Honoring Patient Preference at the End of Life: The MOLST Process and the Family Health Care Decisions Act

By Karen Lipson and Jonathan Karmel

Introduction

Patient self-determination and informed consent are fundamental elements of medical care in the United States. When a patient loses the capacity to make medical decisions, securing informed consent and carrying out the patient's wishes raise complex legal and ethical issues. These issues are particularly challenging when the patient is near the end of life and decisions must be made about whether or not to provide life-sustaining treatment. Advances in medical care in the last fifty years have enabled us to prolong life where death was once imminent, but often cannot promise an acceptable quality of life. As a result, patients and family members today face difficult choices about how they will live and die.

Since the late 1980s, New York State and the federal government have sought to encourage patients with advanced, life-limiting conditions to make decisions concerning life-sustaining treatment in advance so that, in the event that they lose decision-making capacity, their wishes can be honored. Enacted in 1990, New York's health care proxy law provides a mechanism for competent adults to appoint health care agents to make medical decisions on the patient's behalf in the event that they lose the capacity to make those decisions. The federal Patient Self-Determination Act, enacted in 1991, requires hospitals, nursing homes, hospice programs, and home health agencies to inform patients upon admission about their decision-making rights, ask them about advance directives, such as health care proxies and living wills, and document those directives in their medical records.¹

Despite these efforts, studies have shown that the majority of seriously or terminally ill patients lack advance directives.² Moreover, the evidence suggests that the treatment people receive at the end of life is different from the treatment they would have requested, and often the care received is more aggressive than they would have wanted. Opinion polls indicate that a sizeable majority of patients would prefer to die at home.³ Yet, approximately one in five Americans dies in an intensive care unit, and almost one-third die in a hospital.⁴ Another 22 percent die in a nursing home.⁵ According to the Dartmouth Atlas on Health Care, Medicare beneficiaries in New York have the highest rate in the U.S. of inpatient days during the last six months of life—15.5 days per deceased patient.⁶ Even among Medicare beneficiaries with advanced cancer, the rate of hospital deaths is surprisingly high. About 29 percent die in a hospital, and only about half receive hospice care.⁷ The rate of hospital deaths for these patients was the highest in the Manhattan hospital referral region, while hospice use in that region was significantly lower than the national average.⁸

In the absence of advance care planning and an advance directive, when a patient loses decision-making capacity, health care providers and family members often struggle mightily to make treatment decisions consistent with the patient's wishes and values and with New York's laws governing informed consent. Often these decisions are made in the midst of a crisis with little opportunity for reflection. Futile and burdensome treatment may be provided, or life-sustaining treatment may be withheld, without a clear understanding of what the patient would have wanted, causing distress and guilt for family members.

Until June 2010, when an adult patient in New York lacked capacity to make medical decisions and had not appointed a health care agent or executed a living will, family members were legally authorized to consent only to a do not resuscitate (DNR) order. Decisions to withhold other life-sustaining treatment, such as artificially administered nutrition or hydration, could be made only with clear and convincing evidence of the patient's wishes or pursuant to a court order. As a result, patients near death sometimes languished in hospitals receiving futile treatment that family members knew the patient would not want. With the enactment of the Family Health Care Decisions Act (FHCDCA),⁹ effective June of 2010, family members and close friends can be surrogates with authority to make any treatment decision on behalf of a patient who lacks capacity. While FHCDCA facilitates health care decisions for vulnerable patients, it will not succeed in promoting patient autonomy unless prospective surrogates are familiar with their loved one's goals for care, treatment preferences, and values. This can be accomplished through effective advance care planning.

