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DECIDING FOR OTHERS: NEW YORK LAW AND THE RIGHTS OF INCOMPETENT PERSONS TO WITHHOLD OR WITHDRAW LIFE-SUSTAINING MEDICAL TREATMENT

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I. INTRODUCTION

An incompetent patient's right to withhold or withdraw life-sustaining medical treatment has been the subject of much legal, as well as medical, ethical, and moral debate for over a decade.[1] Currently, New York,[2] Missouri,[3] and Michigan[4] are the only states where case law bars family members from making medical decisions on behalf of incompetent patients. There has been much controversy since New York's highest court held that the standard required in cases dealing with life-sustaining medical treatment for incompetent patients is "clear and convincing" evidence that a now-incompetent patient had made a "firm and settled commitment" while competent to withhold or withdraw such treatment.[5] Now, eight years later, a coalition of medical,[6] civic, and religious[7] groups is working to replace this court-created standard with a statute allowing the families of incompetent patients to make medical decisions on their behalf.[8] Although it has taken supporters of the Surrogate Decision-making bill three years to find a sponsor, the bill has been introduced in the Senate and the Assembly.[9] The bill, however, faces significant opposition.[10] The introduction of this bill brings to the forefront once again the controversial issue of whether artificial nutrition and hydration should be distinguished from other forms of life-sustaining medical treatment.[11]

Part II of this note discusses the background of an incompetent person's right to withhold or withdraw life-sustaining medical treatment,

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1. *See infra* notes 25-27.

2. *See In re* Westchester County Med. Ctr., 531 N.E.2d 607 (N.Y. 1988).

3. *See* Cruzan v. Missouri Dep't of Health, 497 U.S. 261 (1990).

4. *See* Martin v. Martin, 538 N.W.2d 399 (Mich. 1995).

5. *See In re Westchester County*, 531 N.E.2d at 608.

6. *See infra* note 108 and accompanying text.

7. *See infra* note 110 and accompanying text.

8. *See* Gary Spencer, *Bill Shifts the Role of Decision Maker to Patient's Family*, N.Y. L.J., June 13, 1995, at 1.

9. The bill was introduced in the Senate by Senator Hannon and in the Assembly by Health Committee Chairman Richard N. Gottfried. *See* S. 5020, 218th Leg., 1st Reg. Sess. (N.Y. 1995); A. 6791, 218th Leg., 1st Reg. Sess. (N.Y. 1995).

10. *See* Spencer, *supra* note 8, at 2; discussion *infra* part IV.B.

11. *See* Spencer, *supra* note 8, at 2.

focusing primarily on the medical, ethical, and legal debate surrounding whether persons in a persistent vegetative state (PVS) should have nutrition and hydration withheld. Part III examines the response by the New York State Legislature, including the enactment of a health care proxy law in 1991 and the more recent introduction of a Surrogate Decision-making bill which empowers surrogates to make decisions on behalf of incompetent patients in life-sustaining medical treatment cases. Part IV analyzes the public's response to this proposed legislation. It identifies the proponents and opponents of the bill and their reasons for their respective positions. It proposes possible amendments to the legislation that would establish better procedural safeguards for persons who are in a PVS and also for persons who do not have family members or close friends to act as surrogates. Part V concludes that decisions regarding life-sustaining medical treatment are best made by family and close friends of the patient. To the extent that the legislation empowers families and friends and establishes guidelines for these surrogates to act on an incompetent's behalf, it should be supported. However, it is critical that better procedural safeguards be established to protect those persons who are most vulnerable in our society. Without these safeguards, we run the risk of legally empowering others to decide who should live and who should die.

II. BACKGROUND

A. *Defining Death*

Traditionally, the definition of death accepted by both physicians and the lay public was the cessation of function of both the heart and the lungs.[12] However, due to major advances in science, persons who at one time would have been declared dead can now be kept alive by means of a mechanical ventilator[13] and other medical interventions.[14] The advent

12. *See* PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MED. & BIOMEDICAL & BEHAVIORAL RESEARCH, DEFINING DEATH: A REPORT ON THE MEDICAL, LEGAL AND ETHICAL ISSUES IN THE DETERMINATION OF DEATH 160 (1981) [hereinafter DEFINING DEATH].

13. A ventilator is a medical device that assists or replaces the natural breathing mechanisms. The terms ventilator and respirator are used interchangeably but ventilator is currently the preferred term. *See* NATIONAL CTR. FOR STATE COURTS, GUIDELINES FOR STATE COURT DECISION MAKING IN AUTHORIZING OR WITHHOLDING LIFE-SUSTAINING MEDICAL TREATMENT glossary (1991) [hereinafter GUIDELINES].

14. *See* DEFINING DEATH, *supra* note 12, at 160.

of this new medical technology necessitated a redefining of the meaning of death.[15]

1. Brain Death

Brain death is defined as the irreversible loss of all brain functions, both the higher levels of the brain (cerebral hemispheres) and the brain stem.[16] The cerebral hemispheres contain the function of consciousness or awareness, as well as other important voluntary and involuntary actions, such as control of movements.[17] The brain stem, which is the lower center of the brain, is responsible for vegetative functions, such as respiration, heartbeat, and blood pressure and primitive stereotyped reflexes, such as eye movements, pupillary response to light, and gag and cough reflexes.[18] Many states, including New York,[19] through either statutes or judicial decisions now recognize this irreversible loss of all brain functions as the definition of death.[20]

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15. *See id.*

16. *See* GUIDELINES, *supra* note 13, at app. A chart; DEFINING DEATH, *supra* note 12, at 31-38; Ronald E. Cranford, *The Persistent Vegetative State: The Medical Reality (Getting the Facts Straight)*, HASTINGS CENTER REP., Feb./Mar. 1988, at 27; Dana E. Johnson, M.D., *Withholding Fluids and Nutrition: Identifying the Populations at Risk*, 2 ISSUES L. & MED. 189, 192-94 (1986).

17. *See* Cranford, *supra* note 16.

18. *See id.*

19. *See* People v. Eulo, 472 N.E.2d 286 (N.Y. 1984).

20. *See* DEFINING DEATH, *supra* note 12, at 160.

The American Bar Association, the American Medical Association, the National Conference of Commissioners on Uniform State Laws, and the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research have proposed the following model statute, intended for adoption in every jurisdiction:

> **Uniform Determination of Death Act**
> An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards.

Id.

2. Neocortical Death

Neocortical death has been defined as the irreversible loss of consciousness and cognitive functions.[21] Thus, under this definition, persons in a PVS could be declared "dead" even though the brain stem is functioning.[22] Although some philosophers and physicians have advocated that the whole brain death criterion should be replaced with this "higher-brain" criterion,[23] this definition has not yet been legally accepted by Western society.[24]

3. The Phenomenon of PVS

Most of the legal,[25] medical,[26] and ethical debate,[27] as well as the

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21. *See* David Randolph Smith, *Legal Recognition of Neocortical Death*, 71 CORNELL L. REV. 850, 851 (1986).

