
**WANT TO TERMINATE LIFE SUPPORT?
NOT IN NEW YORK:
TIME TO GIVE NEW YORKERS A CHOICE**

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I. INTRODUCTION

Twenty years have passed since the New York State Court of Appeals decided the case of *In re O'Connor*.¹ In *O'Connor*, the court held that in order to withhold or remove life-sustaining treatment from an incompetent patient, there must be “clear and convincing proof that the patient had made a firm and settled commitment,” while they were competent, to decline a particular type of medical treatment under the specific circumstances the patient finds themselves.² The *O'Connor* standard is, for all practical purposes, impossible to satisfy. It is a standard that is far higher than any other in the United States.³ Under *O'Connor*, unless a person can predict the exact medical condition they will be suffering from, and choose not to have life sustaining treatment for that condition, there can be no guarantee that their wishes will be respected.⁴ New York is one of only two states with a clear and convincing standard that requires a prior treatment, or refusal of treatment, decision of a specific treat-

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¹ 531 N.E.2d 607 (N.Y. 1988).

² *Id.* at 608.

³ Anthony W. Austin, *Medical Decisions and Children: How Much Voice Should Children Have in Their Medical Care?*, 49 ARIZ. L. REV. 143, 160 (citing *O'Connor*, 531 N.E.2d at 614-15).

⁴ *O'Connor*, 531 N.E.2d at 613.

ment in a particular situation.⁵ Thirty-five other states and the District of Columbia have statutes regarding surrogate decision making; many others have case law dealing with these issues that establish a much more realistic standard than *O'Connor* does for New York.⁶

These other states have developed standards that more fairly balance a patient's right to self-determination against a state's interest in preserving life.⁷ These standards take into consideration technological advances that allow people to be kept alive until all of their organs fail. These standards also account for a layperson's increased access to information that is easily comprehended, allowing for informed decision-making. It is time to revisit the *O'Connor* decision, which does not take any of these factors into consideration.

New York has had a bill languishing in either the Assembly or the Senate since 1992, called the Family Health Care Decision Act ("FHCDA"), which would resolve all of the issues created by *O'Connor*. It is past time for New York to pass the FHCDA, as it is a realistic standard that assures New York's citizens that their final illness will be handled in a way that preserves their values and dignity.

Part II of this Comment presents an in-depth look at the circumstances of Mrs. O'Connor, and the court's decision in her case. Part III examines more recent lower court decisions in New York that distinguished *O'Connor*. Part IV discusses issues related to surrogate decision-making, and will show that these concerns are, largely, un-

⁵ Thérèse Wiley Dancks & Matthew J. VanBeveren, *2005-2006 Survey of New York Law: Health Law*, 57 SYRACUSE L. REV. 1247, 1278 (2007).

⁶ See AM. BAR ASS'N COMM'N ON LAW & AGING, DEFAULT SURROGATE CONSENT STATUTES (2008), www.abanet.org/aging/legislativeupdates/pdfs/Famcon_Chart.pdf; ABIGAIL PETERSEN, AM. BAR ASS'N COMM'N ON LAW & AGING, SURVEY OF HEALTH CARE DECISION-MAKING STANDARDS IN STATE LEGISLATION (2007), <http://www.abanet.org/aging/docs/StandardsforSurrogateDecisionMakingChart.pdf>; see also Mark H. Alcott, Letter to the Editor, *Medical Decisions Law*, N.Y. TIMES, May 20, 2007, §4, at 11; NYSBA Urges Legislature to Pass Family Health Care Decision Act, DAILY REC. (N.Y.), June 21, 2006, 2006 WLNR 24316490 [hereinafter *NYSBA Urges Legislature*].

⁷ See PETERSEN, *supra*, note 6. For example, Indiana states that an agent appointed to make medical decisions "may be empowered to ask in the name of the principal for health care to be withdrawn or withheld when it is not beneficial or when any benefit is outweighed by the demands of the treatment and death may result," and a surrogate "shall act 'in good faith and in the best interest of the individual incapable of consenting.'" *Id.* (citing IND. CODE ANN. §§ 30-5-5-17(a), 16-36-1-5(d) (West 2009)). Alaska has a similar standard which allows an agent or a surrogate to withhold or withdraw life support from a terminally ill or permanently unconscious patient either based on the patient's expressed wishes or the best interests of the patient. *Id.* (citing ALASKA STAT. §§ 13.52.010(h), 13.52.045(2), 13.52.390(36) (2009)).

warranted. Part V examines the current state of New York laws, and a statute from New Jersey that is an excellent decision making model, used to develop the FHCDA. Finally, in Part VI, the FHCDA will be examined, as well as some possible reasons the New York bill has not yet been passed.

II. THE *O'CONNOR* DECISION

A. The Facts

In 1988, the New York State Court of Appeals was presented with *O'Connor*.⁸ Mrs. O'Connor, a mother of two adult daughters, was a seventy-seven year old woman who suffered from a multitude of medical problems.⁹ Mrs. O'Connor had a history of congestive heart failure, a series of strokes resulting in brain damage, disabilities that did not allow her to be able to care for herself, and was rendered incompetent to make decisions for herself regarding her medical care.¹⁰ Those facts were all agreed upon; however, the Court of Appeals diverged significantly from the lower courts in interpreting these facts. It is these facts that play an important role in understanding what is at stake in New York, and the injustice Mrs. O'Connor received.

After a long dissertation on Mrs. O'Connor's prior medical history, the majority stated that Mrs. O'Connor was alert and could follow and respond to simple commands, but that she could not swallow, which led to the application for a nasogastric feeding tube.¹¹ This description makes light of Mrs. O'Connor's ailments and makes it seem as though Mrs. O'Connor's daughters might have ulterior motives in trying to have their mother's life support terminated.

On the contrary, the lower courts and the dissent paint a much graver picture of Mrs. O'Connor's true condition and the suffering she endured. According to the dissent:

Mrs. O'Connor . . . suffered a series of progressively debilitating strokes that have left her bedridden, sub-

⁸ *O'Connor*, 531 N.E.2d 607.

⁹ *Id.* at 608.

¹⁰ *Id.*

¹¹ *Id.* at 609.

stantially paralyzed, and unable to care for herself [She is] “severely demented” and . . . “profoundly incapacitated.” She is neither comatose nor in a vegetative state, but she responds only sporadically to simple questions or commands, and then frequently inappropriately. The doctors agree that the neurological damage from the strokes is irreparable, and no hope exists for significant improvement in her mental or physical condition.¹²

Additionally, her daughters testified that their mother never spoke to or responded to either of them vocally, or by facial or hand movements, even though they saw her daily.¹³ The Medical Center’s physician clarified further that Mrs. O’Connor can “phonate[, but] [t]hat’s about it really,” and that when asked to perform simple tasks for doctors to evaluate her lungs or asked whether she was experiencing pain, she would not respond, presumably from lack of comprehension.¹⁴

In addition to very different descriptions of Mrs. O’Connor’s health, the concurring and dissenting judges took issue with the weight given to Mrs. O’Connor’s statements. Mrs. O’Connor worked in hospital administration for over twenty years.¹⁵ She had cared for or watched several family members die of cancer.¹⁶ Mrs. O’Connor, given her background, most likely understood the ramifications and definition of what “artificial means” encompassed.¹⁷ She absolutely had more knowledge as to what “artificial means” entailed than the average layperson. This advanced knowledge and understanding should have given any statements made by Mrs. O’Connor more weight than those same statements made by the average layperson.

B. The Statements: Majority Opinion

A co-worker and friend of Mrs. O’Connor’s testified that sev-

¹² *Id.* at 621 (Simons, J., dissenting).

¹³ *O’Connor*, 531 N.E.2d at 621.

¹⁴ *Id.* at 621-22 (internal quotation marks omitted).

¹⁵ *Id.* at 608 (majority opinion).

¹⁶ *Id.*

¹⁷ *Id.* at 622 (Simons, J., dissenting).

eral times over four years, Mrs. O'Connor stated that she "would never want to be a burden on anyone and [she] would never want to lose [her] dignity before [she] passed away."¹⁸ Mrs. O'Connor expressed that her religion informed her views and that using artificial means to extend life was unnatural.¹⁹ Mrs. O'Connor also felt it was "monstrous" to keep people alive using artificial means if there was no chance of improvement, and "that people who are suffering very badly should be allowed to die."²⁰

Mrs. O'Connor's daughter testified:

[H]er mother informed her on several occasions that if she became ill and was unable to care for herself she would not want her life to be sustained artificially . . . that she would not want to go on living if she could not take care of herself and make her own decisions . . . and would never want any sort of intervention any sort of life support systems to maintain or prolong her life.²¹

These statements were made by Mrs. O'Connor at various times after helping several relatives through their final days of their terminal illnesses, as well as when comforting others when loved ones had passed.²² Her daughters and friend all agreed that Mrs. O'Connor made statements like these to all of them at some point, but that she had not specifically mentioned food or water medical assistance, or if she would refuse these treatments if it would cause a painful death.²³ The majority goes to great lengths to point out that Mrs. O'Connor never specifically mentioned artificial nutrition or hydration,²⁴ but with Mrs. O'Connor's extensive medical background, artificial life support would have included these forms of life support.