Even when an advance directive is completed, if it does not transition with the patient between health care settings, it may be ineffective in assuring that the patient's care reflects his or her wishes and values. Between 25 and 30 percent of dying patients are cared for in three or more settings in the last months of life.¹⁰ In addition, advance directives may not be implemented properly if they are not discussed with the patient's family members in advance.
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A competent patient and his or her physician and family members. Although health care agents and FHPCA may consent, others may consent, orders on behalf of patients who lack medical decision-making capacity. The best way to assure patient self-determination is for the patient to make these decisions while he or she has capacity to do so. Family members and others are a representative of the patient's best interests, and are typically included in these discussions so that they develop an understanding of the patient's goals for care and values and what the event that the patient loses capacity, will be able to make decisions consistent with their loved one's wishes, portable and

After discussing the patient's prognosis, goals for care, values, options, and any prior advance directives with the patient, his or her family members, and/or close friends, the physician reviews the MOLST form (DOH-5033) with the patient and family and completes and signs it. In some physician practices and facilities, a portion of the conversation may be facilitated by a nurse or social worker; however, a licensed physician must always, at a minimum: (i) confer with the patient and/or the patient's health care agent or surrogate about the patient's diagnosis, prognosis, goals for care, treatment preferences, and consent by the appropriate decision-maker, and (ii) sign the orders derived from that discussion.

The form is bright pink so it can be found and identified easily by emergency medical services personnel responding to a call and by health care facility staff when it is placed in a medical record. The form also includes specific orders concerning resuscitation, intubation, future hospitalization, artificial nutrition and hydration, and administration of artificial nutrition and hydration, including the expectant course and course of treatment. The form includes such terms as "comfort measures only," "limited medical interventions," and "no limitations on medical interventions." The form requires the signature of the physician. Either the name of the person completing the form to be included on the form. In addition, the name(s) of the witness(es) to the consent must be included on the form as well.

The MOLST form is effective in the community and in health care facilities and outpatient settings and, for the patient as he or she transitions from one setting to another. Under FHPCA, rules governing the implementation of orders to withhold or withdraw life-sustaining treatment upon interinstitutional transfers, for hospital-based programs, and nursing home also govern non-hospital orders upon transfer to a hospital or nursing home from the community. Such orders remain effective until another attending physician examines the patient, and either continues the prior orders or determines that they are no longer appropriate or authorized and cancels them. Before canceling them, the attending physician must have reasonable efforts to notify the person who consented to the orders and the hospital.

of a crisis. Absent these discussions, an advance directive may be too vague to provide effective guidance to clinicians and family members when the need for a decision arises. In a 2008 report to Congress, the U.S. Department of Health and Human Services concluded that many of the barriers to effective advance care planning could be addressed through adoption of the MOLST (Physician Orders for Life-Sustaining Treatment) process:

ENCOURAGING ADDITIONAL MOLST EFFORTS

MOLST, known in New York as "MOLST" (Medical Orders for Life-Sustaining Treatment), is a national model for advance care planning that supports shared, informed decision making, porability of advance directives across health care settings, and continuity of care.

This article will discuss how the MOLST process works, the law governing decisions to withhold or withdraw life-sustaining treatment in New York State, and the legal basis for the MOLST process. It will describe how the enactment of FHPCA has affected MOLST. Finally, it will describe the MOLST forms and checklists developed by the New York State Department of Health (DOH), and the applicable law for patients in facilities licensed by the Office for People With Developmental Disabilities (OPWDD) and the Office of Mental Health (OMH).

The MOLST Process

New York's MOLST process is based on the MOLST Paradigm Program initiated in the mid-1990s. Approximately 26 states, plus the District of Columbia, have adopted the local or regional level.12

With the goal of providing patient-centered care and shared decision making, MOLST provides a structured framework for conversations between physicians and their patients (or the patient's authorized decision-maker) concerning prognosis, the benefits and burdens of the life-sustaining treatment and the patient's personal goals for care. The idea of the paradigm is to develop actionable orders recorded on a portable, easily identified forms. Studies have shown that MOLST is useful in initiating conversations about advance directives, in preventing unwanted resuscitations and hospitalizations, and in documenting a range of treatment options.13

Ideally, a completed MOLST form is the culmination of a conversation or series of conversations between

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staff directly responsible for the patient's care. If the notice cannot be made prior to the cancellation, it must be made as soon as practicable thereafter.

Although this article focuses on decisions to withhold or withdraw life-sustaining treatment, due to the complexity of laws surrounding such decisions, the MOLST process does not address an outcome that limits interventions. The form includes a range of options from "attempt CPR" and "no limitations on medical interventions" to "allow natural death" and "comfort measures only." The process is not intended to limit in any way the choices of patients and families, but rather to empower them to make choices consistent with the patient's wishes, values and goals.