22. *See id.* at 851 n.6.

23. *See id.* at 856-57. *But see* James L. Bernat, M.D., *Brain Death: Occurs Only With Destruction of the Cerebral Hemispheres and the Brain Stem*, 49 ARCHIVES NEUROLOGY 569 (1992) (discussing several flaws which render the higher-brain formulation unsatisfactory as a concept of death); Baruch A. Brody, *Ethical Questions Raised by the Persistent Vegetative Patient*, HASTINGS CENTER REP., Feb./Mar. 1988, at 33-34 (stating that seeing a patient in a persistent vegetative state as dead would not resolve the moral issues raised by these cases).

24. *See* Bernat, *supra* note 23, at 570; Smith, *supra* note 21, at 852 (arguing that neocortical death should be considered the death of the person for all legal purposes).

25. *See* James Bopp, Jr., *Nutrition and Hydration for Patients: The Constitutional Aspects*, 4 ISSUES L. & MED. 3 (1988); Council on Scientific Affairs & on Ethical & Judicial Affairs, American Med. Ass'n, *Persistent Vegetative State and the Decision to Withdraw or Withhold Life Support*, 263 JAMA 426, 428-29 (1990) [hereinafter Council on Scientific Affairs].

26. *See* Sheldon Berrol, *Considerations for Management of the Persistent Vegetative State*, 67 ARCHIVES PHYSICAL MED. & REHABILITATION 283 (1986); Brody, *supra* note 23; Cranford, *supra* note 16; Johnson, *supra* note 16.

27. *See, e.g.*, PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MED. & BIOMEDICAL & BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT: A REPORT ON THE ETHICAL, MEDICAL, AND LEGAL ISSUES IN TREATMENT DECISIONS 171-96 (1983) [hereinafter FOREGOING LIFE-SUSTAINING TREATMENT]; Daniel Callahan, *On Feeding the Dying*, HASTINGS CENTER REP., Oct. 1983, at 22; Patrick G. Derr, *Nutrition and Hydration as Elective Therapy: Brophy and Jobes from an Ethical and Historical Perspective*, 2 ISSUES L. & MED. 25 (1986); Willard Green, *Setting Boundaries for Artificial Feeding*, HASTINGS CENTER REP., Dec. 1984, at 8; Germain Grisez, *Should Nutrition and Hydration Be Provided to Permanently Unconscious and Other Mentally Disabled Persons?*, 5 ISSUES L. & MED. 165 (1989); Joanne Lynn & James F. Childress, *Must Patients Always Be Given Food and Water?*,

vast majority of termination-of-treatment cases before the courts in recent years have involved persons in a PVS.[28] PVS is caused by overwhelming damage to the cerebral hemispheres of the brain.[29] This type of brain damage may result from a variety of diseases or traumas to the brain, including stroke, cardiac arrest, poisoning, drug overdose, direct physical injury, or degenerative disease.[30]

PVS is a form of eyes-open permanent unconsciousness.[31] It is characterized by irreversible cessation of cognitive or higher functions of the brain while brain stem functions, such as breathing, remain intact.[32] Although many patients may initially require a ventilator to breathe, due to an intact brain stem, they can usually begin breathing on their own within a few days or weeks of the onset of the condition.[33] PVS patients' eyes are open at times and they experience sleep wake cycles.[34] They may smile, yawn, make unintelligible sounds and respond to loud noises, but make no purposeful movements or meaningful communication.[35] Because their brain stems remain intact, most patients in this state can maintain internal homeostasis, such as respiration,

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HASTINGS CENTER REP., Oct. 1983, at 17; William E. May et al., *Feeding and Hydrating the Permanently Unconscious and Other Vulnerable Persons*, 3 ISSUES L. & MED. 203 (1987); Gilbert Meilaender, *On Removing Food and Water: Against the Stream*, HASTINGS CENTER REP., Dec. 1984, at 11; Kevin O'Rourke, *Should Nutrition and Hydration Be Provided to Permanently Unconscious and Other Mentally Disabled Persons?*, 5 ISSUES L. & MED. 181 (1989); Daniel Wikler, *Not Dead, Not Dying? Ethical Categories and Persistent Vegetative State*, HASTINGS CENTER REP., Feb./Mar. 1988, at 41.

28. *See, e.g.*, Cruzan v. Missouri Dep't of Health, 497 U.S. 261 (1990); Mack v. Mack, 618 A.2d 744 (Md. 1993); *In re* Jobes, 529 A.2d 434 (N.J. 1987); Delio v. Westchester County Med. Ctr., 516 N.Y.S.2d 677 (App. Div. 1987).

29. *See* Council on Scientific Affairs, *supra* note 25, at 427.

30. *See id.*

31. *See* George J. Annas, *The "Right to Die" in America: Sloganeering from* Quinlan *and* Cruzan *to* Quill *and* Kevorkian, 34 DUQ. L. REV. 875, 879-80 (1996); *Position of the American Academy of Neurology on Certain Aspects of the Care and Management of the Persistent Vegetative State Patient, 39 NEUROLOGY 125 (1989) [hereinafter American Academy of Neurology]*.

32. *See* GUIDELINES, *supra* note 13, at app. A chart; Cranford, *supra* note 16, at 27-28; Council on Scientific Affairs, *supra* note 25, at 427-28; Bryan Jennet & Fred Plum, *Persistent Vegetative State After Brain Damage: A Syndrome in Search of a Name*, LANCET, April 1, 1972, at 734; Johnson, *supra* note 16, at 195.

33. *See* Cranford, *supra* note 16, at 28.

34. *See* GUIDELINES, *supra* note 13, at app. A chart; Cranford, *supra* note 16, at 28; Jennet & Plum, *supra* note 32, at 734; Johnson, *supra* note 16, at 195.

35. *See* Council on Scientific Affairs, *supra* note 25, at 426.

circulation and heartbeat.[36] Due to their unconscious state, the patients are unaware of themselves or their environment.[37] They also lack the capacity to experience pain or suffering because these are attributes of consciousness.[38] Neurologists believe this phenomenon results from the continued functioning of the brain stem even though there is total loss of higher brain functioning.[39] By the current accepted definition of death, these patients are not dead[40] and, in most cases, can survive in this state for many years, provided they are given proper nutrition and hydration.[41]

B. *Life Supports - The Legal and Ethical Debate of Artificial Nutrition and Hydration*

According to the American Academy of Neurology, patients in a PVS lose the capacity to chew and swallow in a normal manner because these functions are voluntary, requiring intact cerebral hemispheres.[42] However, other neurologists take the position that because these patients have an intact involuntary swallowing reflex in addition to intact gag and cough reflexes, it is theoretically possible, and in rare cases actually possible, to feed them by hand.[43] Nevertheless, because spoon-feeding usually requires an enormous amount of time by either nursing staff or

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36. *See* Delio v. Westchester County Med. Ctr., 516 N.Y.S.2d 677, 679-80 (App. Div. 1987). Homeostasis is the dynamic process by which an organism maintains a constant internal environment despite external changes. Examples of homeostatic mechanisms include the regulation of blood pressure, body temperature, and blood sugar levels. *See* AMERICAN MED. ASS'N, HOME MEDICAL ENCYCLOPEDIA 544 (1989).