The Court of Appeals found that these statements, even though the statements were repeated over a long period, were made

¹⁸ *O'Connor*, 531 N.E.2d at 610-11 (majority opinion) (internal quotation marks omitted).

¹⁹ *Id.* at 611.

²⁰ *Id.* (internal quotation marks omitted).

²¹ *Id.* (internal quotation marks omitted).

²² *Id.*

²³ *O'Connor*, 531 N.E.2d at 610-11.

²⁴ *Id.* at 614-15.

either casually—without “seriousness of purpose”—or in reaction to an “unsettling experience of seeing or hearing of another’s unnecessarily prolonged death.”²⁵ The majority declined to apply New York’s clear and convincing standard, which was established in a previous case. Instead, the New York Court of Appeals created an entirely new standard: that there has to be “clear and convincing proof that the patient had made a firm and settled commitment, while competent, to decline this type of medical assistance under circumstances such as these.”²⁶

The court acknowledged that this requirement would penalize those who do not make a living will, or other similar writing, and that “repeated oral expressions of the patient” would be sufficient.²⁷ The court then stated, to the contrary, that Mrs. O’Connor’s statements were of the nature “that older people frequently, almost invariably make,” and that her statements did not sufficiently show “a seriousness of purpose.”²⁸ This seems to indicate that if an older person makes statements regarding life support measures, their statements will be dismissed as mere rhetoric. So, how then, would the repeated oral expressions of an older person have any credibility?

The “clear and convincing standard” has been in existence since 1981 in New York, and used in many other states as the standard for determining whether evidence is sufficient to terminate life support. However, the New York State Court of Appeals not only created a new, heightened clear and convincing standard, but the court contradicts itself repeatedly in the decision as to what would be sufficient to meet the heightened standard. The court states that oral statements would be sufficient, but then states that most statements made by older people are not sufficient because they are the types of statements they “almost invariably make.”²⁹ The court states that a patient does not have to contemplate their “precise condition and a particular treatment,” but then states that a person has to have a commitment to decline a particular type of medical assistance under

²⁵ *Id.* at 614.

²⁶ *Id.* at 608; see also Lisa Belkin, *New York Rule Compounds Dilemma Over Life Support*, N.Y. TIMES, May 12, 1992, at A1 (discussing that Judge Wachtler, in interviews, admitted that while writing the *O’Connor* decision, he thought he may have allowed his mother’s similar situation to influence his decision).

²⁷ *O’Connor*, 531 N.E.2d at 614.

²⁸ *Id.*

²⁹ *Id.*

specific circumstances.³⁰ The court has, not only, made incongruous statements, it has created an unrealistic, unattainable standard of proof.

C. The Statements: Concurring and Dissenting Opinions

The concurring and dissenting justices felt that the new standard would be impossible to meet, and that a workable standard or rule must be instituted by the legislature or judiciary.³¹ The concurring justice stated:

Relief depends exclusively upon a showing of a present subjective intent, based upon the patient's past oral or written statements unequivocally expressing her desire not to have artificial life support continued under specific circumstances. Where the patient has never expressed such thoughts or has not done so clearly, artificial life support may simply not be withheld or withdrawn. . . . Thus, even where the incompetent patient is completely and irreversibly comatose and vegetative or, although not comatose or vegetative, in a terminal condition where further treatment would not only be futile but painful, life-sustaining procedures must, apparently, be undertaken and continued.³²

Mrs. O'Connor existed in this semi-conscious and incompetent condition for an additional ten months, until finally passing away.³³

Mrs. O'Connor said that she would never want to be kept alive on life support because she felt it was unnatural and monstrous. The statements she made were informed by over twenty years of working in a hospital. She made them known repeatedly to friends, family, and co-workers and she did not waiver, in this regard, over many years. It is respectfully submitted that if Mrs. O'Connor's

³⁰ *Id.*

³¹ *Id.* at 616 (Hancock, J., concurring); *Id.* at 620 (Simons, J., dissenting).

³² *O'Connor*, 531 N.E.2d at 617 (Hancock, J., concurring).

³³ Charles Green, *Government Might Step Into Fray, Push 'Living Wills,'* LEXINGTON HERALD-LEADER (Ky.), Jan. 12, 1990, at A2.

statements on this issue are not sufficient, then there is no way for anyone to articulate his or her wishes regarding life support.

Eighty-year-old Mary Wohlford from Dyersville, Iowa, in response to *In re Schiavo*,³⁴ tried something drastic to make sure her wishes were followed. She actually tattooed “Do Not Resuscitate” on her chest due to her concerns about her final wishes not being honored.³⁵ There are questions as to whether even this type of instruction would be legally enforceable in New York.

III. LOWER COURTS DISTINGUISH *O’CONNOR*

Ten years after the *O’Connor* decision, the dissent’s prediction that the standard would prove unworkable or inhumane began to come to fruition as lower courts scrambled to distinguish *O’Connor*. *In re Christopher*³⁶ was the first in a string of cases that began to show that lower courts found the *O’Connor* decision unworkable.

Ms. Kushnir was a seventy-nine year old Russian immigrant, who had Alzheimer’s, was non-communicative, incontinent, bedridden, devoid of all cognitive function, and constantly in pain.³⁷

The Supreme Court, Queens County, permitted her son to refuse a feeding tube for his mother after recalling only one statement made by his mother.³⁸ Ms. Kushnir made this one statement, approximately ten years prior, when she had seen a television show about Sunny Von Bulow in which Ms. Von Bulow was shown in a coma.³⁹ The son stated to his mother, “ ‘[i]t’s good to be rich in this country, Mom, because even in her condition, she still looks like a model.’ [Ms. Kushnir] replied, ‘No, [even] if you was rich, I wouldn’t want to be in this condition, never.’ ”⁴⁰

The court in *In re Christopher*, went to great lengths to distinguish the case from *O’Connor*. Its reasoning was that Ms. Kushnir

³⁴ 780 So. 2d 176, 180 (Fla. Dist. Ct. App. 2001) (affirming the trial court’s decision to terminate Terri Schiavo’s life support based on a petition by her husband to do so).

³⁵ Ken Fuson, *80-year-old’s Tattoo Spells Out Last Wishes Inked Instructions*, SEATTLE TIMES, May 17, 2006, at A2. See generally Marian Haglund Juhl, *A Tattoo in Time*, NEWSWEEK, Oct. 13, 1997.

³⁶ 675 N.Y.S.2d 807 (Sup. Ct. Queens County 1998).

³⁷ *Id.* at 808.

³⁸ *Id.* at 808-09.

³⁹ *Id.* at 808.

⁴⁰ *Id.*

contemplated Ms. Von Bulow in a coma with a feeding tube, which was similar to her current condition of no cognitive function.⁴¹ The court's desire to work around the *O'Connor* standard is evidenced by the fact that the court credited the only statement Ms. Kushnir ever made regarding being kept alive by artificial means. This recollection, according to the court, was so unusual "that it bears greater weight than the numerous instances recalled by the family members in the *O'Connor* case," and that Ms. Kushnir's wishes should be followed, and life-support systems removed.⁴² The court went on to criticize the fact that New York has no legislation on this issue to provide guidelines for patient, families, or medical personnel.⁴³

Later decisions, in the Appellate Division, Second Department, and various supreme courts, reflect the courts' agreement with the *O'Connor* dissent; that the standard is unrealistic.

The Appellate Division, Second Department, stated, citing *O'Connor*, that one's wishes might be honored if they "clearly express [one's] intentions, as might be reflected by her expectations, personal choices, moral beliefs, religious convictions and the like."⁴⁴ As such, this is a significantly lower standard than that set forth in *O'Connor*.

The Supreme Court of Suffolk County has gone further, stating that

[w]hile the standards considered in [a previous case], were . . . applied to a patient in an irreversible coma, subsequent authority establishes that a patient with irreversible brain damage, unable to attend to activities of daily living, may, in a proper case, also be entitled to have his or her wishes honored to withhold artificial life-sustaining procedures . . . even where the person is not in a coma⁴⁵

This decision is consistent with the best interest standard, discussed

⁴¹ *Christopher*, 675 N.Y.S.2d at 809.