The Law Governing Decisions to Withhold or Withdraw Life-Sustaining Treatment in New York State

Decisions to withhold or withdraw life-sustaining treatment may be made in several different ways in New York State. A person with capacity to make medical decisions may consent to a specific medical order prior to losing capacity.14 Or, under New York law, common-law health care providers may withhold or withdraw life-sustaining treatment from a patient who is dying and currently lacks the capacity to make his or her own decisions, if doing so is based upon clear and convincing evidence of the patient's wishes.15

Under New York's health care proxy law (Public Health Law Article 29-C, health care agents can make decisions to withhold or withdraw life-sustaining treatment even when patients have not left clear and convincing evidence of their wishes. The agent must make decisions in accordance with the principal's wishes, or if the principal's wishes are not reasonably known and cannot with reason to the principal's best interests.21

The agent's authority to make decisions concerning the withholding or withdrawal of artificial nutrition and hydration is somewhat limited. If the principal's wishes concerning the withholding or withdrawal of nutrition and hydration are reasonably known and cannot with reason to be ascertained, the agent does not have authority to make decisions regarding these measures.22,23 However, it is not necessary to have clear and convincing evidence of a patient's wishes to satisfy the health care proxy law's standard of "reasonably knowing" the patient's wishes. Patients may explicitly state their treatment wishes on their health care proxy, in which case the health care proxy is also functioning as a living will.

When patients lack capacity, have not left clear and convincing evidence of their wishes and do not have a health care proxy, New York law authorizes specified indi

The Legal Basis for the MOLST Process

In 2005, the Public Health Law was amended to give DOH authority to issue "alternative forms" for issuing non-hospital orders not to resuscitate in Monroe and Onondaga Counties. This established MOLST as a pilot program. In 2006, the law was amended to allow such "alternative forms" to be used to issue non-hospital do not intubate (DNI) orders. This was necessary because the Public Health Law makes a distinction between a DNR order and a DNI order. Under the law of New York's law, a DNR order cannot be given when a patient has a cardiac or respiratory arrest, i.e., when a patient has no pulse and/or is not breathing. Even if a patient has a non-hospital DNR order, emergency medical services personnel will still intubate a patient who has a pulse or is breathing, unless the patient also has a non-hospital DNI order.24 In 2008, the law was amended to authorize MOLST as a non-hospital DNR and DNI state-wide.25 MOLST is the only authorized mechanism in New York to put in place a non-hospital order that includes both DNR and DNI.

Life-Sustaining Treatment Orders and MOLST Under FHPCA

Chapter 8 of the Laws of 2010, the legislation that included MOLST (FHL Article 29-C), made significant changes to the process for consenting to DNR orders and other orders to withhold or withdraw life-sustaining treatment. The addition of authorizing surrogate decision making in general hospitals and nursing homes for any type of health care decision, including DNR orders, it also amended FHL Article 29-C (the old DNR law) to make it applicable to decisions in certain medical hygiene facilities. It also moved the provisions for non-hospital DNR orders to a new PHL Article 29-CCC.

Under current law, the legal requirements for issuing medical orders to withhold or withdraw life-sustaining treatment differ depending on the patient, the decision-maker, and the setting. These requirements can be divided into eight different categories:
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of a crisis. Absent these discussions, an advance directive may be too vague to provide effective guidance to clinicians and family members when the need for end-of-life decision-making arises. In a 2008 report to Congress, the U.S. Department of Health and Human Services concluded that many of the barriers to effective advance care planning could be addressed through adoption of the POLST (Physician Orders for Life-Sustaining Treatment) process:

Encouraging additional POLST efforts that translate chronic care patient's [sic] care goals into identifiable, portable and renewable medical orders that follow the patient across settings would go a long way toward enhancing advance care planning in this country.11

POLST, known in New York as "MOLST" (or Medical Orders for Life-Sustaining Treatment), is a national model for advance care planning that supports shared, informed decision making, portability of advance directives across health care settings, and continuity of care.

This article will discuss how the MOLST process works, the law governing decisions to withhold and withdraw life-sustaining treatment in New York State, and the legal basis for the MOLST process. It will describe how the enactment of FHCCA has affected MOLST. Finally, it will describe the MOLST guidelines developed by the New York State Department of Health (DOH), and the applicable law for patients in facilities licensed by the Office for People With Developmental Disabilities (OPWDD) and the Office of Mental Health (OMH).