37. *See American Academy of Neurology*, *supra* note 31, at 125.

38. *See id.*

39. *See id.*

40. *See supra* notes 16-20 and accompanying text.

41. *See American Academy of Neurology*, *supra* note 31, at 125; *see also* Callahan, *supra* note 27, at 22 (commenting that a denial of nutrition may, in the long run, become the only effective way to ensure that a large number of biologically tenacious patients actually die).

42. *See American Academy of Neurology, supra* note 31, at 125.

43. *See, e.g.,* Cranford, *supra* note 16, at 31.

families, most patients are given artificial nutrition and hydration[44] through a feeding tube known as a gastrostomy tube.[45]

Most of the focus of debate over the past ten years in both the courtroom[46] and medical, ethical, and legal literature[47] has centered on the controversial issue of whether artificial nutrition and hydration should be considered basic nourishment or just another form of life-sustaining medical treatment. A general consensus has been emerging among the American Medical Association,[48] some prominent organizations and commissions,[49] and many courts[50] that artificial nutrition and hydration is not distinguishable from other forms of life-sustaining medical treatment.[51] The *Guidelines for State Court Decision Making in Authorizing or Withholding Life-Sustaining Medical Treatment* state in pertinent part, "[a]rtificial nutrition and hydration are forms of medical treatment; in general, their use or discontinuation should be governed by the same principles and practices that govern other forms of medical treatment."[52] Some scholars go so far as to argue that persons in a PVS are suffering from "the fatal pathology of being unable to chew and swallow;"[53] therefore, it is this fatal pathology and not the removal of nutrition and hydration that causes their death.[54] According to this belief, removing a feeding tube is no different from removing a ventilator.

Many interested, reasonable, and concerned persons strongly reject the decision to withhold nutrition and hydration. Arguments that have been advanced in support of the notion that nutrition and hydration is

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44. Artificial nutrition and hydration is the supplying of food and water through a conduit such as a tube or intravenous line where the patient is not required to chew or swallow voluntarily; it includes nasograstic tubes, gastrostomies, and intravenous infusions. *See* GUIDELINES, *supra* note 13, at glossary. Artificial nutrition and hydration does not include assisted feeding such as spoon or bottle feeding. *Id.*

45. A gastrostomy tube is an enteral tube inserted through the patient's abdomen into the stomach. *See* GUIDELINES, *supra* note 13, at glossary.

46. *See supra* note 28 and accompanying text.

47. *See supra* notes 25-27 and accompanying text.

48. See Council on Scientific Affairs, *supra* note 25, at 429 (stating the current opinions of the American Medical Association on life-sustaining medical treatment); Charles L. Sprung, M.D., *Changing Attitudes and Practices in Forgoing Life-Sustaining Treatments*, 263 JAMA 2211 (1990).

49. *See, e.g.*, FOREGOING LIFE-SUSTAINING TREATMENT, *supra* note 27, at 171-96.

50. *See* GUIDELINES, *supra* note 13, at 118-21.

51. *See id.* at 120 n.188; Annas, *supra* note 31, at 883.

52. GUIDELINES, *supra* note 13, at 120.

53. O'Rourke, *supra* note 27, at 183.

54. *See* Grisez, *supra* note 27, at 178.

distinguishable from other forms of medical treatment and, therefore, should not be removed from patients in a PVS include, but are not limited to, the following: (1) food and water are universal human needs; modern medical and surgical therapy are not;[55] (2) withholding or withdrawing nutrition and hydration would result in the patient's death by starvation and dehydration rather than by the underlying disease or condition;[56] and (3) because a person in a persistent vegetative state cannot experience pain or suffering, a feeding tube cannot be considered burdensome to the patient, thus, the benefit/burden analysis that is often invoked in favor of removal fails. Therefore, removal becomes a choice to kill to end the miserable state the patient is in rather than to relieve him of any burden.[57]

Vast disagreement is due in part to the fact that an infallible procedure for diagnosing PVS has yet to be produced.[58] Although a diagnosis can usually be made with a high degree of medical certainty,[59] "there is no broadly accepted, published set of specific medical criteria with as much clinical detail and certainty as the brain death criteria."[60] "Furthermore, even the generally accepted criteria, when properly applied, are not infallible."[61] The fact that some patients have recovered varying degrees of cognitive functions[62] undermines the conclusion that all such patients

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55. *See* Callahan, *supra* note 27, at 22; Derr, *supra* note 27, at 29; Lynn & Childress, *supra* note 27, at 17; Meilaender, *supra* note 27, at 11.

56. *See* Bopp, *supra* note 25, at 43-46; May et al., *supra* note 27, at 209.

57. *See* Derr, *supra* note 27, at 36; Grisez, *supra* note 27, at 171; Meilaender, *supra* note 27, at 13.

58. *See* Cranford, *supra* note 16, at 29-30; Wikler, *supra* note 27, at 46.

59. *See American Academy of Neurology*, *supra* note 31, at 126.

60. Cranford, *supra* note 16, at 29.

61. *Id.*

62. *See* W.F.M. Arts et al., *Unexpected Improvement After Prolonged Posttraumatic Vegetative State*, 48 J. NEUROLOGY NEUROSURGERY & PSYCHIATRY 1300 (1985) (reporting unexpected gradual recovery of patient after being in PVS for approximately two and one-half years); K. Higashi et al., *Five-year Follow-up Study of Patients With Persistent Vegetative State*, 44 J. NEUROLOGY NEUROSURGERY & PSYCHIATRY 552 (1981); Harvey S. Levin et al., *Vegetative State After Closed-Head Injury*, 48 ARCHIVES NEUROLOGY 580 (1991); Gary A. Rosenberg, M.D., et al., *Recovery of Cognition After Prolonged Vegetative State*, 2 ANNALS NEUROLOGY 167 (1977) (studying the cognitive recovery of patient after being in PVS for one and one-half years); *A Doctor Sees Hope for "Hopeless"* Patients, N.Y. TIMES, Jan. 4, 1996, at A16 (reporting that a woman returns to consciousness after 15 months in a PVS and a doctor states that the fate of these patients is simply too hard to predict to imply that recovery is impossible).

have suffered brain damage that permanently precludes consciousness.[63] Some doctors further suggest that unexpected recoveries signify that the diagnostic categories are not sufficiently well developed,[64] while another suggests that it may mean that the diagnoses were made in error.[65] These prognostic assessments are not free from controversy and, therefore, any legal authority, whether a court or a legislature, that attempts to establish guidelines for these cases must proceed with caution.

