

REFUSING LIFE-SUSTAINING TREATMENT FOR INCOMPETENT PATIENTS: NEW YORK'S RESPONSE TO *CRUZAN*

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INTRODUCTION

Who makes decisions about life-sustaining treatment for patients who cannot decide for themselves, and according to what criteria? In *Cruzan v. Director, Missouri Department of Health*,¹ the United States Supreme Court held that the states are the proper parties to resolve these questions. The Court acknowledged that competent patients have a liberty interest protected by the Due Process Clause of the Fourteenth Amendment in refusing medical treatment, including life-sustaining treatment.² The states, however, are to establish the standards and procedures to govern these decisions. Accordingly, the Court upheld Missouri's refusal to permit Nancy Cruzan's parents to authorize the termination of life-sustaining artificial nutrition and hydration because of the lack of clear and convincing evidence, as required by the state, that Ms. Cruzan wanted to forgo this treatment.³

The *Cruzan* decision has important consequences for incapacitated patients who are currently receiving life-sustaining treatment and did not adequately articulate their consent to or refusal of this treatment. The broad discretion given to the states by the *Cruzan* Court essentially created a class of patients for whom decisions about their medical treatment can no longer be made by others. As a result, many of these patients will receive unsought and often, burdensome life-sustaining treatment which offers them no benefit and from which the law provides no escape. This Article examines the current approaches of New York law, and summarizes the major points and rationales for a proposal to change the New York law.

I

THE NEW YORK APPROACH

New York law displays a fundamental ambivalence toward surrogate decisions to forgo life-sustaining treatment. While competent adults have broad authority to accept or reject life-sustaining treatment, those who become in-

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1. 110 S. Ct. 2841 (1990).

2. *Cruzan*, 110 S.Ct. at 2851.

3. *Id.* at 2845.

competent without a legally adequate advance directive must receive treatment until they die.

In *In re Storar*,⁴ the New York Court of Appeals first recognized the right of an adult with capacity⁵ to refuse life-sustaining treatment, even when the treatment is beneficial or necessary to sustain life. This principle was subsequently reaffirmed by the court and found to be protected by the state constitution. This was despite countervailing state interests that included preventing suicide, maintaining the ethical integrity of the medical profession, and assuring a continued parental relationship for a minor child.⁶

Competent patients are authorized to leave two types of advance directives that permit other parties to make decisions concerning life-sustaining treatment. In the *Storar*⁷ and *O'Connor*⁸ decisions, the Court of Appeals ruled that written instructions about treatment (known as a living will) and other written or oral evidence of the patient's wishes, made known while the patient had capacity, can serve as the basis for decisions about life-sustaining treatment. These statements must constitute clear and convincing evidence that the patient, while competent, held a firm and settled commitment to forgo treatment under circumstances not qualitatively different from those actually confronting the patient.⁹

In addition, New York public health statutes empower people to appoint a person, called a health care agent,¹⁰ to make health care decisions on the patient's behalf after the onset of incapacity.¹¹ The agent, appointed through the execution of a health care proxy, has authority to decide whatever health care matters the patient wishes to delegate to the agent, including the rejection of life-sustaining treatment.¹² The agent must make these decisions in accordance with the patient's known wishes, to the extent that they are reasonably known; if the patient's wishes are not known, the decision must be made in

4. *In re Storar* (*In re Eichner*), 420 N.E.2d 64, cert. denied sub nom. *Storar v. Storar*, 454 U.S. 858 (1981).

5. 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 informal decision." N.Y. PUB. HEALTH LAW, § 2980(3) (McKinney 1991).

6. See *Fosmire v. Nicoleau*, 551 N.E.2d 77 (1990) (holding that the lower court should not have authorized a blood transfusion knowing that the patient personally objected to it); *Rivers v. Katz*, 495 N.E.2d 337 (1986) (holding that the due process clause of the state constitution affords involuntarily committed mental patients the fundamental right to refuse antipsychotic medication).