⁴² *Id.*

⁴³ *Id.* at 810.

⁴⁴ *Haymes v. Brookdale Hosp. Med. Ctr.*, 731 N.Y.S.2d 215, 217 (2d Dep't 2001) (citing *O'Connor*, 531 N.E.2d 607).

⁴⁵ *In re Balich*, No. 10487/03, 2003 WL 21649907, at *3 (Sup. Ct. Suffolk County July 10, 2003).

in Part IV(C), and included in two tiers of the FHCDA.

The Supreme Court of Nassau County, in a thorough discussion regarding termination of life support, cited *O'Connor* as standing for the fact that the “ ‘clear and convincing’ evidence standard must be satisfied in order to terminate artificial life supports for a now-incompetent patient based upon that patient’s previously expressed wishes, while competent, not to be kept alive by artificial means,” and that the evidence must be unequivocal.⁴⁶ This certainly is not the high standard set by *O'Connor*. It is further evidence that the courts are trying to work around a standard that is unworkable and unfeasible.

Courts have been distinguishing *O'Connor* or widening the scope of what satisfies the *O'Connor* standard for more than a decade.⁴⁷ However, that does not resolve the underlying problem. Lower courts becoming more permissive does not mean that the New York Court of Appeals will see things in the same light. Even Judge Wachtler, who wrote the *O'Connor* decision, said that the *O'Connor* ruling has been applied more strictly than intended.⁴⁸ It is clear that *O'Connor* is not workable, and major action by the New York Court of Appeals or the Legislature is required to remedy this issue.

⁴⁶ *In re Gianelli*, 834 N.Y.S.2d 623, 627 (Sup. Ct. Nassau County 2007).

⁴⁷ See *In re Gianelli*, 834 N.Y.S.2d at 627 (reciting a lesser standard than required in *O'Connor*, such that the patient only need to expressed their wish not to have artificial life support while competent); *In re Chantel R.*, 791 N.Y.S.2d 324, 327 (Surr. Ct New York County 2004) (distinguishing *O'Connor*, a case involving a previously competent person, from cases involving those who are mentally retarded); *Balich*, 2003 WL 21649907, at *3 (reciting a list of criteria in which artificial life support measure might be withheld, based on *O'Connor*); *In re AB*, N.Y.S. 2d 256, 260 (Sup. Ct. New York County 2003) (distinguishing *O'Connor*, a case involving an adult, from cases involving minors); *Haymes*, 731 N.Y.S.2d 215, 217 (indicating that if one makes a living will that expressly states one’s wishes regarding artificial life support, which also reflects one’s decision based on their “expectations, personal choices, moral beliefs, religious convictions, and the like,” their wishes might be upheld in court); *Christopher*, 675 N.Y.S.2d. at 809 (distinguishing on the grounds that the patient did not have a gag reflex problem as Mrs. *O'Connor* did).

⁴⁸ Belkin, *supra* note 26, at A1.

IV. ISSUES WITH SURROGATE DECISION MAKING**A. States' Rights to Preserve Life vs. Individuals' Rights to Refuse Treatment**

New York State courts have held that competent individuals have a right to refuse medical treatment, including life support measures.⁴⁹

There are four state interests that must be balanced against the patient's right to refuse treatments (self-determination); of those four interests, the right of the state to preserve life is the right most implicated in this discussion.⁵⁰ In New York, as a result of Court of Appeals decisions, a competent patient has a right to forgo even minimally invasive life-sustaining measures.⁵¹ Incompetent patients, however, no longer have the ability or right to make these decisions, except to the extent that others know of, and are required to follow, any previous wishes the patient had expressed.⁵² This means that unless you tell others what your wishes are in a "clear and convincing" manner, your wishes will not be followed. In New York, the *O'Connor* standard defines what "clear and convincing" entails, which is an impractical and unachievable standard. Very few, if any, New York residents will satisfy this standard and have their final wishes carried out.

B. Current Attitudes Toward Surrogate Decision Making

Two of the most common arguments against terminating life

⁴⁹ N.Y. STATE TASK FORCE ON LIFE AND THE LAW, WHEN OTHERS MUST CHOOSE: DECIDING FOR PATIENTS WITHOUT CAPACITY 25 (1992) [hereinafter TASK FORCE]. See *In re M.B.*, 813 N.Y.S.2d 349, 350 (2006) ("Under New York common law, a competent adult generally has the right to make health care decisions, including the right to refuse life-sustaining treatment."); *Chantel*, 791 N.Y.S.2d at 326 ("[T]he right to refuse unwanted medical treatment is a constitutionally protected liberty interest . . ." (citing *Cruzan v. Missouri Dep't of Health*, 497 U.S. 261, 278 (1990))); *Christopher*, 675 N.Y.S.2d at 808 ("New York, as well as most states, recognizes the common-law right of a competent person to decline medical treatment.").

⁵⁰ TASK FORCE, *supra* note 49, at 25.

⁵¹ *Id.*

⁵² *Id.* at 28.

support for a person who did not put their wishes in writing are: (1) how can one know what the person would have wanted; and (2) how does one know the surrogate decision maker will not impute their own wishes on what they think the patient would want? These arguments are used time and time again to stall any progress on reforming life-support termination laws for incompetent patients.

However, a 2006 study by The Pew Research Center for the People & the Press uncovered some surprising results, which support surrogate decision-making. Seventy-four percent of the people interviewed believed that, when a terminally ill patient is no longer able to communicate their wishes, a close family member should be able to make a decision as to whether to continue medical treatments.⁵³ However, only fifty-three percent would stop their own treatment from an incurable disease or if suffering great physical pain, and thirty-four percent would want their doctor to do everything possible to save them if they were suffering from an incurable disease or suffering great physical pain.⁵⁴ Of the respondents polled, African Americans, youths aged eighteen to twenty-nine, and those with a high school or lesser degree were the groups that, statistically, felt that everything should be done to preserve life.⁵⁵ These results demonstrate that, while about a third of people would do everything they could to prolong life, and a simple majority would choose to terminate life support, an overwhelming majority support a person's right to choose for themselves.

Of those who responded that they had discussed their end-of-life decisions with someone, sixty-nine percent had discussed with a spouse, fifty-seven percent with a mother, and forty-eight percent with a father.⁵⁶ Seventy-four percent of the respondents wanted a close family member to be the one to determine their treatment if

⁵³ THE PEW RESEARCH CENTER FOR THE PEOPLE & THE PRESS, STRONG PUBLIC SUPPORT FOR RIGHT TO DIE (2006), <http://people-press.org/report/266/strong-public-support-for-right-to-die> [hereinafter PEW RESEARCH CENTER].

⁵⁴ *Id.*

⁵⁵ *Id.*; see also Peter Steinfeld, *Beliefs': In the Right-to-Die Debate, the Public Reveals Strong Views, but also the Ability to Make Distinctions*, N.Y. TIMES, Feb. 11, 2006, at A12 (stating that, generally, African Americans "may suspect that talk of ending treatment and allowing patients to die will work especially to their disadvantage").

⁵⁶ PEW RESEARCH CENTER, *supra* note 53 (demonstrating that these results are up eighteen percent with spouses, fourteen percent with mothers, and twenty percent with fathers according to answers given in 1990).

they were unable to communicate their wishes.⁵⁷

These results are significant because they indicate that at least sixty percent of respondents rely on oral statements to either a spouse or parent to have their wishes carried out. The study directly contradicts the first argument against surrogate decision making that no one could know what an individual on life support would want. With almost seventy percent of the population stating their wishes—orally or in writing—it is obvious that people are communicating their wishes. These results directly implicate *O'Connor* and its unachievable standard. If most people are discussing their wishes with their immediate family members, there is something seriously wrong with New York jurisprudence that permits a significant amount of the population's direct wishes not to be honored.

Interestingly, the Pew Research Center also asked respondents if Congress was correct to get involved in the case of Terri Schiavo. Terri Schiavo was a twenty-seven year old woman who was in a persistent vegetative state, whose husband wanted to disconnect life support, and whose parents opposed it.⁵⁸ Terri's parents, and both Florida and national politicians, got involved. The politicians came back early from recesses, passed special laws—mostly deemed unconstitutional—and even tried to switch jurisdiction from the state courts to federal courts to intervene in the case.⁵⁹ The case went all the way to the United States Supreme Court, but review was denied.⁶⁰ The study found that only seventeen percent of the respondents felt that Congress did the right thing in involving themselves in Schiavo's case.⁶¹ An extraordinary eighty-three percent felt that politicians should stay out of these personal decisions. This further indicates that New York needs legislation that would allow for the minimization of state and court interference with these deeply personal decisions.

