitting ethics committees to render the final decisions regarding life-sustaining treatment, the value of such committees is grounded more in the important advice they can render to those entrusted with such decisions.

In resolving cases where an agent has not been appointed, New York should either impart the choice to the person whom the patient himself would most likely have chosen, or leave the decision to the patient's family.¹²⁵ Commonsense, as well as public opinion polls, tells us that patients would prefer to have family members, rather than physicians, judges or legislators decide a matter so fundamentally personal as the decision of whether to use artificial life supports.¹²⁶ Family members best know the patient's attitudes regarding medical treatment and life in general since they were present as the patient developed his or her values. An individual would be most likely to convey his or her thoughts regarding the withdrawal of life-prolonging treatment to family members. Entrusting this decision to the patient's family will ensure that the decision is carried out, as these are the people who generally are most concerned with the patient's welfare.¹²⁷

Courts¹²⁸ and commentators¹²⁹ have concluded that confer-

¹²⁴ *Id.*

¹²⁵ *Cruzan*, 110 S. Ct. at 2876 (Brennan, J., dissenting).

¹²⁶ Orentlicher, *supra* note 102, at 2929 (citing *In re Jobes*, 108 N.J. 394, 418 n.11, 529 A.2d 434, 446-47 n.11 (1987)). The opinion polls cited in *Jobes* indicate that society believes that a patient's family members should function as surrogate decision makers. The polls cited included a 1986 nationwide poll, reported in N.Y. Times, Nov. 29, 1986, at A32, col. 1. This nationwide poll showed that 73% of the 1,510 respondents approved "withdrawing life support systems from a hopelessly ill patient if they or their family requested it." *Id.* Also, 70% of the 2,000 persons, nationwide, who participated via television in a conference on life-sustaining medical treatment at the United States Chamber of Commerce in Washington, D.C., during the fall of 1986, "strongly agreed" that family members should make decisions for the incompetent patient. *Jobes*, 108 N.J. at 418 n.11, 529 A.2d at 446-47 n.11 (citing N.Y. Times, Dec. 2, 1986, at C10, col. 2).

¹²⁷ *Jobes*, 108 N.J. at 417, 529 A.2d at 445 (a desire to err on the side of preserving life is a sentiment that family members will always consider when making treatment decisions on behalf of relatives). Furthermore, a study revealed that spouses tend to overestimate the amount of treatment desired by the patient, thereby safeguarding against overly hasty withdrawal or removal of life-sustaining procedures. Orentlicher, *supra* note 101, at 2929 (citing Uhlman, Pearlman & Cain, *Physicians' and Spouses' Predictions of Elderly Patients' Resuscitation Preferences*, 43 J. GERONTOLOGY 115 (1988)).

¹²⁸ See *Jobes*, 108 N.J. at 415-16, 529 A.2d at 445 (a family member is the best person, in most circumstances, to make treatment decisions for an incompetent patient).

ring legal power to make health care decisions upon the incompetent patient's family is sufficiently justified by these advantages. A court-appointed guardian, who could use the state's powers of discovery to determine the patient's wishes, can solve problems presented when the patient either has no close family members or where there is concern that the patient's family will present an unjustified, biased view.¹³⁰

The New York legislature considered the situation of incompetent patients who do not appoint surrogates or otherwise make their preferences known. Article 29-B of the Public Health Law provides a method for deciding whether to issue a do-not-resuscitate order in the event that no surrogate is designated or available to make this decision on behalf of an incompetent adult patient who has not expressed his or her wishes regarding cardiopulmonary resuscitation.¹³¹ In these instances, the attending physician may issue an order not to treat an incompetent patient during cardiac arrest.¹³² Although it has been argued that this section fails to promote the statutory goal of self-determination since the physician is placed under no duty to attempt to ascertain the patient's wishes,¹³³ it is significant that in this situation the legislature provided a method that avoids resort to the judicial system. Furthermore, Article 29-B provides procedures for issuing such orders in the event the patient is a minor.¹³⁴ This section does follow the standards of substituted

See also *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983) (physician's reliance on family's wishes to terminate treatment of the incompetent patient was not unlawful); *J.F.K. Memorial Hosp. v. Bludworth*, 452 So.2d 921 (Fla. 1984) (close family members may refuse treatment on behalf of the incompetent patient); *In re Colyer*, 99 Wash. 2d 114, 660 P.2d 738 (1983) (family members may exercise the rights of the incompetent to refuse life sustaining treatment), modified on other grounds by *In re Hamlin*, 102 Wash. 2d 810, 689 P.2d 1372 (1984).

¹²⁹ Note, *Privacy, Family, and Medical Decision Making for Persistent Vegetative Patients*, 11 CARDOZO L. REV. 713, 721-23 (1990). One author further suggests that physicians wishing to override a family's nontreatment decision should have the burden of going to court to demonstrate that the family's decision is unreasonable. Rhoden, *Litigating Life and Death*, 102 HARV. L. REV. 375, 440-41 (1988).