7. 420 N.E.2d at 72.

8. *In re Westchester County Medical Center on behalf of O'Connor*, 531 N.E.2d 607, 613-14 (1988).

9. *Id.*

10. N.Y. PUB. HEALTH LAW § 2980(5) (McKinney 1991).

11. *Id.* §§ 2980-2994. See NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, LIFE-SUSTAINING TREATMENT: MAKING DECISIONS AND APPOINTING A HEALTH CARE AGENT (1987).

12. N.Y. PUB. HEALTH LAW § 2982(2).

accord with what the agent perceives to be in the patient's best interests.¹³ Decisions to reject life-sustaining artificial nutrition and hydration, however, can be made only in accord with the patient's known wishes.¹⁴ Health care professionals must honor the agent's decision as if it had been made by the patient,¹⁵ and no liability will follow for doing so.¹⁶

New York law becomes highly restrictive, however, if a patient lacking capacity has not left a living will which meets the clear and convincing evidence standard and has not appointed a health care agent.¹⁷ Only in the limited context where a do-not-resuscitate (DNR) order is contemplated, are surrogates empowered to make decisions on behalf of an incapacitated patient lacking an advance directive. A DNR order, which directs health care professionals not to provide cardio-pulmonary resuscitation (CPR) in the event of cardiac or respiratory arrest, can be consented to by specified surrogates pursuant to legislation enacted in 1987.¹⁸ Consent may be given only if the patient faces specific medical circumstances,¹⁹ and the surrogate decides that the DNR order is consistent with the patient's best interests. If the patient has no surrogate, the physician can enter the order if it is determined that CPR would be medically futile for the patient.

If no advance directive exists and a DNR order is not at issue, the Court of Appeals has held that no one — neither family nor physician nor court — can authorize the withholding or withdrawal of life-sustaining treatment from an incapacitated patient.²⁰ The court analogizes this patient to a minor child whose parents lack authority to make decisions concerning life-sustaining treatment. As a consequence, health care professionals have no alternative but to continue to provide treatment despite the lack of benefit to the patient and potential burden to family and friends.

In theory, the competent patient can avoid losing control over these decisions by executing a health care proxy or a living will. However, despite the intense interest in advance directives sparked by the *Cruzan* decision and the passage of the New York health care proxy law in 1990, it is generally assumed that significant numbers of people will not prepare such documents.

13. *Id.*

14. *Id.*

15. *Id.* § 2984(2). Living wills, too, must be implemented by the healthcare provider. *Id.* § 2803-C.

16. *Id.* § 2986(1).

17. *In re Westchester County Medical Center on behalf of O'Connor*, 531 N.E.2d 607 (1988); *In re Storar*, 420 N.E.2d 64 (1981).

18. N.Y. PUB. HEALTH LAW §§ 2960-79. See NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, DO NOT RESUSCITATE ORDERS (2d ed. 1988).

19. The attending physician, with the concurrence of another designated physician, must determine after personal examination of the patient that, to a reasonable degree of medical certainty: (i) the patient has a terminal condition; (ii) the patient is permanently unconscious; (iii) resuscitation would be medically futile; or (iv) resuscitation would impose an extraordinary burden on the patient in light of the patient's medical condition and the expected outcome of resuscitation for the patient. N.Y. PUB. HEALTH LAW § 2965(3)(C) (McKinney 1991).

20. *O'Connor*, 531 N.E.2d 607; *Storar*, 420 N.E.2d 64.

This may be because of lack of information, inertia, or a failure to perceive the need for them. Nor is the DNR law an adequate vehicle for dealing with the range of decisions involved in forgoing life-sustaining treatment because of the limited and conditional nature of a DNR order.²¹

To fill this legal vacuum in decision making authority for incapacitated patients, the New York State Task Force on Life and the Law has recently proposed comprehensive legislation to establish a system for identifying and authorizing surrogates for these patients.²² The system includes an array of standards and procedures governing decision making to guard against abuse of vulnerable patients and to resolve disputes among surrogates, family members, and health care providers.