Another study published in 2007, analyzing data from a 2004

⁵⁷ *Id.* (demonstrating that these results are approximately the same from the seventy-one percent reported in 1990).

⁵⁸ *Schiavo*, 780 So. 2d at 177-78.

⁵⁹ John A. Robertson, *Schiavo and Its (In)significance*, 35 STETSON L. REV. 101, 108-10 (2005).

⁶⁰ *Schiavo v. Schiavo*, 403 F.3d 1289 (11th Cir. 2005), *cert. denied*, 544 U.S. 957 (2005).

⁶¹ PEW RESEARCH CENTER, *supra* note 53 (noting that this is down from a survey conducted three months earlier, which found that twenty percent thought Congress acted properly).

Wisconsin Longitudinal Study, shows that ninety percent of married persons discussed their end-of-life wishes with a spouse, while over sixty-six percent of parents discussed their wishes with a child.⁶² These results affirm the idea that many people are discussing their end of life decisions with loved ones, again, implicating the *O'Connor* predicament in New York.

A second study published in 2008, again analyzing data from the 2004 Wisconsin Longitudinal Study, studied surrogate accuracy in the end-of-life decision making given two scenarios: the first, comparing surrogate accuracy when the patient was “mentally intact, but in severe and constant physical pain;” second, comparing surrogate accuracy when the patient “had minimal physical pain, but had limited ability to speak, walk, or recognize others.”⁶³

The study found that in the first scenario—pain, but no mental impairment—surrogates were accurate sixty-two percent of the time in determining what their spouse would have wanted.⁶⁴ However, significantly, the study found that in the second scenario—minimal pain, but deficient mental and physical ability—surrogates were accurate seventy-seven percent of the time.⁶⁵ Surprisingly, having a health care proxy and/or a living will was not “a significant predictor of surrogate accuracy.”⁶⁶ Additionally, the accuracy rates remained the same independent of the decisions the surrogate-spouse would

⁶² Deborah Carr & Dmitry Khodyakov, *End-of-Life Health Care Planning Among Young-Old Adults: An Assessment of Psychosocial Influences*, 62B J. GERONTOLOGY S135, S137 (2007) (reflecting higher percentages than those in the Pew study). One of the limitations to the 2007 study is that it concentrated more generally on white Americans, at least high school educated adults, who have a higher percentage of discussing and implementing end-of-life directives than younger, African American, or less than high school educated individuals. *Id.* at S138, S140.

⁶³ Sara M. Moorman & Deborah Carr, *Spouses' Effectiveness as End-of-Life Health Care Surrogates: Accuracy, Uncertainty, and Errors of Overtreatment or Undertreatment*, 48 GERONTOLOGIST 811, 813 (2008).

⁶⁴ *Id.* at 815. Finding that in this first scenario, surrogates were uncertain of their decision between eleven and sixteen percent of the time and made errors in decisions that resulted in the slight over treating or under treating of their spouse between eleven and twenty-two percent of the time. *Id.* at 811. This twenty-two percent in slight over/under treatment is statistically relevant as the surrogate is still generally making the decisions the principle would.

⁶⁵ *Id.* The surrogates, in this second scenario were also uncertain of their decision eleven percent of the time, and made errors in decision that would result in slight over or under treatment of their spouse twelve percent of the time. *Id.* This twelve percent is also statistically relevant as the surrogate is still generally making the decision the principle would. Moorman & Carr, *supra* note 63, at 811.

⁶⁶ *Id.* at 816.

have made for themselves.⁶⁷

These results are significant in contradicting the second argument most frequently used against surrogate decision making: how do we know the surrogates will not substitute their wishes for those of the patient. In this scenario, which the FHCDA would address, incompetence due to mental and physical deficiencies with little chance of recovery, spouses made the correct or slight over or under treatment choices for their incompetent spouse eighty-five percent of the time—even when it differed from what they would choose for themselves.

These study results indicate several conclusions: first, people are overwhelmingly willing to let people decide for themselves what their end-of-life decisions should be, even if it differs with their own wishes; second, people are almost evenly split between whether they want everything possible done to preserve life, or whether they would choose to stop treatment, further indicating the need to protect peoples wishes; third, people are significantly more likely to discuss their end-of-life wishes than they are to complete a living will; fourth, those who did prepare a living will usually did so only in response to being involved in making these decisions for a friend or relative; fifth, it is not appropriate for the government to insert itself into very personal end-of-life decisions; and lastly, surrogates who are spouses make correct decisions regarding their spouse-patient's wishes eighty-five percent of the time in the case where a patient was mentally and physically incapacitated. These results reinforce the suitability of incorporating the substituted judgment standard for surrogate decision making that is incorporated into the proposed New York legislation.

C. Ethical Considerations in Surrogate Decision Making

There are two standards of surrogate decision-making that are the most widely accepted: the substituted judgment standard and the best interest standard. There are praises and criticisms of each type of substituted decision making. The FHCDA incorporates both standards.

The substituted judgment standard attempts to carry out the

⁶⁷ *Id.*

patients' wishes in furtherance of the right to self-determination. It takes into account information known from and about the patient, including personal preferences, values, morals, and religious ideologies.⁶⁸ A major criticism of the substituted judgment standard is that no one can really know what a presently incompetent patient would have wanted in their current situation, and that in certain situations this standard offers no guidance.⁶⁹ The above referenced studies seem to indicate that, at least, spousal surrogates pretty accurately decide as their patient-spouses would have decided. In situations where there is no guidance available, decisions should be made under the best interest standard.

The best interest standard "serves primarily to protect and promote the well-being of vulnerable patients."⁷⁰ The standard should consider the patient's pain level, his or her treatment goals, the prolongation of life verses the burdens of living with the amount of pain and suffering the patient is experiencing, and the ability to either preserve the current functional level of the patient, or the ability to restore function to the patient.⁷¹ The surrogate should ask if the treatment would unnecessarily prolong the dying process for the patient.⁷² Those who criticize surrogate decision making often state that, "[n]o matter how burdened it may be, human life remains inherently a good of the person. Thus, remaining alive is never rightly regarded as a burden."⁷³ Still, others view life as always intrinsically good, but as it relates to other living activities, "our capacity for consciousness, thought, and human interactions," not just a "biological function."⁷⁴ The best interest standard implies that a patient's best interests inherently involve "the value of the patient's life for the patient, not the value of the patient's life to others."⁷⁵

A separate study showed that sixty-one percent of respondents "would have allowed their surrogates at least some leeway 'to over-

⁶⁸ TASK FORCE, *supra* note 49, at 54.

⁶⁹ *Id.*

⁷⁰ *Id.* at 55.

⁷¹ *Id.* at 55-56.

⁷² *Id.*

⁷³ TASK FORCE, *supra* note 49, at 57 (quoting William E. May et al., *Feeding and Hydrating the Permanently Unconscious and Other Vulnerable Persons*, 3 ISSUES L. & MED. 205, 208 (1987) (internal citation omitted)).

⁷⁴ *Id.* at 57-58.

⁷⁵ *Id.* at 59.

ride their advance directive if overriding were in their best interest.”⁷⁶ The study also showed that eighty-seven percent of respondents wanted surrogate decision makers to consider their quality of life in making a decision on their behalf.⁷⁷ The result of this study bolsters the Wisconsin Longitudinal Study and the Pew Research Center studies, both of which indicate that if the surrogate takes the incompetent’s best interest and quality of life into account, the surrogate’s decisions would be acceptable almost ninety percent of the time. This greatly supports the FHCDA since it would permit surrogate decision making for life support decisions, especially since the second and third tiers incorporate the best interest standard.

D. Technological Advances

Since the decision in *O’Connor*, medical technology has advanced at an astonishing rate. These technologies “are now able to sustain life using aggressive treatments despite severe debilitating illness. In many cases, technological advances have obvious benefits However, for those with irreversible disabilities, aggressive measures can postpone death and merely serve to prolong suffering and extend the dying process.”⁷⁸ The *O’Connor* decision failed to take medical advances into consideration in developing the standard.

There are a variety of medical technologies that can be used to extend life. Percutaneous endoscopic gastrostomy (“PEG”) feeding tubes for artificial hydration and nutrition, ventilators, and machines for kidney dialysis are most often referred to in referencing life support. There is, however, a trend to overuse these technologies at the end of one’s life. Dr. Kenneth Fisher, a physician at the Michigan State University and at Henry Ford Hospital, feels that “[p]atients who have no chance of survival are subjected to unnecessary tests, treatments, and procedures.”⁷⁹ This further supports a need

⁷⁶ Hana Osman & Terry M. Perlin, *Patient Self-Determination and the Artificial Prolongation of Life*, 19 HEALTH & SOC. WORK 245 (1994) (quoting A. Sehgal et al., *How Strictly do Dialysis Patients Want Their Advance Directives Followed?*, 267 J. AM. MED. ASS’N. 59, 63 (1992)).