The MOLST Process

New York’s MOLST process is based on the POLST Paradigm Program initiated in the mid-1990s. Approximately 26 states, Puerto Rico, and the District of Columbia have adopted the model at the local or regional level.12

With the goal of providing patient-centered care and shared decision making, POLST provides a structured framework for conversations between physicians and their patients (or the patient's authorized proxy decision maker) concerning prognosis, the benefits and burdens of the life-sustaining treatment and the patient’s personal goals for care. The process of discussion is facilitated by careless, actionable orders recorded on a portable, easily identifiable forms. Studies have shown that POLST is useful in initiating conversations about end-of-life care, in preventing unwanted resuscitation and hospitalizations, and in decreasing the length of treatment options.13

Ideally, a completed MOLST form is the culmination of a conversation or series of conversations between a competent patient and his or her physician and family members.14 Although health care agents and FHCCA surrogates must consent to the MOLST orders on behalf of patients who lack medical decision-making capacity, the best way to assure patient self-determination is for the patient to make these decisions while he or she has capacity. Typically included in these discussions so that they develop an understanding of the patient’s goals for care and values and the event the patient loses capacity, will be able to make decisions consistent with their loved one’s wishes and beliefs.

After discussing the patient’s prognosis, goals for care, values, options, and any prior advance directives with the patient, his or her family members, and/or close friends, the physician reviews the MOLST form (DOH-5030) with the patient and family and completes and signs it. In some physician practices and facilities, a portion of the conversation may be facilitated by a nurse or social worker; however, a licensed physician must always, at a minimum: (i) confer with the patient and/or the patient’s health care agent or surrogate about the patient’s diagnosis, prognosis, goals for care, treatment preferences, and consent by the appropriate decision-maker, and (ii) sign the orders derived from that discussion.

The form is bright pink so it can be found and identified easily by emergency medical services personnel responding to a call and by health care facility staff when it is placed in a medical record. The form includes specific orders concerning resuscitation, intubation, future hospitalization, artificial nutrition and hydration, withdrawal of artificial nutrition and hydration, and treatment limitations, such as “comfort measures only,” “limited medical interventions,” and “no limitations on medical interventions.” The form requires the signature of the physician. Either the patient, the physician, or the patient’s proxy charged with making decisions concerning the patient’s care must be included on the form. In addition, the name(s) of the witness(es) to the consent must be included on the form as well.15

The MOLST form is effective in the community and in health care facilities and long-term care institutions. Family members know that the patient as he or she transitions from one setting to another. Under FHCCA, rules governing the implementation of orders to withhold or withdraw life-sustaining treatment apply to inpatient hospitals and nursing homes. The hospital may also order non-hospital orders under a hospital or nursing home from the community. Such orders remain effective until an attending physician examines the patient, and either continues the prior orders or determines that they are no longer appropriate or authorized and cancels them.16 Before canceling them, the attending physician must use reasonable efforts to notify the person who consented to the orders and the hospital staff directly responsible for the patient’s care. If the notice cannot be made prior to the cancellation, it must be made as soon as practicable afterwards.17

Although this article focuses on decisions to withhold or withdraw life-sustaining treatment, due to the complex laws surrounding such decisions, the MOLST process does not presume an outcome that limits interventions. The form includes a range of options from “attempt CPR” and “no limitations on medical interventions” to “allow natural death” and “comfort measures only.” The process is not intended to limit in any way the choices of patients and families, but rather to empower them to make decisions consistent with the patient’s wishes, values and goals.