II

SUMMARY OF THE TASK FORCE PROPOSAL

*1. Determinations about a patient's lack of capacity to make her own decisions about life-sustaining treatment will be made at bedside in the health care institution, rather than in a courtroom.*²³

In order to create a system of surrogate decision making for incompetent persons who have left no advance directive, one must first ask who should determine that a patient lacks capacity to make her own health care decisions. New York currently allows only judges to make such determinations through a court proceeding to appoint a committee for the person²⁴ or a guardian.²⁵ Typically, the primary evidence in a proceeding for appointment of a committee is a medical report prepared by an examining physician who often is not actually present in the court.²⁶ Only a few dozen proceedings are held each year, probably because of the expense and delay involved. In virtually all, the petition to appoint a committee is readily granted.

The facility-based determination of incapacity authorized by the DNR law is the model chosen by the Task Force to appoint surrogates under its new proposal. The patient's attending physician will assess capacity and state the

21. N.Y. PUB. HEALTH LAW §§ 2960-79 (McKinney 1991).

22. NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN OTHERS MUST CHOOSE: DECIDING FOR PATIENTS WITHOUT CAPACITY (1992) [hereinafter TASK FORCE, WHEN OTHERS MUST CHOOSE].

23. *Id.* at 83-92.

24. N.Y. MENTAL HYG. LAW § 78 (McKinney 1988). A committee of the person is an individual to whom the custody of a person is given by a court after a hearing at which the person has been determined to be incompetent. A committee may be appointed if a person is "incompetent to manage himself or his affairs by reason of age, alcohol abuse, mental illness, or other cause, or is a patient . . . who is unable adequately to conduct his personal or business affairs." *Id.* § 78.01. Conservators appointed under § 77 of the Mental Hygiene Law are not authorized to make health care decisions. *Id.* § 77. See also *In re Grinker* (Rose), 77 N.Y.2d 703 (1991).

25. N.Y. SURROGATE'S COURT PROCEDURE ACT § 17-A (McKinney Supp. 1992). This law authorizes appointment of a guardian for a person who is developmentally disabled.

26. J. Spring & N. Dubler, *Conservatorship in New York State: Does It Serve the Needs of the Elderly?*, 45 THE RECORD 288, 298 (1990).

basis for the determination, as well as an opinion about the extent, duration, and possibility of restoration of capacity, in the patient's medical record.²⁷ To minimize the risk of error, one other health care professional (not necessarily a physician) designated by the facility and possessing appropriate expertise must provide a written confirmation of this determination.²⁸

The standard for capacity, like that in the DNR law, is the patient's ability to understand and appreciate the nature and consequences of proposed health care, and to arrive at an informed decision.²⁹ Thus the patient must be able to understand information about treatment and the alternatives, relate that information to her own medical condition, and weigh the risks and benefits of treatment in terms of the patient's personal values or some identified goal of treatment.

The physicians must reach their determination of incapacity to a reasonable degree of medical certainty,³⁰ which appears to be equivalent to the legal standard of clear and convincing evidence. If the patient is conscious and has any ability to comprehend the information, she and one potential surrogate must be informed of the capacity determination.³¹ Any objection by the patient, despite the incapacity determination, nullifies the process and requires a judicial determination of incompetency.³² The physicians' determinations must also be reconfirmed at the time that the surrogate's decision to forgo life-sustaining treatment is to be implemented.³³

2. *The surrogate will be identified from a statutory priority list by operation of law, rather than by court appointment.*

After the patient has been determined to lack capacity, the proposed law establishes a priority list of those entitled to be named as surrogate.³⁴ One person is to be chosen from the following list from the class highest in priority when persons in prior classes are not reasonably available, willing, or competent to act:

1. a committee or guardian of the person;
2. an individual, eighteen years of age or older, designated by others on the surrogate list, provided no other person on the surrogate list objects to the designation;
3. the patient's spouse, if not legally separated;
4. a son or daughter age eighteen or older;
5. a parent;

27. NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, *Surrogate Decision Making Proposed Legislation*, § 3(2) in TASK FORCE, WHEN OTHERS MUST CHOOSE, *supra* note 22, at 247-68 [hereinafter *Proposed Legislation*].