⁷⁷ Mary Daisy Boehm, *Sticking to Advance Directives*, 17 SECOND OPINION 108, 108 (1992).

⁷⁸ D. W. Molloy et al., *Technology and Educating Seniors About Advance Directives*, 26 EDUC. GERONTOLOGY 357, 357-58 (2000).

⁷⁹ Linda S. Mah, *Health-Care Priorities Lambasted*, TIMES (N.J.), June 23, 2008, at B1.

to change the *O'Connor* standard, so people are not simply kept alive because technology can do so.

A research study by the Dartmouth Atlas Project shows that twenty-seven percent of Medicare costs are spent in the final year of a patient's life.⁸⁰ This supports doctors and patients contentions that patients are left in limbo, somewhere between life and death, exposed to unnecessary and futile tests and treatments.⁸¹ This is true in New York, as most patients who have stated their wishes, but not in a way sufficient to meet the *O'Connor* standard, are kept in limbo for significant periods of time. This, not only, goes against their wishes, but is a significant and unnecessary waste of valuable resources.

Overuse of life-sustaining medical technology is found when looking at the history of the PEG.⁸² In 1979, PEGs were first used by Dr. Michael Gauderer in the University Hospitals of Cleveland as "emergency care for younger patients."⁸³ It was intended for use over a few months and designed to get a person past their current crisis, not for those suffering from an irreversible illness.⁸⁴ PEGs have not been found to prolong the lives of the terminally ill, but their use is still very widespread.⁸⁵

These issues with advanced technologies only emphasize the need for a mechanism to carry out the wishes of those who have decided that if there is no hope for their recovery from an incompetent state, they do not wish to prolong a life which, to them, has no quality that makes it worth living. Furthermore, why should people be subjected to medical procedures that they do not want, who have stated

⁸⁰ Julie Appleby, *Debate Surrounds End-of-Life Expenses*, USA TODAY, Oct. 19, 2006, at B1.

⁸¹ Jeffrey Zaslow, *Moving On: Waiting for the End: When Loved Ones Are Lost in Limbo*, WALL ST. J., Aug. 16, 2007, at D1; see also Mah, *supra* note 79, at B1 (stating that the lives of patients are extended because of medical technologies and treatments often thought to be unnecessary considering the circumstances).

⁸² Mark Fritz, *Last Rights: How Simple Device Set Off a Fight Over Elderly Care; Invented for Younger Patients, Feeding Tube Now Figures in End-of-Life Debate; A Missed Box on a Living Will*, WALL ST. J., Dec. 8, 2005, at A1.

⁸³ *Id.*

⁸⁴ *Id.* See also Scott Thomas, *Feeding the Dying—Medical or Moral Decision? While Moral Debate Continues to Rage After the Terri Schiavo Case, There's New Scientific Evidence that Forced Feeding is Not Beneficial*, BUFF. NEWS (N.Y.), Feb. 19, 2006, at H1 ("The PEG tube was developed for use with patients who need to get over the hump—those with a reversible illness, such as a severe infection, or those who are recovering from surgery. Soon doctors were using feeding tubes for patients with more permanent disabilities . . .").

⁸⁵ Fritz, *supra* note 82, at A1; see also Thomas, *supra* note 84, at H1.

to friends and family that they do not want, and made these statements with the expectation that these requests will be fulfilled. The overuse of technology in New York is partly attributable to *O'Connor*. Since most people cannot meet the *O'Connor* standard to have life support terminated, they are kept on life support for an extended time until they pass.

V. CURRENT NEW YORK LAW AND A MODEL FROM NEW JERSEY

A. Health Care Proxies in New York

Approximately two years after the *O'Connor* decision, and only six days after the Supreme Court handed down the decision in *Cruzan v. Missouri Department of Health*,⁸⁶ the New York Legislature passed Article 29-C, an amendment to the Public Health Law.⁸⁷ Article 29-C provides for Health Care Agents and Proxies to make certain medical decisions for an incapacitated patient. A Health Care Proxy, however, cannot make decisions regarding artificial nutrition or hydration unless he or she knows the wishes of the patient. Health Care Proxy forms are most effective when used in conjunction with a living will.

However, there is a gaping hole in proxy planning in New York State. Article 29-C does not overcome the *O'Connor* standard, which requires that people contemplate their exact situation and treatment over time. In other words, they must reflect on that decision over time and come to a firm and settled commitment with respect to their decision prior to an actual occurrence and communicate that to their proxy for the proxy to be able to act on their life support wishes.

⁸⁶ 497 U.S. 261, 284 (1990) (“State[s] may apply a clear and convincing evidence standard in proceedings where a guardian seeks to discontinue nutrition and hydration of a person diagnosed to be in a persistent vegetative state.”).

⁸⁷ Jill Hollander, *Health Care Proxies: New York's Attempt to Resolve to the Right to Die*, 57 BROOK. L. REV. 145, 147 (1991); Marina Martino, Note, *Deciding for Others: New York Law and the Rights of Incompetent Persons to Withhold or Withdraw Life-Sustaining Medical Treatment*, 41 N.Y.L. SCH. L. REV. 285, 297 (1996). See also N.Y. PUB. HEALTH LAW §§ 2980-2991 (McKinney 2008).

B. Living Wills in New York

In New York, living wills are only relevant for probative value in a hearing to determine if the *O'Connor* standard has been met. Thus, even a living will does not guarantee that one's wishes will be followed.⁸⁸ Without a living will, family members of an incapacitated individual are only permitted to make decisions about whether cardiopulmonary resuscitation can be used to sustain life. A Health Care Proxy, in combination with a living will, gives incapacitated patients the best chance that their wishes will be fulfilled; however, again, these are both written instruments. There is no solution for those who have not put anything in writing, but have relied only on oral statements made to family and friends.

C. MOLST in New York

Governor Paterson signed a bill into law in July of 2008 called Medical Orders for Life Sustaining Treatment ("MOLST").⁸⁹ While this bill does not replace living wills or health care proxies, it does allow "[s]eriously ill patients with advanced chronic illness and frailty, after talking to their doctor, to complete the MOLST form about the kind of care they want at the end of their life."⁹⁰ This law seems to fill the gap in the law in New York for making sure one's final wishes are carried out, but this form, like a living will, must be completed while a patient is competent to make decisions about their care known to their physician, it does not help if there is some sudden occurrence in a previously healthy person that renders them incompetent.⁹¹ MOLST also is required to be signed by a physician, not the patient.⁹² As a result, the MOLST form is just another stop-gap measure to do what the New York Legislature failed to do, pass legislation that will implement a more reasonable standard than *O'Connor*.

⁸⁸ See Hollander, *supra* note 87, at 161.

⁸⁹ Gov. Paterson Signs End-of-Life Program into Law, U.S. ST. NEWS, July 9, 2008, http://www.compassionand support.org/pdfs/news/MOLST_Press_Release.070908.pdf.

⁹⁰ *Id.*

⁹¹ *Id.*

⁹² James T. Mulder, *Hospitals Adopt Patient-Care Form: Onondaga County Facilities Use Uniform Record for Life-Sustaining Treatment Orders*, POST STANDARD (N.Y.), Mar. 26, 2005, at A5.

D. Potential Solutions to New York's Problem: *In re Conroy*

New York would benefit greatly from adopting the FHCDA, which was modeled on New Jersey's three-tier decision-making model. New Jersey's model has been in place since 1985 when *In re Conroy*⁹³ was decided, and which the New Jersey legislature later codified.

In re Conroy involved an eighty-four year old woman who was bedridden and had a host of physical and mental diseases from which she would not be able to recover, but who could interact, in limited ways, with her environment.⁹⁴ Her nephew, who was also her guardian, said that his aunt feared and avoided doctors; in one instance, when she had pneumonia, he could not get her to allow a doctor into the house, and in another instance, when she was taken to an emergency room, she would not sign herself in.⁹⁵ Ms. Conroy was also Roman Catholic, and the church she attended had a document that discussed "weighing of the burdens and the benefits to the patient of remaining alive with the aid of extraordinary life-sustaining medical treatment."⁹⁶ This was considered strong evidence that Ms. Conroy's decision would have been reflected upon and informed by the dictates of her religion. The court determined that Ms. Conroy would never regain significant cognitive function, and permitted her feeding tube to be removed.⁹⁷

Ms. Conroy passed away during the appeals process, but both the appellate court and supreme court felt the case was "capable of repetition but would evade review."⁹⁸ The Supreme Court of New Jersey, unlike the New York courts or legislature, which have largely remained silent, felt something needed to be done. The court decided there needed to be guidelines and procedures developed to help

determine the circumstances under which life-sustaining treatment may be withheld or withdrawn from an elderly nursing-home resident who is suffer-

⁹³ 486 A.2d 1209 (N.J. 1985).