The Law Governing Decisions to Withhold or Withdraw Life-Sustaining Treatment in New York State

Decisions to withhold or withdraw life-sustaining treatment may be made in several different ways in New York State. A person with capacity to make medical decisions may consent to a specific medical order prior to losing capacity.18 Or, under New York’s common law, health care providers may withhold or withdraw life-sustaining treatment from a patient who is dying and currently lacks the capacity to make his or her own decisions, if doing so serves the patient’s clear and convincing evidence of the patient’s wishes.19

Under New York’s health care proxy law (Public Health Law Article 29-C.), health care agents can make decisions to withhold or withdraw life-sustaining treatment even when patients have not left clear and convincing evidence of their wishes. The agent must make decisions in accordance with the principal’s wishes, or if the principal’s wishes are not reasonably known and cannot with reasoning and convincing evidence of the patient’s wishes. The agent must make decisions in accordance with the principal’s wishes, or if the principal’s wishes are not reasonably known and cannot with reasoning and convincing evidence of the patient’s wishes. The agent must make decisions in accordance with the principal’s wishes, or if the principal’s wishes are not reasonably known and cannot with reasoning and convincing evidence of the patient’s wishes. The agent must make decisions in accordance with the principal’s wishes, or if the principal’s wishes are not reasonably known and cannot with reasoning and convincing evidence of the patient’s wishes. The agent must make decisions in accordance with the principal’s wishes, or if the principal’s wishes are not reasonably known and cannot with reasoning and convincing evidence of the patient’s wishes. The agent must make decisions in accordance with the principal’s wishes, or if the principal’s wishes are not reasonably known and cannot with reasoning and convincing evidence of the patient’s wishes. The agent must make decisions in accordance with the principal’s wishes, or if the principal’s wishes are not reasonably known and cannot with reasoning and convincing evidence of the patient’s wishes.

The Legal Basis for the MOLST Process

In 2005, the Public Health Law was amended to give DOH authority to issue “alternative forms” for issuing non-hospital orders not to resuscitate in Monroe and Onondaga Counties. This established MOLST as a pilot program. In 2006, the law was amended to allow such “alternative forms” to be used to issue non-hospital do not intubate (DNI) orders. This was necessary because the Public Health Law makes a distinction between a DNR order and a DNI order. Under the law of New York’s law, a DNR order controls when a patient has a pulse or is breathing, while the patient also has a non-hospital DNI order.20 In 2008, the law was amended to authorize MOLST as a non-hospital DNR and DNI order statewide. MOLST is the only authorized mechanism in New York to put in place a non-hospital order that includes both DNR and DNI.

Life-Sustaining Treatment Orders and MOLST Under FHCCA

Chapter 86 of the Laws of 2010, the legislation that included FHCCA (FHL Article 29-C.), made significant changes to the process for consenting to DNR orders and other orders to withhold or withdraw life-sustaining treatment. The “attorney in fact” or surrogate decision making in general hospitals and nursing homes for any type of health care decision, including DNR orders, it also amended PHL Article 29-B (the old DNR law) to make it applicable to all decisions in certain medical hygiene facilities. It also moved the provisions for non-hospital DNR orders to a new PHL Article 29-CCC.

Under current law, the legal requirements for issuing medical orders to withhold or withdraw life-sustaining treatment differ depending on the patient, the decision-maker, and the setting. These requirements can be divided into eight different categories:

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1. Adult Patients with Medical Decision-Making Capacity (Regardless of Setting)

Adults are presumed to have decision-making capacity to make medical decisions, unless a contrary determination has been made by a court or by the requisite health care professional pursuant to FHCDA. Adults with medical decision-making capacity must consent to or refuse elective life-sustaining treatment. Prior to the enactment of FHCDA, there was a therapeutic exception to the rule that a DNR order for a patient with capacity must be based upon the patient's own decision, which typically occurred that exceptions can.

As explained above, adults with capacity also have the right to execute advance directives, such as a living will, to avoid getting life-sustaining treatment that they do not want after they lose capacity. A living will may not be fully effective in accomplishing this goal, because a living will may not be written with sufficient specificity to provide clear and convincing evidence of the patient's wishes. In order to provide greater assurance that their wishes will be carried out, patients can consent to medical orders for life-sustaining treatment. With the informed consent of the patient, the patient's physician can issue a variety of medical orders using DOH's MOLST form—provide comfort measures (palliative care) only; do not attempt resuscitation (allow natural death); do not intubate (DNI); do not hospitalize; no feeding tube; no IV fluids, do not use antibiotics; no medical interventions. Physicians may also issue other medical orders related to other life-sustaining treatments (e.g., dialysis) in the space on the form available for "other instructions."