28. *Id.* § 3(3).

29. *Id.* § 1(6).

30. *Id.* § 3(2).

31. *Id.* § 3(4).

32. *Id.* § 3(6).

33. *Id.* § 3(7).

34. *Id.* § 4(1).

6. a brother or sister age eighteen or older;
7. a close friend or close relative age eighteen or older.

If the incapacitated person is a patient or resident of a health care facility, the operators, administrators, and employees of the facility are disqualified from serving as surrogates, unless the would-be surrogate is related by blood, marriage, or adoption to the incapacitated person.³⁵ Often these health care professionals may be more familiar with the patient's values and preferences, but the potential conflict of interests between their duties of loyalty to the facility and to the patient persuaded the Task Force not to permit them to serve as a surrogate.³⁶

The presumption in favor of family members as the preferred surrogates is based on custom, culture, tradition, clinical practice, and the status of the family in society.³⁷ Family members are viewed as more likely than any other persons, such as physicians, other health care professionals, judges, or court-appointed representatives, to know the patient's wishes and values. At the same time, however, tension and disagreement among family members may surface in a crisis, which suggested to the Task Force that an informal mechanism to provide assistance for resolving disputes should be readily available within the facility.³⁸ The patient may also have been closer to a "significant other" in life than to her family, and hence the category of "close friend" was added to the list. The proposed law, however, fails to provide an expedited process whereby a close friend can function immediately as a surrogate ahead of hostile family members with a higher rank on the priority list, particularly when the close friend's relationship with the patient clearly warrants giving him or her the top rank. The dispute mediation process is not entirely satisfactory in that it puts the close friend in the difficult position of being viewed as a challenger to the family member's authority when, in reality, their positions should be reversed.

Apart from providing a priority list of potential surrogates, the proposed statute is silent as to the precise procedure whereby the surrogate is named. An informal and flexible process is anticipated which will lead the attending physician and those family members close to the patient to reach an agreement as to which person on the priority list should serve as surrogate. Rank on the list will help guide the selection process, but the individual must also be willing, available, and competent to serve. If several members of the same class are equally qualified, presumably they will designate one of their number as surrogate or seek dispute mediation if they cannot agree. Persons with a lower rank who believe they should serve as surrogate must also enter the mediation process. Experience with a similar list in the DNR law suggests that the pro-

35. *Id.* § 4(2).

36. TASK FORCE, WHEN OTHERS MUST CHOOSE, *supra* note 22, at 99.

37. *Id.* at 93.

38. *Proposed Legislation*, *supra* note 27, § 11(2)(b).

cess is effective, at least to the extent that no petition for judicial review of disputes concerning the selection of a surrogate has been reported.

Once identified, the surrogate is obliged to acquire medical information about the patient sufficient to make an informed decision on behalf of the patient.³⁹ If the surrogate makes such decisions in good faith, the law will protect her from personal liability⁴⁰ and financial obligation for the costs of care.⁴¹

3. *The surrogate will be empowered to make decisions on the basis of the patient's wishes and values to the extent that they are reasonably known, or if not known, on the basis of the patient's best interests.*

Generally speaking, the principle of substituted judgment will guide the surrogate's decisions.⁴² The surrogate will be seeking to answer the question, "What would the patient choose?"⁴³ The surrogate's close relationship to the patient is likely to provide the surrogate with insight into the patient's values and wishes and thus lead to a decision more likely to approximate what the patient would choose if competent. The clear and convincing evidence standard of the *O'Connor* decision⁴⁴ does not apply; if it did, there would be no need for a surrogate.