⁹⁴ *Id.* at 1216-17.

⁹⁵ *Id.* at 1218.

⁹⁶ *Id.*

⁹⁷ *Id.* at 1218-19.

⁹⁸ *Conroy*, 486 A.2d at 1219.

ing from serious and permanent mental and physical impairments, who will probably die within approximately one year even with the treatment, and who, though formerly competent, is now incompetent to make decisions about her life-sustaining treatment and is unlikely to regain such competence.⁹⁹

As a result, the court developed a three-tiered system to set out how to decide whether to withhold or remove life-sustaining treatment. Only one of the tiers needs to be satisfied, with preferences in the following order: subjective test, limited-objective test, and pure-objective test. The subjective test is similar, if not slightly broader, than a standard clear and convincing evidence test, which incorporates the best evidence of the patient's wishes. The limited-objective standard is used if the evidence is substantial, but not quite enough to meet a standard clear and convincing test, but is then looked at and combined with a weighing of the patient's condition. The pure-objective standard strictly takes into account the patient's condition. This model is best suited to effectuate a patient's wishes, or if not known, at least balances the burdens of the patient's life, including pain, against the benefits the patient gets from life.

The first test, the subjective test, states that "life-sustaining treatment may be withheld or withdrawn from an incompetent patient when it is clear that the particular patient would have refused the treatment under the circumstances involved."¹⁰⁰ This test is broadly construed to encompass a wide variety of evidence that would constitute the patient's intent. It will be evaluated for its probative value in "remoteness, consistency, and thoughtfulness of the prior statements or actions and the maturity of the person at the time of the statement or acts,"¹⁰¹ as well as the specificity of the statements, and "medical evidence bearing on the patient's condition, treatment, and prognosis."¹⁰² The subjective test is very similar to New York's old "clear and convincing test," which is used in many states.¹⁰³ It is the best

⁹⁹ *Id.* at 1219-20.

¹⁰⁰ *Id.* at 1229.

¹⁰¹ *Id.* at 1230.

¹⁰² *Id.* at 1230-31.

¹⁰³ Petersen, *supra* note 6 (explaining that a clear and convincing standard is used in: Alabama, Delaware, Florida, Illinois, Kentucky, Maine, Michigan, Missouri, New Jersey (this is the subjective test), New York, Ohio, Oklahoma, Wisconsin (although Wisconsin's clear and

test to assure that either living wills or direct evidence of repeated, detailed oral statements by an individual would be considered and fulfilled. A majority of people would most likely fall into this tier.

The second tier, the limited-objective standard, allows the withholding or removal of life-sustaining treatment “when there is some trustworthy evidence that the patient would have refused the treatment, and the decision-maker is satisfied that it is clear that the burdens of the patient’s continued life with the treatment outweigh the benefits of that life for him.”¹⁰⁴ This test examines all the patient’s medical diagnosis, prognosis, and pain levels and duration.¹⁰⁵ The test attempts to determine whether the “pain and suffering outweigh the benefits that the patient is experiencing. The medical evidence should make it clear that the treatment would merely prolong the patient’s suffering and not provide him with any net benefit.”¹⁰⁶ This test also requires evidence that the patient would have consented to withdraw or withhold treatment.¹⁰⁷ Any of the evidence that would have been considered under the subjective test can be considered, even if the evidence, on its own, would not have been enough to fulfill the subjective test.¹⁰⁸ The limited-objective standard would allow for circumstantial evidence of what the individual would want to be considered and followed. It is a blend of circumstantial evidence and the best interest test. This tier would be the second most used tier of the legislation.

The third tier, the pure-objective standard, would be satisfied if the

net burdens of the patient’s life with the treatment should clearly and markedly outweigh the benefits that the patient derives from life. Further, the recurring, unavoidable and severe pain of the patient’s life with the treatment should be such that the effect of administering life-sustaining treatment would be inhumane.¹⁰⁹

convincing standard is actually used as a best interest standard)).

¹⁰⁴ *Conroy*, 486 A.2d at 1232.

¹⁰⁵ *Id.*

¹⁰⁶ *Id.*

¹⁰⁷ *Id.*

¹⁰⁸ *Id.*

¹⁰⁹ *Conroy*, 486 A.2d at 1232.

This test does not require any of the evidence that would have been considered under the subjective test, or any evidence that might have satisfied the subjective prong of the limited-objective standard.¹¹⁰ This tier is strictly the substituted judgment standard. It is a balancing test of the benefits and the burdens of the patient's life, in determining what would be a humane and dignified decision for the patient. This test would be the least used of any of the tiers, but it is still relevant, because of documented research showing that spouses are excellent surrogate decision makers for their incompetent spouses.

The court goes on to clearly state that none of the tests should be used to permit withholding or withdrawal of life-sustaining treatment from a "patient who had previously expressed a wish to be kept alive in spite of any pain that he might experience."¹¹¹ Additionally, the court stated that if the evidence is "equivocal, it is best to err . . . in favor of preserving life."¹¹² The State of New Jersey codified this ruling in 1992.¹¹³

This three-tier decision making model has been in use, with no major detractors, for twenty-three years. It is an excellent model for New York to have used to develop its own legislation. It incorporates both the substituted judgment standard and the best interest standard between the three decision levels. It has an exception to protect the rights of people who have indicated they want physicians to do everything possible to preserve their lives. It gives a flexible, workable, achievable standard that is reasonable to implement.

VI. NEW YORK'S PROPOSED LEGISLATION

A. The Task Force on Life and the Law and Proposed Legislation

In 1992, the Task Force on Life and the Law was formed as a state task force to look into this gaping hole in New York legislation,

¹¹⁰ *Id.*

¹¹¹ *Id.*

¹¹² *Id.* at 1233.

¹¹³ N.J. STAT. ANN. §§ 26:2H-63, 26:2H-67, 26:2H-69 (West 2008).

and to propose legislation that took into consideration: “expertise from many disciplines, and . . . opinion and belief about bioethics issues in New York [S]tate.”¹¹⁴ The Task Force proposed the legislation in 1992, and New York has had Assembly and/or Senate legislation based on the Task Force recommendations since at least 1996 that would implement a decision making model on when termination of life support for incompetent individuals, who have not made a writing, would be permissible. There are two separate pieces of legislation, one in the Senate, and one in the Assembly, both of which are currently the same.¹¹⁵ The FHCDA is very similar to the *Conroy* three-tiered system, and is supported by over forty-eight different organizations, including religious, medical, and civic associations, as well as the New York State Bar Association.¹¹⁶

The FHCDA provides a list of potential health care decision making surrogates if the patient is found incompetent in case the patient has not already selected one; it outlines who is not eligible to be a surrogate; and it also has a provision for people who do not have a surrogate who is willing or able to act as a surrogate.¹¹⁷ The FHCDA sets standards for decision making.¹¹⁸ It allows for surrogates to make decisions on a tier-system, similar to the New Jersey statute; it allows for decisions based on what are known patient wishes.¹¹⁹ If the patient’s wishes are not known to a certain enough standard, the wishes that are known are looked at in conjunction with what are in the best interests of the patient.¹²⁰ If a patient’s wishes are not known, or cannot be discovered, then treatment can be withheld or withdrawn if the

¹¹⁴ Vincent Buzard, *New Yorkers in Need of Health Care Decision Act*, ALB. TIMES UNION (N.Y.), June 4, 2006, at C6.

¹¹⁵ S.B. 3164, 233rd Leg., Sess. (N.Y. 2009) [hereinafter N.Y. PUB. HEALTH LAW § 2994]; Assemb. B. 7729, 233rd Leg., Sess. (N.Y. 2009) [hereinafter N.Y. PUB. HEALTH LAW § 2994]. Please note, each bill has its own bill number assigned to it; however, the bills are currently identical and, if passed will become N.Y. PUB. HEALTH LAW § 2994. For ease of discussing individual sections of the bill, the citations will refer to section 2994 as this will allow for quick reference, because the bills are numbered internally with that prospective law number. However, when looking for the bill itself, the appropriate Senate bill number and Assembly bill number should be used.

¹¹⁶ Buzard, *supra* note 114, at C6; see also *NYSBA Urges Legislature*, *supra* note 6.

¹¹⁷ N.Y. PUB. HEALTH LAW § 2944-d(1)-(2), *supra* note 115.

¹¹⁸ *Id.* at § 2994-d(4), *supra* note 115.

¹¹⁹ *Id.* at § 2994-d(4)(a)(i), *supra* note 115.