C. *Case History*

The right to decline life-sustaining medical treatment has been based upon either the common-law right of self determination[66] or the constitutional right to privacy or liberty.[67] New York courts have consistently applied the common law right of self determination in deciding life-sustaining medical treatment cases.[68]

1. New York

In 1987, in *Delio v. Westchester County Medical Center*,[69] the Appellate Division, Second Department, held that the wife of a patient in a PVS, as conservator, was entitled to act in accordance with the patient's prior clearly expressed wishes to discontinue the use of feeding and hydration tubes.[70] The court found clear and convincing evidence that

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63. *See* FOREGOING LIFE-SUSTAINING TREATMENT, *supra* note 27, at 176-77; Jeremy Brown, *The Persistent Vegetative State: Time for Caution?*, 66 POSTGRADUATE MED. J. 697 (1990).

64. *See, e.g.*, David C. Thomasma & Joel Brumlik, M.D., *Ethical Issues in the Treatment of Patients With a Remitting Vegetative State*, 77 AM. J. MED. 373, 374 (1984).

65. *See* Berrol, *supra* note 26, at 283; NEW YORK STATE TASK FORCE ON LIFE & THE LAW, WHEN OTHERS MUST CHOOSE: DECIDING FOR OTHERS WITHOUT CAPACITY 61 (1992) [hereinafter TASK FORCE].

66. *See* Delio v. Westchester County Med. Ctr., 516 N.Y.S.2d 677, 685-86 (App. Div. 1987).

67. *See* Bartling v. Superior Court, 209 Cal. Rptr. 220 (Ct. App. 1984); Satz v. Perlmutter, 379 So. 2d 359 (Fla. 1980); Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417 (Mass. 1977).

68. *See Delio*, 516 N.Y.S.2d at 686 ("[T]he common-law right of self determination with respect to one's body also forms the foundation for a competent adult patient's right to refuse life-sustaining treatment even if the effect is to hasten death." (citing Rivers v. Katz, 495 N.E.2d 337 (N.Y. 1986))).

69. 516 N.Y.S.2d 677.

70. *See id.* at 693.

the patient, while competent, had made statements to his close family members regarding his strongly held beliefs on the quality of life and his right to die.[71] Then, after looking to other states for guidance,[72] the court concluded that nutrition and hydration should not be distinguished from other forms of life-sustaining medical treatment.[73] The Second Department relied upon *In re Storar*,[74] in which the court of appeals stated that a court must focus primarily on the patient's desires and his right to direct the course of his medical treatment rather than upon the specific treatment involved.[75]

In 1988, the New York Court of Appeals decided the highly criticized case of *In re Westchester County Medical Center*.[76] The daughters of Mary O'Connor, an incompetent elderly woman, refused to permit doctors to insert in their mother a nasograstic feeding tube[77] needed to provide nutrition and hydration.[78] The hospital petitioned the court for permission to perform the procedure.[79] The trial court denied the hospital's application, concluding that it was contrary to the patient's wishes, and the hospital appealed.[80] The Appellate Division affirmed and the hospital appealed by permission.[81] Upon review of the lower court's record, the Court of Appeals concluded that the proof was not clear and convincing that the patient had made a firm and settled commitment, while competent, to decline the prescribed type of medical assistance under these circumstances.[82] In doing so, the court noted that although the clear and convincing evidence standard is stringent, and has pitfalls and inevitable

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71. *See id.* at 682-83.

72. *See id.* at 688-89 (discussing decisions in New Jersey and Massachusetts regarding nutrition and hydration).

73. *See id.* at 689.

74. 420 N.E.2d 64, 67 (N.Y. 1981) (allowing respirator to be removed after finding prior statements of patient in PVS to be clear and convincing).

75. *See Delio*, 516 N.Y.S.2d at 687-88.

76. 531 N.E.2d 607 (N.Y. 1988).

77. A nasograstic tube is an enteral feeding tube inserted through a patient's nose, down the esophagus, and into a patient's stomach. *See* GUIDELINES, *supra* note 18, at glossary.

78. *See In re* Westchester County Med. Ctr., 531 N.E.2d at 608.

79. *See id.*

80. *See id.* at 611.

81. *See id.*

82. *See id.* at 614-15.

uncertainties, it is the appropriate standard to ensure that a potential error will be made on the side of life.[83]

The different outcomes in these cases suggest that one should be critical of New York courts because what happens to an incompetent person depends on the interpretation by courts of what the person said when competent, to whom, and with what degree of vehemence.

2. U.S. Supreme Court - The *Cruzan* case

On January 11, 1983, Nancy Beth Cruzan was severely injured in an automobile accident.[84] When emergency personnel arrived, she was without a pulse, but her respiration and heartbeat were restored with resuscitative measures.[85] Nancy remained in a coma for approximately three weeks and then began to show some signs of improvement.[86] Although she was able to take her nutrition orally, a gastrostomy feeding tube was implanted in order to assist her recovery and to ease the feeding process.[87] Efforts were made to rehabilitate Nancy over a substantial period of time, but those efforts failed and she remained in a PVS.[88] After it became apparent that Nancy would not regain her mental faculties (approximately five years after her accident), her parents asked the hospital to remove her artificial nutrition and hydration.[89] When the hospital refused to honor this request, her parents sought and received approval from the state trial court for termination.[90] The Supreme Court of Missouri reversed.[91] The United States Supreme Court granted certiorari,[92] and affirmed the judgment of the Missouri Supreme Court.[93]

A majority of the Court found that a competent person has a constitutionally protected liberty interest in refusing life-sustaining

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83. *See id.* at 613.

84. *See* Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 266 (1990).

85. *See id.*

86. *See id.*

87. *See id.*

88. *See id.*

89. *See id.* at 267.

90. *See id.* at 268.

91. *See* Cruzan v. Harmon, 760 S.W.2d 408 (Mo. 1988).

92. *See Cruzan*, 497 U.S. at 269.

93. *See id.* at 287.

nutrition and hydration.[94] However, the Court refused to extend this right unconditionally to an incompetent person and concluded that the United States Constitution did not prohibit Missouri from requiring clear and convincing evidence of a person's prior wishes concerning the withholding or withdrawing of life-sustaining medical treatment.[95] Like New York, the Supreme Court relies on how forthright a person was when competent in stating his or her wishes.