Where there is no real guidance from the patient, the proposed law will explicitly authorize the surrogate to make a decision which is in the best interests of the patient.⁴⁵ Here the surrogate is seeking to answer the question, "What is best for the patient, taking the patient's values and beliefs into account insofar as possible?"⁴⁶ No simple formula for defining the patient's interests is proposed. The emphasis is on an individualized assessment that recognizes the dignity and uniqueness of the particular patient. From this starting point, the proposed law includes such interests as the possibility and extent of preserving the patient's life; the preservation, improvement, or restoration of the patient's health or functioning; the relief of the patient's suffering; and such other factors as a reasonable person in the patient's circumstances would want others to consider.⁴⁷

Should the interests of other persons also be considered by the surrogate? For example, many patients would be concerned about the emotional and financial burden imposed on their family by their illness and treatment. At the same time, however, general assumptions about the preferences of "reasonable people" may be too speculative in individual cases, especially when a best in-

39. *Id.* § 4(3)(c).

40. *Id.* § 13(2).

41. *Id.* § 14.

42. *Id.* § 4(4)(a).

43. TASK FORCE, WHEN OTHERS MUST CHOOSE, *supra* note 22, at 104.

44. *In re Matter of Westchester County Medical Center on behalf of O'Connor*, 531 N.E.2d 607 (1988).

45. *Proposed Legislation*, *supra* note 27, § 4(4)(a).

46. TASK FORCE, WHEN OTHERS MUST CHOOSE, *supra* note 22, at 104.

47. *Proposed Legislation*, *supra* note 27, § 4(4)(b).

terests assessment is being made. The Task Force recommendation attempts to reconcile these complex forces. They require that the surrogate's consideration of the interests of others be based on clearly articulated information about the patient's own evaluation of these interests and their significance for treatment decisions.⁴⁸ In a best interests assessment, an even stronger showing about the weight an average person would give to the interests of others would be required.

If a patient's surrogate is not from the priority list, the surrogate is not permitted to consider financial cost in making a decision to forgo life-sustaining treatment. The proposed law makes no other mention of factors which should *not* enter into the surrogate's decision. Nonetheless, no surrogate should consider in an evaluation of the patient's best interests, the patient's race, sex, religion, ethnic background, age, disability, mental health, intelligence, or wealth, except insofar as the characteristic is directly related to the efficacy of the treatment.

When the surrogate is contemplating a decision to forgo life-sustaining treatment, the proposed law mandates that additional standards and procedures constrain and guide the surrogate. Inherent in the surrogate's calculus of the benefits and burdens of forgoing such treatment are value judgments about what the patient's quality of life would be with or without the treatment. The surrogate can never be certain that her decision will be the same as the patient would have made. It is possible that the self-interest of the surrogate may influence her decision. These subjective factors, combined with the serious and irreversible nature of the decision, suggest that some objective, non-judgmental factors ought to be present before life-sustaining treatment is withheld or terminated.

In accord with this line of thought, the proposed law allows the surrogate to withhold or withdraw life-sustaining treatment only if (i) treatment would be an excessive burden to the patient and (ii) at least one of the following circumstances is present:⁴⁹

1. The patient has a terminal condition, *i.e.*, an illness or injury from which there is no recovery, and which reasonably can be expected to cause death within six months. This determination must be made by an attending physician with the concurrence of another physician to a reasonable degree of medical certainty.
2. The patient is permanently unconscious, as determined to a reasonable degree of medical certainty by an attending physician with the concurrence of another physician.
3. For patients who are neither terminally ill nor permanently unconscious, the surrogate's judgment that treatment would be an excessive burden is confirmed by the attending physician and approved by the bioethics review committee.

48. TASK FORCE, WHEN OTHERS MUST CHOOSE, *supra* note 22, at 109.

49. *Proposed Legislation*, *supra* note 27, § 4(5)(b)(ii).