¹²⁰ *Id.* at § 2994-d(4)(a)(ii), *supra* note 115.

treatment would be an extraordinary burden to the patient and . . . the patient has an illness or injury which can be expected to cause death within six months, whether or not treatment is provided; or . . . the patient is permanently unconscious; or . . . treatment would involve such pain, suffering or other burden that it would reasonably be deemed inhumane or extraordinarily burdensome under the circumstances and the patient has an irreversible or incurable condition.¹²¹

The FHCDA also has provisions if the patient is in a residential facility for health care or in a hospital, which requires an added layer of protection by requiring a review of the decision by an ethics review committee of the facility.¹²²

Additionally, the FHCDA sets standards for patient protection after a surrogate has made a decision. The physician, after recording the decision as to whether to withhold or withdraw life support, has the option of following the decision; or objecting to the decision and allowing the patient to be treated by another physician, or a referral to the ethics committee can be made.¹²³ It also has instructions for the physician to refer the case to the ethics review board if people, who have a designated relationship with the patient, disagree with the choice of surrogate or the decision of the surrogate.¹²⁴ It allows for policies on how to implement these decisions, as well as how to re-

¹²¹ *Id.* at § 2994-d(5)(a)(i)-(ii), *supra* note 115. Even though this tier would rarely be used, and maybe because it would rarely be used, it could be eliminated if there are insurmountable ethical concerns. Argument over this tier is not reason enough to keep this extremely important legislation from passing. Some commentators have pointed out that “[p]ain can usually be controlled through medications” and concern that the pain the patient is experiencing could be due to substandard care. David M. English, *Comment Defining the Right to Die*, 56 *LAW & CONTEMP. PROBS.* 255, 259 (1993). See also Herbert Keating, *A Simple Statement that can Avert so Much Hardship*, *HARTFORD COURANT* (Conn.), Nov. 26, 2006, at H4 (stating that a doctor in Connecticut has also taken it upon himself to create a questionnaire to give *every one of his patients* at their annual physical in which they can either fill out at that time or take home and mail back—if they are inclined—which would inform the doctor as to the patient’s wishes for end-of-life decisions if they are not competent to make them for herself); see also Interview by Neal Conan with Michael Schiavo, at NPR Talk of the Nation, (Mar. 30, 2006) (stating that a hospital in South Dakota asked patients if, when they go into the hospital, they have a living will to avert confusion and because they feel that respecting patient wishes are important).

¹²² N.Y. PUB. HEALTH LAW § 2944-d(5)(b)-(c), *supra* note 115.

¹²³ *Id.* at § 2994-f(1), *supra* note 115.

¹²⁴ *Id.* at § 2994-f(2), *supra* note 115.

view them, including review by an ethics committee.¹²⁵ Additionally, it allows privately owned hospitals and individual providers to make a conscience objection and adopt policies on how to handle these patients.¹²⁶

The FHCDA is a reasonable, workable, and attainable standard that allows the final wishes of patients to be carried out, whether that is to have life support measures undertaken, or not, or something in between. It allows for a humane death, not a drawn out, withering existence. It balances a state's interest in preserving life with a patient's right of self determination by incorporating, not just the substituted judgment standard, but also the best interest standard. It also has built in protections for the patient to be sure that a patient's wishes are followed, and that the patient is not subject to impure motives. This is excellent legislation that would allow a patient to have their final wishes followed, regardless of what those wishes are.

B. The Road Ahead in the New York Senate

The New York Assembly has amended, revised, and passed their version of the FHCDA. It passed 137 to 5 and was delivered to the Senate on January 20, 2010.¹²⁷ The Senate has now adopted the bill passed by the Assembly in its entirety and the bill has set for a meeting before the Senate Committee on Health, and has been referred to the Senate Code Committee.¹²⁸

There are two major impediments to passing the FHCDA in the Senate: first, is the lack of wording which indicates what should be considered regarding a pregnant comatose woman,¹²⁹ and second, the inclusion of same-sex partners in the list of surrogates, which implicates gay rights issues.¹³⁰

¹²⁵ *Id.* at § 2994-k, § 2994-m, *supra* note 115.

¹²⁶ *Id.* at § 2994-n, *supra* note 115.

¹²⁷ New York State Assembly Summary (Feb. 22, 2010), <http://www.assembly.state.ny.us/leg/?bn=A07729>.

¹²⁸ *See* N.Y. PUB. HEALTH LAW § 2994, *supra* note 115.

¹²⁹ *See* Hollie J. Paine, Symposium: "Caring for the Dying: Reexamining Our Approach" Notes, 2 J. HEALTH CARE L. & POL'Y 371, n.85 (1999) ("[T]he Conference did oppose the bill because . . . it did not offer 'higher decision-making standards' for . . . 'treatment of pregnant patient[s] to the detriment of the unborn child.'" (citing Letter from John M. Kerry, New York State Catholic Conference, to Hon. Joseph Lentol, Chairperson, Assembly codes Comm. and Comm. Members (June 23, 1997)).

¹³⁰ *End-of-Life Logjam*, N.Y. Times, May 13, 2007, at 411.

The lobbying arm of The New York State Catholic Conference (“The Catholic Conference”) is the leading opponent to the bill due to the wording regarding treatment of women who are pregnant at the time the decision is made regarding life support.¹³¹ Initially, The Catholic Conference opposed prior versions of the bill because it did not require a surrogate decision maker to take into consideration the impact of the decision on the fetus.¹³² The wording was changed to require the surrogate to take into consideration “the impact of the treatment decisions on the fetus”—including the “course and outcome” the treatment decision would have on the pregnancy.¹³³ This wording was also carefully fashioned so that it would not create “special rights for the fetus,” and would be acceptable to pro-choice groups.¹³⁴ This caused The Catholic Conference to withdraw their opposition to the bill, but they did not support it either.¹³⁵

An additional change, made at the same time the change was made to the wording regarding pregnant patients, was to remove domestic partners from the list of surrogate decision makers.¹³⁶ This created an entire new group of opponents who wanted gay partners included on the surrogate list and who wanted the language regarding pregnant patients changed back to the original wording.¹³⁷

As a result, the current bill was changed back to the original language, causing The Catholic Conference to again oppose the bill.¹³⁸ However, Assemblyman Richard Gottfried, sponsor of the Assembly bill, feels that the bill “would require anyone making a decision for [a pregnant patient] to consider the woman’s ‘moral values and wishes.’ ”¹³⁹ It remains to be seen whether The Catholic Conference lobby is strong enough to defeat this important legislation. Because, the Catholic Conference does not actively object to the wording of the bill, the FHCDA should return to this language to ensure

¹³¹ Henry L. Davis, *Life and Death—Who Should Make the Choice?: Controversial Bill Gets Support From Families Asking That the Decision be Put in Their Hands*, BUFF. NEWS (N.Y.), Mar. 24, 2005, at A1.

¹³² *Id.*

¹³³ *Id.*

¹³⁴ *Id.*

¹³⁵ *Id.*

¹³⁶ Davis, *supra* note 129, at A1.

¹³⁷ *Id.*

¹³⁸ *Id.*

¹³⁹ Harvy Lipman, *Giving Family a Role in Health Care Bill Would Provide Relatives More Say in Caring for Very Ill*, ALBANY TIMES UNION (N.Y.), June 26, 1995, at B2.

the bills passage.

As for same sex couples, the current Assembly bill, which has been adopted by the Senate, includes same sex partners in the list of surrogate decision makers at the same level of a spouse, only behind a guardian.¹⁴⁰ There is some hope that a problem will not exist in the Senate regarding this issue, as the Senate backed a bill that was signed by Governor Pataki, which gives domestic partners—same sex or opposite sex—the right to make decisions about how to dispose of their partners remains.¹⁴¹ This seems to indicate a trend in favor of domestic partners.

As for same sex partners, twenty-eight states and the District of Columbia list a patient's partner in the list of acceptable surrogates to make medical decisions for someone who is incapacitated.¹⁴² Of those, twenty states allow a partner to make the decisions only as "one who has exhibited special care and concern" or "close friend" with a list of up to seven people who come before the partner in the surrogate list.¹⁴³ Unfortunately, this article cannot take on same-sex discrimination issues, although it seems that our notions of equality should allow same-sex partners—who, in most states, do not have the right to marry and, therefore, cannot legally be assigned the term

¹⁴⁰ N.Y. PUB. HEALTH LAW § 2944-a(7)(c), *supra* note 115. Defines a Domestic Partner as being:

[D]ependent or mutually interdependent on the other person for support, as evidenced by the totality of the circumstances indicating a mutual intent to be domestic partners including but not limited to: common ownership or joint leasing of real or personal property; common householding, shared income or shared expenses; children in common; signs of intent to marry or become domestic partners

Id.