3. Clear and Convincing Evidence Standard

The clear and convincing evidence standard required by New York, Missouri, and Michigan, and affirmed by the Supreme Court, is an example of a procedural safeguard that states may establish in life-sustaining medical treatment cases.[96] This standard seeks to ensure that the actions of a surrogate, acting on behalf of an incompetent person, conform as closely as possible to the wishes expressed by the patient while competent.[97] This standard, however, has been criticized as unworkable and inhumane in practice.[98] First, it is unworkable because it requires persons to "forecast in advance what their medical conditions will be at some future time and the treatments that will be available."[99] Second, because many adults will never sign a health care proxy[100] or provide clear and convincing evidence of their wishes,[101] the standard may deny a large number of incompetent patients any right to death with dignity.[102] Furthermore, it does not give any legal weight to a family's understanding of what the patient would want, or to the family's beliefs as to which treatment will best serve the patient.[103]

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94. *See id.* at 279; Linda Greenhouse, *High Court to Decide if the Dying Have a Right to Assisted Suicide*, N.Y. TIMES, Oct. 2, 1996, at A1.

95. *See Cruzan*, 497 U.S. at 280.

96. *See id.*

97. *See id.*

98. *See* TASK FORCE, *supra* note 65, at 74.

99. *Id.*; *accord In re* Westchester County Med. Ctr., 531 N.E.2d 607 (N.Y. 1988) (Simons, J., dissenting).

100. *See infra* text accompanying notes 105-07.

101. *See* TASK FORCE, *supra* note 65, at 75.

102. *See* Cathaleen A. Roach, *Paradox and Pandora's Box: The Tragedy of Current Right-To-Die Jurisprudence*, 25 U. MICH. J.L. REFORM 133, 182 (1991).

103. *See id.*; *see also* TASK FORCE, *supra* note 65, at 74-75 (discussing reasons why the clear and convincing evidence standard is unworkable and inhumane).

New York State courts have expressed their reluctance to establish policy in this area, stating that the obligation to do so rests with the legislature, not the courts.[104]

III. LEGISLATIVE RESPONSE

A. *Health Care Proxy Law*

Soon after the Court of Appeals in *Westchester County Medical Center* affirmed that clear and convincing evidence is the proper standard of proof required in life-sustaining medical treatment cases, the New York legislature adopted a health care proxy law,[105] which went into effect January 18, 1991. This proxy law allows patients to designate someone, in writing, to make decisions on their behalf if they become incapacitated.[106] However, to date, only fifteen to twenty percent of New York State residents have used the proxy to choose an agent, leaving the decision about termination of nutrition and hydration up to the courts.[107] Now, the legislature—supported by various medical,[108] legal,[109] civic and religious,[110] and patients' rights[111]

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104. *See* Delio v. Westchester County Medical Ctr., 510 N.Y.S.2d 415, 419 (Sup. Ct. 1986), *rev'd*, 516 N.Y.S.2d 677 (App. Div. 1987).

> In this most difficult area there seems to be but one unanimous conclusion—legislatures are better suited than courts to balance the various interests involved in determining whether to permit termination of care. The legislature, possessing as it does, the broad plenary power to make laws and regulation for public health, safety and welfare, are the elected representatives of the people and as such reflect the collective will of the people.

Id.

105. N.Y. PUB. HEALTH LAW §§ 2980-83 (McKinney 1993).

106. *See id.* § 2981.

107. *See* Spencer, *supra* note 8, at 2.

108. Association for Hospital Risk Management; Association of Nursing Service Administrators; Greater New York Hospital Association; Healthcare Association of New York State; Medical Society of the State of New York; National Association of Social Workers, New York Chapter; New York Academy of Medicine; New York Association of Homes and Services to the Aging; New York Medical Directors Association; New York State Health Facilities Association; New York State Hospice Association; New York State Nurses Association; Western New York Institutional Ethics Committee Network.

109. Association of the Bar of the City of New York; Health Law Committee - New York State Bar Association; New York City Department for the Aging; New York County Lawyers' Association, Elder Law Committee.

110. AARP; American Jewish Congress; Council of Churches; New York Civil Liberties Union; Statewide Lutheran Advocacy; Women's City Club.

organizations—has introduced a bill that will authorize family members or close friends to make decisions on behalf of incompetent patients.[112]

B. *Surrogate Decision-Making Bill*

1. Legislative Intent

Under article 29-C of the Public Health Law, a competent adult may appoint an agent to make medical decisions for him in the event he becomes incapacitated.[113] The proposed legislation will fill a gap that remains in New York law.[114] It adds, among other things, a new article 29-D to the Public Health Law,[115] establishing a procedure to appoint a surrogate[116] empowered to make health care decisions for incompetent patients who have neither appointed a proxy nor provided clear and convincing evidence of treatment wishes.[117] Special procedures and standards are provided for making decisions regarding life-sustaining medical treatments.[118]

Section 2995-D establishes procedures and guidelines for making health care decisions for adult patients who lack capacity.[119] It lists, in

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111. Alliance for the Mentally Ill; Association for Community Living; Brookdale Center on Aging; Cancer Care; Center for Medical Consumers; Choice in Dying; Coalition of Institutionalized Aged and Disabled; Coalition of New York State Alzheimer's Association Chapters; Friends and Relatives of the Institutionalized Aged; Gay Men's Health Crisis; Mental Hygiene Legal Services; Nassau County Long-Term Care Ombudsmen Program; New York Citizens Committee on Health Care Decisions; New York Foundation for Senior Citizens; New York State Association for Retarded Children; New York State Chapter - Patient Representatives Society; New York Statewide Senior Action Council; Nursing Home Community Coalition of New York State.

112. *See* S. 5020, 218th Leg., 1st Reg. Sess. (N.Y. 1995); A. 6791, 218th Leg., 1st Reg. Sess. (N.Y. 1995).

113. N.Y. PUB. HEALTH LAW § 2981 (McKinney 1993); Memorandum in Support of S. 5020, New York State Senate [hereinafter Senate Support Memo] (copy on file with *New York Law School Law Review*).

114. *See* S. 5020 § 1; A. 6791 § 1.

115. *See* S. 5020 § 1; A. 6791 § 1.

116. *See infra* note 125 and accompanying text.

117. *See* S. 5020 § 1; A. 6791 § 1.

118. *See* Senate Support Memo, *supra* note 113, at 2.