4. The surrogate's decision has been approved by a court of competent jurisdiction.

The first standard, excessive burden to the patient, must be met in all cases. The burden to others caused by the patient's continuing illness and treatment is not recognized here as a basis for the surrogate's decision, although, as noted earlier, this burden may enter into the decision making process as part of the substituted judgment or best interests evaluation by the surrogate.

Rather, the burden is that of suffering excessively, combined with the presence of one of the four listed circumstances. The first two of these circumstances, terminal illness or permanent unconsciousness, were chosen because they are the most common conditions in which people would choose to discontinue treatment, and because both are ultimately irreversible.⁵⁰ In both situations, however, the decision to forgo treatment is still the surrogate's, not the physician's. Thus the proposal rejects the position urged by physicians and ethicists in the *Wanglie* case⁵¹ that treatment of the permanently unconscious is medically futile and should be left to professional medical judgment rather than to family members.⁵² Likewise, in both situations, absolute certitude about the prognosis is not required; however, the physician is expected to utilize state-of-the-art criteria and procedures in assessing the patient. For patients who are neither terminally ill nor in a persistent vegetative state but for whom the burdens of treatment exceed its benefits, the decision to terminate life support must undergo a procedural requirement. The surrogate's decision to forgo life-sustaining treatment is subject to review and approval by an interdisciplinary institutional review committee known as the "bioethics review committee,"⁵³ discussed in Section II-5 below.

4. *Special procedures, adapted to the type of health care decision to be made, should be created to permit surrogate decisions on behalf of patients who lack family or close friends.*

One of the most difficult cases encountered by facilities and health care professionals is the patient who lacks capacity but has no family or close friends to act as a "natural" surrogate on the patient's behalf. These vulnerable individuals are often elderly nursing home patients, AIDS patients, drug abusers, or homeless persons. Health care decisions are currently made for these patients through a patchwork combination of court petitions, the emergency exception to the informed consent requirement, and informal practices.⁵⁴

50. TASK FORCE, WHEN OTHERS MUST CHOOSE, *supra* note 22, at 109.

51. See *In re Conservatorship of Wanglie*, No. PX-91-283 (D.Minn. June 28, 1991); see also Alexander M. Capron, *In re Helga Wanglie*, 21 HASTING CENTER REPORT 26 (1991); Steven Miles, *Informed Demand for "Non-Beneficial" Medical Treatment*, 325 NEW ENG. J. MED. 512 (1991).

52. TASK FORCE, WHEN OTHERS MUST CHOOSE, *supra* note 22, at 198.

53. *Proposed Legislation*, *supra* note 27, § 4(5)(b)(ii)(C).

54. TASK FORCE, WHEN OTHERS MUST CHOOSE, *supra* note 22, at 158.

The Task Force rejected paradigms which would place total authority in the attending physician, because the decision to forgo life support is not purely medical and should reflect the values of the patient. The Task Force also rejected models which would require court approval of all decisions, because of the burdens involved in bringing the decision to a stranger who is not familiar with the patient. Also rejected was a non-judicial system centered outside of health care facilities, such as a public guardian, a state ombudsman, or committees like those authorized in New York for the mentally disabled, because they would rely on administrative systems that would be unfamiliar with the individual characteristics of the patient.⁵⁵ Rather, the proposed law would place the locus for these decisions within the patient's health care facility, subject to a series of checks and balances that should ensure that the values of the patient are at the heart of the decision making process.

The law distinguishes between decisions involving routine medical treatment, those concerning major medical treatment, and those to forgo life-sustaining treatment. Routine medical treatment is defined as any treatment, service, or procedure to diagnose or treat an individual's physical or mental condition for which physicians ordinarily seek specific consent, such as the administration of medication, the extraction of bodily fluids for analysis, or dental care performed with a local anesthetic.⁵⁶ It does not include long-term treatment, such as ventilator support or a nasogastric tube. Major medical treatment, by contrast, involves the use of a general anesthetic, any significant risk, any significant invasion of bodily integrity (requiring an incision, producing substantial pain, discomfort, debilitation, or having a significant recovery period), or a significant period of chemical or physical restraint.⁵⁷