Under FHCDA, surrogate consent is not required if the decision was not necessitated by the patient's loss capacity "either orally during hospitalization (including during residency in a nursing home) in the presence of two witnesses eighteen years of age or older, at least one of whom is a health care services provider affiliated with the hospital, or in writing." The phrase in writing includes any legally executed non-hospital DNR order or MOLST form, if the form was completed prior to hospitalization with the oral consent of the patient to just one witness who was the attending physician who signed the order(s). However, two witnesses are recommended.

2. Adult Patients Without Medical Decision-Making Capacity Who Have a Health Care Proxy (Any Setting)

A patient without medical decision-making capacity is still presumed competent to appoint a health care agent, unless such person has been adjudged incompetent or otherwise adjudged not competent to appoint a health care agent. A patient or guardian of the person has been appointed under the Mental Hygiene Law or Surrogate's Court Procedure Act (SCPA).

The health care agent named in the health care proxy can consent to medical orders relating to life-sustaining treatment. If the patient's wishes are reasonably known, the health care agent must make decisions in accordance with those wishes. When there is evidence of the patient's wishes, the health care agent should still be asked to consent to the medical orders and given an opportunity to provide additional evidence of the patient's wishes. So long as the health care agent represents that he or she is acting in accordance with the patient's wishes, the health care provider should generally follow the decisions of the health care agent, unless a court has determined otherwise under FHL section 2991.

Under current law, if the principal's wishes regarding the administration of artificial nutrition and hydration are not reasonably known and cannot reasonably be ascertained, the health care agent does not have authority to make decisions regarding these measures. Health care providers may assume that patients' wishes regarding the administration of artificial nutrition and hydration are reasonably known when health care providers state that the patients have discussed their wishes with their health care providers and know their wishes about artificial nutrition and hydration. Even if the patient's wishes regarding artificial nutrition and hydration are not known, the person named as health care agent may still have authority to make the decision if the agent is a "health care surrogate." It is likely that the health care agent is also highest in priority on the FHCDA surrogate list or could be designated as surrogate by a person higher in priority.

Health care agents can consent to decisions to withhold or withdraw life-sustaining treatment in a general hospital or a nursing home and therefore have authority to consent to the medical orders on a MOLST form no matter where the form is completed.

3. Adult General Hospital or Nursing Home Patients Without Medical Decision-Making Capacity Who Do Not Have a Health Care Proxy, and Decision Maker Is FHCDA Surrogate

Decisions to withhold and withdraw life-sustaining treatment in a general hospital or nursing home are governed by FHCDA. Unlike the Article 29-B, FHCDA does not explicitly state that patients are presumed to consent to life-sustaining treatment. However, FHCDA requires a number of conditions to be satisfied before life-sustaining treatment may be withheld or withdrawn. These include patient-centered decision-making standards for surrogates and clinical standards that must be verified by two physicians. Unless these conditions are satisfied, life-sustaining treatment can be withheld or withdrawn under a "irreversibility and incurable condition" statute, presumably must be provided.

Under FHCDA, the rules for issuing orders to withhold or withdraw life-sustaining treatment in general hospital or nursing home settings are described in a number of ways. As noted above, FHCDA authorizes surrogate decision making for all medical decisions, not just DNR decisions. Surrogate consent to a DNR order is now governed by the FHCDA rules for decisions to withheld or withdraw life-sustaining treatment. Before FHCDA, a surrogate could consent to a DNR order if the patient had a "terminal condition," which was defined as "an illness or injury from which there is no recovery, and which reasonably can be expected to cause death within one year." By contrast, FHCDA requires a "an illness or injury which can be expected to cause death within six months, whether or not treatment is provided." Under FHL section 2991, a hospital is not required to provide the "terminal condition" or "irreversibility and incurable condition" required by FHCDA. As a result, FHCDA eliminates the requirement for the patient to be "in imminent danger of death" to have a "terminal condition." A court of competent jurisdiction may make this decision.