119. *See id.*; S. 5020 § 2; A. 6791 § 2.

order of priority, the persons who may act as a surrogate.[120] The section grants the surrogate authority to make all health care decisions on the adult patient's behalf, subject to the standards and limitations of the article.[121] Although the section grants surrogates the authority to consent to and to refuse treatment, it does not obligate health care providers to offer or provide medically futile or inappropriate treatment that they would have no duty to offer or provide to a competent patient.[122] Health care providers have a duty to give the surrogate medical information and clinical records necessary to make an informed decision.[123]

2. Decision-Making Standards

The surrogate is required to decide about treatment based on knowledge of the patient's wishes, including the patient's religious and moral beliefs or, if the patient's wishes are not reasonably known and cannot with reasonable diligence be ascertained, in accordance with the patient's best interests.[124] An assessment of the patient's best interests shall include consideration of: (1) the dignity and uniqueness of every person; (2) the possibility and extent of preserving the patient's life; (3) the preservation, improvement or restoration of the patient's health or functioning; (4) the relief of the patient's suffering; and (5) any medical

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120. Those who are able to act as a surrogate include:

(A) A guardian authorized to decide about health care pursuant to article eighty-one of the mental hygiene law or a guardian appointed under article seventeen-A of the Surrogate's Court Procedure Act;

(B) An individual, eighteen years of age or older, designated by another otherwise qualified to act as the surrogate provided that no person on the surrogate list objects to the designation;

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

(D) A son or daughter eighteen years of age or older;

(E) A parent;

(F) A brother or sister eighteen years of age or older;

(G) A close friend or close relative eighteen years of age or older.

S. 5020 § 2 (to be codified at N.Y. PUB. HEALTH LAW § 2995-D); A. 6791 § 2 (to be codified at N.Y. PUB. HEALTH LAW § 2995-D).

121. *See* Senate Support Memo, *supra* note 113, at 2-3.

122. *See id.* at 3.

123. *See id.*

124. *See id.*; S. 5020 § 2 (to be codified at N.Y. PUB. HEALTH LAW § 2995-D); A. 6791 § 2 (to be codified at N.Y. PUB. HEALTH LAW § 2995-D).

condition and such other concerns and values as a reasonable person in the patient's circumstances would wish to consider.[125]

A surrogate can consent to withhold or withdraw life-sustaining treatment if treatment would be an excessive burden to the patient in light of the patient's known wishes or best interests.[126] In addition, one of the following circumstances must exist: (i) the patient must be terminally ill or permanently unconscious;[127] or (ii) treatment would involve such pain or suffering or other burden that it would reasonably be deemed inhumane or extraordinary; or (iii) the decision to withdraw or withhold life-sustaining treatment accords with the patient's reasonably known wishes.[128] In residential health care facilities, a surrogate can decide to forego life-sustaining treatment for patients who are not terminally ill or permanently unconscious only if three members of the bioethics committee, including at least one physician who is not directly responsible for the patient's care, review the decision and determine that it meets the standards set forth in the article for such decisions.[129]

According to the New York State Task Force on Life and the Law,[130] thousands of decisions are made every year in health care facilities across New York State for patients who cannot decide for themselves.[131] "The question for New York State policy is not whether surrogate decisions will be made, but who will make them and by what criteria."[132] In practice, most health care providers consult family members prior to rendering treatment to incompetent patients.[133] However, under existing New York law, an adult patient must have signed a health care proxy[134] or left clear evidence of his or her wishes in order to forego life-sustaining treatment.[135] This standard is at odds with the

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125. *See* S. 5020 § 2 (to be codified at N.Y. PUB. HEALTH LAW § 2995-D 5(b)); A. 6791 § 2 (to be codified at N.Y. PUB. HEALTH LAW § 2995-D 5(b)).

126. *See* Senate Support Memo, *supra* note 113, at 3.

127. Persons in a persistent vegetative state fall under the permanently unconscious category. *See* GUIDELINES, *supra* note 13, at app. A chart.

128. *See* Senate Support Memo, *supra* note 113, at 3.

129. *See id.*

130. The Task Force has devised a proposal for legislation on surrogate decisions. *See* TASK FORCE, *supra* note 65, at 247.

131. *See id.* at 73.

132. *Id.*

133. *See* Senate Support Memo, *supra* note 113, at 8.

134. *See supra* notes 105-06 and accompanying text.

135. *See supra* text accompanying notes 76-83; TASK FORCE, *supra* note 65, at 74.

laws of several other states, where either statutes[136] or court decisions[137] expressly permit family members to decide about life-sustaining treatment, subject to public standards. New York's legislative proposal recognizes that few families have the emotional or financial resources to pursue judicial relief.[138] It establishes a process to review sensitive cases and to resolve disputes within health care facilities, relying on the courts only as a last resort.[139] According to the *Guidelines for State Court Decision Making in Authorizing or Withholding Life-Sustaining Medical Treatment*, "[t]he court should not be used as a clearinghouse for the rendering of medical decisions which are best made by the patient and the family and the physician of the patient."[140] A court should only be involved in the event a disagreement arises among the patient's family and the physicians or health care facility which cannot be resolved.[141] This proposed legislation is consistent with these guidelines.

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136. *See, e.g.*, N.M. STAT. ANN. § 24 (Michie 1978); WYO. STAT. ANN. § 35 (Michie 1977).

137. *See, e.g., In re* Estate of Longeway, 549 N.E.2d 292 (Ill. 1990) (holding, inter alia, that the guardian of an incompetent patient who is terminally ill and diagnosed as irreversibly comatose may exercise right to refuse nutrition and hydration on behalf of patient); *In re* Jobes, 529 A.2d 434 (N.J. 1987) (holding, inter alia, that the right of a patient in an irreversibly vegetative state to determine whether to refuse life-sustaining medical treatment may be exercised by patient's family or close friend); *In re* Fiori, 652 A.2d 1350 (Pa. Super. Ct. 1995) (holding that a close family member, with the approval of two physicians, may exercise the right of a person in a long-term persistent vegetative state to terminate life-sustaining treatment even though a person's views were not previously expressed).

138. *See* Senate Support Memo, *supra* note 113, at 8.

139. *See id.*

140. GUIDELINES, *supra* note 13, at 36 & n.61; *see also* The Hon. Charles M. Leibson, *The Role of the Courts in Terminating Life-Sustaining Medical Treatment*, 10 ISSUES L. & MED. 437 (1995).

141. *See* GUIDELINES, *supra* note 13, at 36; *see also* Michele Yuen, Comment, *Letting Daddy Die: Adopting New Standards for Surrogate Decisionmaking*, 39 UCLA L. REV. 581, 600 (1992) ("Although several courts initially suggested that the judicial system was the appropriate forum to decide whether life-sustaining [medical] treatment could be withdrawn from an incompetent patient, courts have more recently declined to require judicial intervention as a prerequisite to making such decisions.").