The attending physician would be authorized to decide about routine medical treatment for these patients.⁵⁸ The rationale is that such treatment is minimally invasive, involves little or no risk, and is clearly beneficial.⁵⁹ Delaying or denying this treatment would pose greater risk than providing it. Decisions to provide major medical treatment would be made by the attending physician in consultation with the facility staff directly responsible for the patient's care and with the approval of another physician designated by a hospital or the medical director in a residential health care facility.⁶⁰ To forgo life-sustaining treatment, the same consultations and approvals would be required as well as the approval of the bioethics review committee.⁶¹

5. *Interdisciplinary bioethics committees should be established in each facility to serve as consultants to parties involved in the surrogate decision making process, to mediate disputes, and to approve or reject decisions to forgo life-*

55. *Id.* at 158-162.

56. *Proposed Legislation*, *supra* note 27, § 1(23).

57. *Id.* § 1(15).

58. *Id.* § 7(3).

59. TASK FORCE, WHEN OTHERS MUST CHOOSE, *supra* note 22, at 163.

60. *Proposed Legislation*, *supra* note 27, § 7(4).

61. *Id.* § 7(5).

sustaining treatment in sensitive or special cases. Judicial review is available for unresolved disputes.

The system envisioned by the proposed law is structured like a three-layer pyramid. At the base level, decisions to forgo life-sustaining treatment are made by the appropriate surrogate in consultation with the attending physician and in accordance with the statutory standards. If both agree and other interested parties, either on the family's or the provider's side, do not object, the decision must be implemented.⁶² If any of the interested parties is uncertain as to the best course of action, or if disputes among these parties arise, a second level of review may be desirable. Hospitals and nursing homes are required to establish bioethics review committees which would serve as consultants in cases of uncertainty and as mediators for the disputes, but ordinarily not to make or approve the surrogate's decision concerning treatment.⁶³ Only in the case where the surrogate believes that the burdens of continued treatment exceed its benefits for a patient who is neither terminally ill nor in a persistent vegetative state is the committee's approval required before treatment is terminated.⁶⁴

The proposed legislation also includes specific aspects of the composition and procedures of these committees. To promote diversity in membership, different health professions must be represented, as well as a person trained in ethics or theology, who would be particularly sensitive to the personal values and principals that are dimensions of the decision.⁶⁵ An ethicist or theologian would also help to assure the committee's independence from the facility administration. In nursing homes, the committee must include a representative of the residents' council. Nursing home committees must also include a representative or a person from the state long-term care ombudsman program or a not-for-profit organization that advocates for the elderly. Nursing homes are encouraged to include persons from their affiliated hospital's bioethics committee or to form a joint bioethics committee with other nursing homes in their area. Because these committees are quasi-administrative bodies, each facility is required to adopt policies concerning the procedures for access to the committee and notice to the interested parties of committee action.⁶⁶ Committee members are also bound to rules of confidentiality concerning the proceedings and records of the group,⁶⁷ and outside parties are denied access to these matters.⁶⁸ Two exceptions are noted: the State Health Department may review records and proceedings involving the withholding or withdrawal of life-sustaining treatment from patients lacking a surrogate, emancipated minor patients, and patients who are neither terminally ill nor permanently uncon-

62. *Id.* § 6(1)(a).

63. *Id.* § 11.

64. *Id.* §§ 4, 5(b)(ii)(c), 11(2)(b).

65. *Id.* § 11(3); TASK FORCE, WHEN OTHERS MUST CHOOSE, *supra* note 22, at 52.

66. *Proposed Legislation*, *supra* note 27, § 11(1).

67. *Id.* § 11(5), (6).