¹³⁰ *Cruzan*, 110 S. Ct. at 2876 (Brennan, J., dissenting).

¹³¹ N.Y. PUB. HEALTH LAW §§ 2960-2968 (McKinney Supp. 1991).

¹³² *Id.* § 2963. The attending physician may issue an order not to resuscitate the patient provided that the physician determines that, "to a reasonable degree of medical certainty, resuscitation would be medically futile." *Id.* Another physician must review and concur with such a determination. *Id.*

¹³³ See Note, *supra* note 117, at 241.

¹³⁴ N.Y. PUB. HEALTH LAW § 2982(2) (McKinney Supp. 1991).

judgment adopted elsewhere in the statute as it designates a surrogate for the incompetent minor patient, that is, his or her parent or legal guardian.¹³⁵

The New York legislature should have followed its own precedent and provided such a procedure for individuals who either fail to, or are not permitted, because of age or incompetency, to execute an advance directive in the form of a health care proxy. The statute should provide that life-sustaining procedures may be withheld or withdrawn from incompetent patients, including minors, if there is consultation between the attending physician and/or a hospital ethics committee and individuals designated on a specific list. This list of individuals legally empowered to make treatment decisions for the incompetent patient who has no agent should include, in order of priority: a legal guardian of the patient, if one has been appointed; the spouse of the patient; an adult child of the patient; a parent of the patient; an adult sibling of the patient; or the patient's clergy, close friend or others with firsthand knowledge of the patient's intention.¹³⁶ A decision by these individuals to grant or withhold consent must be made in the best interests of the patient, consistent with the

¹³⁵ *Id.* § 2967(2).

¹³⁶ Numerous other states have passed legislation that provides for terminating or withholding life-sustaining treatment from minors or individuals who fail to execute a living will or appoint a health care agent. Generally, these provisions provide a list of individuals who shall be authorized to grant, refuse, or withdraw consent on behalf of the patient with respect to the provision of any health care. The only restriction under these provisions is that a witness (or witnesses) be present at the time the decision is made. In providing these procedures, the states have found a means of avoiding judicial proceedings whenever questions regarding life-sustaining treatment arise. These legislatures have conferred legal authority upon the individuals who should be making such decisions. See *Arkansas Rights of the Terminally Ill or Permanently Unconscious Act*, ARK. STAT. ANN. § 20-17-214 (1987); *Connecticut Removal of Life Support Systems Act*, CONN. GEN. STAT. § 19a-571 (1989); *District of Columbia Health Care Decisions Act*, D.C. CODE ANN. § 21-2210 (1989); *Indiana Living Wills and Life-Prolonging Procedures Act*, IND. CODE ANN. § 16-8-11-14 (Burns Supp. 1989); *Iowa Life-Sustaining Procedures Act*, IOWA CODE ANN. § 144A.7 (West 1989); *Louisiana Life-Sustaining Procedures Act*, LA. REV. STAT. ANN. § 40:1299.58.5, .6 (West Supp. 1989); *Maine Uniform Rights of the Terminally Ill Act*, ME. REV. STAT. ANN. tit. 18a, § 5-707 (1990); *New Mexico Right to Die Act*, N.M. STAT. ANN. § 27-7-4, 7-8.1 (1986); *Oregon Durable Power of Attorney for Health Care Act*, OR. REV. STAT. § 127.635 (1989) (this statute goes even further and provides that if none of the designated persons are available, then life-sustaining treatment may be withdrawn upon the direction and under the supervision of the attending physician); *Texas Natural Death Act*, TEX. HEALTH & SAFETY CODE ANN. §§ 672.006, .009 (Vernon 1991); *Virginia Natural Death Act*, VA. CODE ANN. § 54.1-2986 (1988); *Virginia Surrogate Decision Making Statute*, VA. CODE ANN. § 37.1-134.4 (1990).

patient's desires, if known, and in good faith. By instituting such procedures and standards, the state can be assured that irrational decisions contrary to the patient's wishes will not be made. Such additions to the existing law would support the policy of the legislature which requires that individuals be permitted to die with dignity.

CONCLUSION

The United States Supreme Court, in deciding the *Cruzan* case, has affirmed that there is a right under the United States Constitution to refuse medical treatment that survives the patient's incompetence. The New York State Legislature, by passing the health care agent and proxy law, took a giant step toward ensuring that this right will be effectuated. However, while it is true that the added anguish of legal uncertainty and confusion will now be removed for patients who have created a health care proxy, the law fails to provide any guidance for the families or guardians of individuals who either delay appointing an agent until it is too late or are unaware of the legal necessity for doing so. Unfortunately, in these cases, resort to the judicial system and the specific subjective intent standard it espouses will be inevitable as medical providers, fearing liability for the resulting deaths, will persist in refusing to honor the wishes of families and guardians to terminate life-sustaining procedures without prior court approval.

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