IV. PUBLIC OPINION

The purpose of the bill is supported by many organizations[142] as well as by the public at large.[143] Opinion polls suggest that a majority of the public feels that a decision as important as whether to withhold or withdraw life-sustaining medical treatment from a loved one should be decided by the patient's family rather than the courts.[144]

A. *Proponents*

The New York Association of Homes and Services for the Aging (NYAHSA)[145] strongly supports this bill.[146] According to NYAHSA, many residents in health care facilities have neither a living will nor a health care proxy and, in the absence of these protections, are forced to rely on the courts for important treatment decisions.[147] Because the adversarial nature of a court proceeding is usually an inappropriate setting for making these sensitive decisions, the Association, among others, believes that it is best if a patient's family or physicians make these decisions without court intervention.[148]

The Greater New York Hospital Association (GNYHA) also strongly supports the bill.[149] It believes the legislation will clarify the confusion that presently exists in New York State law on this issue.[150] GNYHA believes that the current law is in dire need of reform because, in part, it leads to unwanted, unnecessary, and non-beneficial treatment.[151] It

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142. *See supra* notes 108-11 and accompanying text.

143. *See* Roach, *supra* note 102, at 186-87 (discussing results of public opinion polls taken shortly after the *Cruzan* decision).

144. *See id.*

145. NYAHSA represents more than 440 not-for-profit and public providers of long term care, including residential health care facilities, adult care facilities, adult day care programs, and home care providers. *See* Memorandum from NYAHSA in Support of A. 6791 to Assembly Health Committee (n.d.) (on file with *New York Law School Law Review*). Its members provide long term care to more than 250,000 of New York State's frail elderly. *See id.*

146. *See id.*

147. *See id.*

148. *See id.*

149. *See* Memorandum from GNYHA in Support of A. 6791 to Members of the Assembly Health Committee (May 8, 1995) (on file with *New York Law School Law Review*).

150. *See id.*

151. *See id.*

supports the fact that the legislation does not distinguish artificial nutrition and hydration from other forms of life-sustaining medical treatment.[152]

B. *Opponents*

The New York State Catholic Conference[153] supports the spirit of the bill,[154] but opposes the bill in substance precisely because it does not distinguish nutrition and hydration from other forms of medical treatment.[155] The Conference strongly believes that nutrition and hydration provide basic nourishment, rather than medical care.[156] Furthermore, it acknowledges both the disagreement among ethicists about when it is morally permissive to withhold or withdraw nutrition and hydration, and the disagreement among physicians about when such withdrawal is medically appropriate.[157] In the absence of unanimity, the Conference has decided that these decisions should be guided by a presumption in favor of continuing nutrition and hydration, unless the continued treatment itself is an excessive burden on the patient.[158] Moreover, it emphasizes that the New York legislature has acknowledged the higher standards that must be afforded decisions pertaining to artificial nutrition and hydration.[159] New York's current Health Care Agents and Proxies law states that an agent is not authorized to make decisions regarding nutrition and hydration unless the patient's wishes are

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152. *See id.*

153. The New York State Catholic Conference is the public policy office of the 26 Roman Catholic Bishops in the state. It is responsible for the development, coordination, and communication of the Bishops' positions on critical public policy issues. *See* Letter from New York State Catholic Conference to the Honorable Richard Gottfried, Chairman, Assembly Committee on Health 1 (May 8, 1995) [hereinafter Gottfried Letter] (on file with *New York Law School Law Review*). It is intimately involved in crafting sound public policies which respond to pressing human needs and serve the common good of all people in the state. *See id.*

154. *See* Gottfried Letter, *supra* note 153; New York Academy of Med., Surrogate Decision-Making Presentation (May 17, 1995) (on file with *New York Law School Law Review*).

155. *See* Gottfried Letter, *supra* note 153, at 2; New York Academy of Med., *supra* note 154, at 3.

156. *See* Gottfried Letter, *supra* note 153, at 2; New York Academy of Med., *supra* note 154, at 3.

157. *See* New York Academy of Med., *supra* note 154, at 3.

158. *See id.*

159. *See* Gottfried Letter, *supra* note 153, at 2; New York Academy of Med., *supra* note 154, at 3.

reasonably known or can with reasonable diligence be ascertained.[160] The Conference believes that a higher standard in law is warranted for such a sensitive and critical decision and should be included in the proposed legislation.[161] This is imperative, it says, particularly because surrogates are being designated by law[162] and not by patients.[163] It also emphasizes that the legislation does not sufficiently protect from potential abuses those patients who have either outlived or been abandoned by their families.[164]

Agudath Israel of America[165] supports and opposes the bill on basically the same grounds as the Conference.[166] However, its main concern is with the concept of "personal autonomy" and how the trend of recent legal developments appears to be moving inexorably in a direction that places "greater emphasis on the *quality* of human life and less on the inherent *sanctity* of human life."[167] It fears this trend is leading society down a "slippery slope."[168] The argument warns against "taking a first step that is itself ethically justified when doing so is expected to lead to the acceptance of other actions that are not likewise justified."[169] "If the slope is indeed slippery and no likely stopping points exist to provide a toehold, then the wisest course may be to avoid taking the first step."[170]

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160. N.Y. PUB. HEALTH LAW § 2982-2 (McKinney 1993).

161. *See* Gottfried Letter, *supra* note 153, at 2; New York Academy of Med., *supra* note 154, at 3.

162. *See supra* note 120 and accompanying text.

163. *See* Gottfried Letter, *supra* note 153, at 2; New York Academy of Med., *supra* note 154, at 3.

164. *See* Gottfried Letter, *supra* note 153, at 2; New York Academy of Med., *supra* note 154, at 2.

165. Agudath Israel of America is a national grassroots Orthodox Jewish movement which has long been interested in developments in bio-medical ethics. *See* Memorandum from Agudath Israel of America to Senate Majority Leader Joseph L. Bruno et al. 1 (June 14, 1995) [hereinafter Agudath Israel] (on file with *New York Law School Law Review*).

166. *See id.*

167. *Id.* at 2.

168. *Id.* at 5; *see also* Tamara Lewin, *Fight for Life of a Hopeless, Brain-Damaged Man Goes to the Supreme Court*, N.Y. TIMES, Feb. 19, 1996, at A8.

169. FOREGOING LIFE-SUSTAINING TREATMENT, *supra* note 27, at 28.

170. *Id.* For articles discussing the "slippery slope" argument see Green, *supra* note 32, at 9; Frederick Schauer, *Slippery Slopes*, 99 HARV. L. REV. 361 (1985); Tom Stacy, *Death, Privacy, and the Free Exercise of Religion*, 77 CORNELL L. REV. 490, 509 (1992); Robert Steinbrook, M.D., & Bernard Lo, M.D., *Artificial Feeding - Solid Ground, Not a Slippery Slope*, 318 NEW ENG. J. MED. 286 (1988).