68. *Id.* § 11(5).

scious;⁶⁹ and persons on the surrogate list are granted access.⁷⁰

The bioethics review committee closely resembles the ethics committees which are a familiar part of most hospitals and many long-term care facilities in New York State. These committees emerged in hospitals in the 1970s as a resource for responding to the problems posed by decisions to forgo life-sustaining treatment. The mediation role assigned to them by the DNR law gave new impetus to their formation in New York in the late 1980s. It is likely that in many facilities the functions and membership of the ethics committee will be integrated into the bioethics review committee, which in turn will become a standard feature of these facilities.

The final stage of review is a petition to the courts. A dissatisfied person on the surrogate list, physician, member of the bioethics review committee, facility representative, or authorized government agency, who is unable to resolve a dispute through the bioethics review committee, is authorized to bring a special judicial proceeding.⁷¹ Contrary to the *Storar*⁷² and *O'Connor*⁷³ holdings, the courts are expressly empowered to resolve these disputes and to direct a course of health care in compliance with the standards of the proposed law.⁷⁴ Their discretion is limited to the extent that they can only authorize the forgoing of life-sustaining treatment if such a decision meets the substituted judgment or best interests standards of the proposed law.⁷⁵

While courts may still become decision makers of last resort, the proposed legislation shifts primary decision making responsibility from judges to family members. There remain certain functions which only the courts should perform, including clarification of state law where legislation has gaps or is unclear, and to conduct conservatorship⁷⁶ and committee⁷⁷ proceedings in cases of long-term or permanent incapacity where comprehensive power over person and/or property needs to be vested in a surrogate. Judicial involvement is also necessary when the interested parties have opposing positions or conflicting interests.

A system which would allow only judges to make all major health care decisions for incompetent persons lacking advance directives, or which demands not only that courts alone appoint surrogates for all incapacitated persons but also that they supervise and approve all major decisions by those surrogates, is a waste of family and judicial resources. Such a system is excessively time-consuming and expensive,⁷⁸ and generally produces no better deci-

69. *Id.* § 11(6)(i).

70. *Id.* § 11(6)(a)(ii).

71. *Id.* § 16.

72. *In re Storar*, 420 N.E.2d 64 (1981).

73. *In re Westchester County Medical Center on behalf of O'Connor*, 531 N.E.2d 607 (1988).

74. *Proposed Legislation*, *supra* note 27, § 16(2).

75. *Id.* § 16(2)(b).

76. N.Y. MENTAL HYG. LAW § 77 (McKinney 1988).

77. *Id.* § 78 (McKinney 1988).

78. Spring & Dubler, *supra* note 26.

sions than if the parties were authorized to act without court supervision. As noted earlier,⁷⁹ conservatorship and committee proceedings and petitions for court orders in treatment cases rely on the very same parties—family members and treating physicians—to provide the primary evidence on which the court's decision will be based. The results of court proceedings are often that the parties are several thousand dollars poorer, a patient's suffering has been needlessly prolonged, and a stranger has intruded into a family's effort to cope with tragedy. The offsetting benefits of this system are difficult to discern.

But can family members be trusted to make the right decision? The Task Force believes that, in the vast majority of cases, the answer is yes.⁸⁰ In those cases where the surrogate's own interests or the medical facts suggest that a wrong decision is likely, the recommended procedures provide the necessary opportunity for prevention of error.

CONCLUSION

It is hoped that enactment of the Task Force proposal would fill the need for health care decisions that closely reflect the values and concerns of incapacitated patients who have not left explicit directives. Other important provisions of the proposal not explained in this Article concern decisions by and for minor patients, the issues surrounding the provision of medically futile treatment, the right of providers to transfer patients for whom the facility is not willing to forgo treatment, and sanctions for providers who fail to implement the decisions of surrogates. Following publication of the Task Force's Report, its provisions will be the subject of extended public discussion, comments from interested groups around the state, and legislative hearings. By 1993, this process should lead to state legislation envisioned by the *Cruzan* decision as the ultimate guarantor of the rights of the incompetent patient.

79. See *supra* text accompanying note 26.

80. TASK FORCE, WHEN OTHERS MUST CHOOSE, *supra* note 22, at 94.