¹⁴¹ Davis, *supra* note 129, at A1.

¹⁴² Human Rights Campaign, Healthcare Laws: State by State, <http://www.hrc.org/issues/7935.htm> (last visited Jan. 23, 2010) (demonstrating that the following states maintain a patient's partner in the list of acceptable surrogates: Alaska, Arizona, California, Colorado, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Maine, Maryland, Massachusetts, Mississippi, New Jersey, New Mexico, New York, North Dakota, Oregon, Pennsylvania, South Dakota, Tennessee, Utah, Vermont, Washington, West Virginia, Wisconsin, Wyoming).

¹⁴³ *Id.*; see also Gay & Lesbian Medical Association, Visitation Guidelines for Hospitals, http://www.hrc.org/documents/GLMA_-_Sample_Visitation_Policy.pdf (recommending that hospitals use the definition of family promulgated by the Joint Commission: "[A]ny person(s) who plays a significant role in an individual's life. This may include a person(s) not legally related to the individual This includes both spouses and same-sex domestic partners").

“spouse,” which in turn denies them the approximately 1300 rights to which married couples are entitled¹⁴⁴—to act as a surrogate, just as opposite-sex, legal spouses are allowed to act as surrogates. Inclusion of same sex partners, as surrogates equal to that of a spouse, needs to be included, particularly in light of the defeat of Governor Paterson’s same sex marriage proposal.

VII. CONCLUSION

There must be a mechanism by which New Yorkers can ensure that their final wishes will be honored. The *O’Connor* decision effectively took that decision away from most. Technological advances now allow people to be kept alive, but incompetent or unconscious for a very long time. This not only goes against their wishes, it wastes valuable resources on treatments that the patients themselves do not want. Whether to terminate life support, or not, is too important, and too personal of a decision to rely on chance that one’s wishes will be followed.

New York State has had legislation pending for almost seventeen years that incorporates not only an evidentiary standard for making a decision, but which also incorporates the substituted judgment and best interest standards, which are two of the best standards for surrogate decision making.

It is evident that many people discuss their final wishes orally with loved ones, but not enough are memorializing their wishes in writing. There is significant evidence that surrogate decision makers do, in fact, make choices consistent with what the patient would have chosen. As a result, there can be little concern regarding the accuracy of surrogate decisions, because those closest to the patient often have knowledge from the patient themselves about the end-of-life care they want, and surrogates will follow the patient’s wishes even if it is different than what they would want for themselves. Furthermore, surveys have shown that people are willing to give their decision makers some leeway in making decisions different from the patient’s own if the decision maker takes into account the patients best inter-

¹⁴⁴ Larry McShane, *Gov. Paterson Introduces Legislation to Legalize Gay Marriage in New York*, DAILY NEWS (N.Y.), Apr. 17, 2009, http://www.nydailynews.com/ny_local/2009/04/16/2009-04-16_gov_paterson_introduces_legislation_to_legalize_gay_marriage_in_new_york.html.

ests and quality of life in making the decision. Moreover, people generally support the right to make one's own decisions, and not have politicians or the courts make their decisions for them.

The legal procedure involved with going to court to obtain the right to make decisions for a loved one is "lengthy, expensive and emotionally draining" according to former New York Court of Appeals Judge Hugh Jones.¹⁴⁵ Julianne Chase Delio, who watched her thirty-three year old husband, Danny, who became brain-dead after a problem during surgery, waste away while fighting in court to have his life support removed based on his oral wishes, agrees: "Court is the last place a family belongs when they are facing their darkest hours."¹⁴⁶

There is room for disagreement. There is a clear need to protect patients from people with impure motives. There is a need to protect a person's wishes if that person wishes to be kept alive at all costs. There is a need to protect a person's wishes if that person does not want any medical intervention. There is also a need to protect a person's wishes if that person wants medical intervention in certain circumstances. So, should not New Yorkers have a law that will allow the wishes of all people to be honored? Let the people of New York state decide what their final health care wishes and values are. The FHCDCA should be passed, and soon. This would give New Yorkers legislation that will allow their wishes to be carried out, one way or the other.

VIII. AFTERWORD

Since the completion of this Comment, the New York State Senate, by a vote of fifty-five to three, has passed the Family Health Care Decisions Act, and Governor Paterson has signed it into law.¹⁴⁷ However, the structure of the law has changed from the initial proposal and the *Conroy* model.

Surrogates are permitted to make general medical decisions

¹⁴⁵ Deborah Barfield, *State Right-to-Die Legislation Debated*, NEWSDAY, Feb. 8, 1996, at A19.

¹⁴⁶ *Id.*

¹⁴⁷ New York State Senate Votes (Feb. 24, 2010), <http://open.nysenate.gov/legislation/bill/S3164B>. See also New York State Governor David A. Paterson, Newsroom Press Releases, *Governor Paterson Signs Family Health Care Decisions Act Into Law* (Mar. 16, 2010), <http://www.state.ny.us/governor/press/031610FHCDCA.html>.

for the patient under one of two standards: 1) “in accordance with the patient’s wishes,”¹⁴⁸ similar to the subjective test under *Conroy*; or 2) “if the patient’s wishes are not reasonably known and cannot with reasonable diligence be ascertained, in accordance with the patient’s best interests,” this is the best interest standard for surrogate decision making.¹⁴⁹ Using either one of these standards, the surrogate must also use a form of the substituted judgment standard for surrogate decision making by taking into account the “values of the patient, including the patient’s religious and moral beliefs”¹⁵⁰

However, when surrogates are making decisions regarding withdrawing or withholding life support, in addition to the subjective or best interest tests and the substituted judgment standard, this decision has additional conditions that must be met.¹⁵¹ If the treatment “would be an extraordinary burden to the patient” and two independent physicians agree that “to a reasonable degree of medical certainty and in accord with accepted medical standards” the patient is expected to die within six months regardless of whether they are treated or not for their injury or illness,¹⁵² or if the patient is found to be permanently unconscious, life support can be withheld or withdrawn.¹⁵³ Alternatively, the decision could also be made if two independent physicians agree that the burdens of the treatment would be extraordinary or inhumane and if it is determined that the patient is suffering from is “an irreversible or incurable condition.”¹⁵⁴

In regards to who can be a surrogate the list includes same-sex partners, at the same level as spouses.¹⁵⁵ Same-sex partners would fall under the category of domestic partners, which the law defines, in part, as “mutually interdependent on the other person for support, as evidenced by the totality of the circumstances indicating a mutual intent to be domestic partners”¹⁵⁶ The statute includes a non-exhaustive list of factors to be considered in determining whether people are domestic partners, which would cover most same-sex

¹⁴⁸ N.Y. PUB. HEALTH LAW § 2994-d(4)(a)(i), *supra* note 115.

¹⁴⁹ *Id.* at § 2994-d(4)(a)(ii), *supra* note 115.

¹⁵⁰ *Id.* at § 2994-d(4)(b), *supra* note 115.

¹⁵¹ *Id.* at § 2994-d(5), *supra* note 115.

¹⁵² *Id.* at § 2994-d(5)(a)(i)(A), *supra* note 115.

¹⁵³ N.Y. PUB. HEALTH LAW § 2994-d(5)(a)(i)(B), *supra* note 115.

¹⁵⁴ *Id.* at § 2994-d(5)(a)(ii), *supra* note 115.

¹⁵⁵ *Id.* at § 2994-d(1)(b), *supra* note 115.

¹⁵⁶ *Id.* at § 2994-a(7)(c), *supra* note 115.

couples who are, at the present time, not permitted to marry.¹⁵⁷

In terms of surrogate decision making for pregnant women, the language requiring the surrogate to take into consideration the effect of the decision on the outcome of the pregnancy is not included. But, even without the language, and despite continued opposition from The Catholic Conference, The New York State Right to Life Committee supports the bill, because it is unfathomable “that someone making a decision about whether or not to protect the life of a mom has not considered the baby.”¹⁵⁸

Twenty-two years after the decision in *O'Connor*, and eighteen years after initial legislative proposals to counter the effect of *O'Connor*, New York finally has legislation that fills a big gap in New York end-of-life decision making that allows every New Yorker to have their final wished carried out, no matter what those wishes are.

¹⁵⁷ *Id.* at § 2994-a(7)(c), *supra* note 115.

¹⁵⁸ Anemona Hartocollis, *Law Dictates Who Decides on Care for the Incapable*, N.Y. TIMES, Mar. 18, 2010, at A26; Editorial, *Do It Yourself*, BUFFALO NEWS, Aug. 3, 2009, available at <http://www.buffalonews.com/2009/07/30/748712/do-it-yourself.html>.