Agudath Israel expresses its fear that this legislation would bring us "one step closer to the bottom of the slope."[171]

The bill is also opposed by the New York State Trial Lawyers Association.[172] While it supports the purpose of the bill, it objects to two sections that it says "confers overly broad civil immunity"[173] on physicians, ethics committees, and health care facilities when they act on surrogate decisions made pursuant to the bill.[174]

C. *Possible Amendments*

The critical importance of living wills and health care proxies cannot be emphasized enough. They are the best means available to enforce one's wishes in the event one becomes incapacitated. However, only a very low percentage of New York State residents have living wills or have actually designated a proxy.[175] This may be because the public is unaware of the current state of the law regarding health care decisions, unwilling to consider such tools as health care proxies or simply not willing to think about sickness while in good health. Whatever the reason, some other means of enforcing one's "probable" wishes needs to be established. This is the goal of New York's proposed legislation.[176] Family and friends are often in the best position to know one's beliefs, values, and preferences and, therefore, they should be appointed to make decisions in the event a loved one becomes incapacitated. That this view is widely shared is evidenced by the numerous supporters of the bill.[177]

However, although the bill does establish some procedural safeguards regarding decisions to withhold or withdraw life-sustaining medical treatment (i.e., it provides for a limited application and establishes ethics review committees)[178] there still remains potential for abuse in practice. First, it is possible that family members may not always act in the

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171. Agudath Israel, *supra* note 165, at 5.

172. *See* Spencer, *supra* note 8, at 2.

173. *Id.*

174. *See* S. 5020, 218th Leg., 1st Reg. Sess. § 2 (N.Y. 1995) (holding medical professionals to a "good faith" standard) (to be codified at N.Y. PUB. HEALTH LAW § 2995-O); A. 6791, 218th Leg., 1st Reg. Sess. § 2 (N.Y. 1995) (to be codified at N.Y. PUB. HEALTH LAW § 2995-O).

175. *See* Spencer, *supra* note 8, at 2.

176. *See* Senate Support Memo, *supra* note 113, at 2.

177. *See supra* notes 108-11 and accompanying text.

178. *See* S. 5020 § 2 (to be codified at N.Y. PUB. HEALTH LAW §§ 2995-D 6(a), 2995-M); A. 6791 § 2 (to be codified at N.Y. PUB. HEALTH LAW §§ 2995-D 6(a), 2995-M).

patient's best interest. "Family members, although they may care for the patient, can be influenced by their own viewpoints about death and quality of life."[179] Additionally, some family members may be motivated by interests other than those of the patient, such as severe financial and emotional burdens.[180] Second, patients' families may be easily influenced by physicians who believe that a diagnosis of PVS can be made with a high degree of medical certainty within one to three months.[181] In many cases, the fate of these patients is unpredictable[182] because an infallible procedure for diagnosing PVS has not yet been developed.[183] Furthermore, although the bill establishes ethics committees[184] to review cases and to act on behalf of patients without families, unless these committees are chosen carefully, their contribution may be less than helpful because they may be biased, uneducated, and ignorant regarding ethics in particular.[185] Therefore, better safeguards need to be established.

Despite ethical and moral objections of some groups, there appears to be an emerging consensus that nutrition and hydration is indistinguishable from other forms of life-sustaining medical treatment.[186] However, because questions remain about the accuracy of prognostic assessments of persons in a PVS and because cases of recovery have been "reported,"[187] the legislature should provide additional safeguards. Amending the bill to provide a provision granting the surrogate the right to withdraw nutrition and hydration from persons in a PVS only in cases where the person has been continuously unconscious for a period of three

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179. Bopp, *supra* note 25, at 27.

180. *See* FOREGOING LIFE-SUSTAINING TREATMENT, *supra* note 27, at 185. *But see* Grisez, *supra* note 27, at 172 ("In our affluent society, can we justify abandoning the comatose in order to save the cost of caring for them as we care for others who cannot care for themselves?").

181. *See American Academy of Neurology*, *supra* note 31, at 126.

182. *See supra* text accompanying notes 58-63.

183. *See* Cranford, *supra* note 16, at 29; Wikler, *supra* note 27, at 46.

184. Section 2995-M does set forth some requirements for the composition of these committees. N.Y. PUB. HEALTH LAW § 2995-M.

185. *See* Green, *supra* note 27, at 8-9 (raising caution as to ethics committees).

186. *See supra* notes 48-51 and accompanying text.

187. In just one facility alone, there are quite a few patients that have recovered some degree of cognitive awareness after being in a persistent vegetative state for about two to three years. Their original prognoses was that they would never regain any cognitive function. These cases have never been "officially" reported, which may be the case with many other patients in facilities all around the nation. Informal Interviews by Author with Patients' Families at Seaview Hospital Rehabilitation Center & Home, Staten Island, New York (Oct. 15, 1995).

or more years[188] would better ensure that nutrition and hydration is not being removed from persons who may recover.

Further, providing a special provision to protect patients residing in health care facilities who do not have family or close friends to act as surrogates would avoid the possibility of institutional bias by ethics committees.[189] One alternative may be to create a state ombudsman program similar to the one in effect in New Jersey.[190] Whenever life-sustaining treatment is to be withheld or withdrawn either to effectuate an incompetent patient's wishes or because it is considered to be in the patient's best interest, the state ombudsman must be notified.[191] "The ombudsmen is required to treat every notification that life-sustaining treatment will be withheld or withdrawn from an institutionalized elderly patient as possible abuse."[192] Another alternative may be to create an independent office which is not subject to facility control or influence, to act as "watchdog" in these cases.[193]

V. CONCLUSION

As medical technology becomes more advanced, decisions regarding medical treatment for loved ones which were once troublesome have now become nearly insurmountable. Therefore, it is essential that the legislature enact a responsible statute that will provide adequate and appropriate guidance. The proposed legislation is commendable because it recognizes that these critical decisions should be made by the patient's family rather than by a judge unfamiliar with the patient. However, the legislation fails to sufficiently protect those most vulnerable in our society—persons diagnosed as being in a PVS and persons who do not have family to care for them—from possible abuses. The legislation should be amended to address this critical issue.

In all cases there should be a presumption in favor of life through continued treatment. There will never be a "right" or "clear" answer to the question of when to withhold or withdraw nutrition and hydration from a person in a PVS. Courts cannot duplicate the knowledge and love of families watching a patient suffer. Therefore, it is families who must

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188. *See* Nancy Gibbs, *Love and Let Die*, TIME, Mar. 19, 1990, at 62, 71.

189. *See* Green, *supra* note 27, at 8-9.

190. *See* Bopp, *supra* note 25, at 26.

191. *See id.*

192. *Id.*; *see also* CAL. CIV. CODE § 2412.5 (West 1983) (outlining procedures for investigating decisions made by a surrogate on behalf of incompetent patients).

193. *See* New York Academy of Med., *supra* note 154, at 3.

make the decision to hold on or to forego hope.[194] What is needed from the legislature are responsible guidelines to help make the best choice in the unfortunate event that a choice must be made.

Marina Martino

194. *See* Donald D. Tresch, M.D., et al., *Patients in a Persistent Vegetative State: Attitudes and Reactions of Family Members*, 39 J. AM. GERIATRICS SOC'Y 17, 19-21 (1991).