FHCDA provides that the facility may withhold or withdraw life-sustaining treatment if the decision is consistent with the patient's wishes, if known, or in the patient's best interests, and two physicians determine that treatment "offers the patient no medical benefit because the patient will die, reasonably, even if the treatment is provided," and "the provision of life-sustaining treatment would violate accepted medical standards." Before FHCDA, a general hospital or nursing home could issue a DNR order for a patient for whom no surrogate was available if CPR was "medically futile," a term that does not appear in FHCDA. Although the law now uses different words, there is substantial similarity in Article 29-B and the FHCDA in this fourth category where a DNR order legally could have been issued before FHCDA but could not be issued under FHCDA.

5. Adult Patients Outside of a General Hospital or Nursing Home Without Medical Decision-Making Capacity Who Do Not Have a Health Care Proxy (Except Patients in Categories Seven and Eight)

Non-hospital DNR and DNI orders are now governed by the new FHL Article 29-C, which is derived from former FHL section 2997. One difference between FHL Article 29-C and former FHL section 2997 is that now hospitals and nursing homes have the authority to determine whether a patient's condition can be considered "irreversibly or incurable." Presumably, this term was not intended to include conditions that are literally irreversible and incurable, but are in no way debilitating. On the other hand, the consideration of the patient who is over 100 years old and has lost medical decision-making capacity, but has no "irreversible or incurable" condition (other than the frailty that naturally accompanies old age). The application of the law to this patient is not entirely clear.

Although the law defines CPR as a type of life-sustaining treatment, it distinguishes between DNR and other orders to withhold or withdraw life-sustaining treatment. Significant differences between DNR orders and other orders to withhold or withdraw life-sustaining treatment are evident under the definition of "irreversible and incurable condition." Surrogates and clinical standards that must be verified by two physicians. Unless these conditions are satisfied, life-sustaining treatment cannot be withdrawn under a "irreversibility and incurable condition" statute, presumably must be provided.

Other orders to withhold or withdraw life-sustaining treatment under that standard.

4. Adult General Hospital or Nursing Home Patients Without Medical Decision-Making Capacity Who Do Not Have a Health Care Proxy, and For Whom No Surrogate is Available

In limited cases, facilities may withhold or withdraw life-sustaining treatment from patients who lack medical decision-making capacity, have no health care agent, and for whom no surrogate is available. In these cases, treatment is being withheld or withdrawn without consent. A court of competent jurisdiction may make this decision.

FHCDA provides that the facility may withhold or withdraw life-sustaining treatment if the decision is consistent with the patient's wishes, if known, or in the patient's best interests, and two physicians determine that treatment "offers the patient no medical benefit because the patient will die, reasonably, even if the treatment is provided," and "the provision of life-sustaining treatment would violate accepted medical standards." Before FHCDA, a general hospital or nursing home could issue a DNR order for a patient for whom no surrogate was available if CPR was "medically futile," a term that does not appear in FHCDA. Although the law now uses different words, there is substantial similarity in Article 29-B and the FHCDA in this fourth category where a DNR order legally could have been issued before FHCDA but could not be issued under FHCDA.

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As explained above, adults with capacity also have
the right to execute advance directives, such as a living will,
to avoid getting life-sustaining treatment that they do not
want even after they lose capacity. A living will may not be
fully effective in accomplishing this goal, because a living will
may not be written with sufficient specificity to provide
clear and convincing evidence of the patient’s wishes. In
order to provide greater assurance that their wishes will
be followed, patients can consent to medical orders for
life-sustaining treatment. With the informed consent of
the patient, the patient’s physician can issue a variety of
medical orders using DOH’s MOLST form—form to provide
comfort measures (palliative care) only; do not attempt
resuscitation (allow natural death); do not intubate (DNI);
do not hospitalize; no feeding tube; no IV fluids, do not
use antibiotics; no medical interventions. Physicians may
issue other medical orders related to
other life-sustaining treatments (e.g., dialysis) in the space
on the form available for “other instructions.”

Under FHCA, surrogate consent is not required if the
decision was made by the patient, unless the patient
lost capacity “either orally during hospitalization [including
during residency in a nursing home] in the presence of
two witnesses eighteen years of age or older, at least one
of whom is a known health care services provider associated
with the hospital, or in writing.” The phrase “in writing”
includes any legally executed non-hospital DNR order or
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italization with the oral consent of the patient to just one
witness who was the attending physician who signed the
order(s). However, two witnesses are recommended.

2. Adult Patients Without Medical Decision-Making Capacity Who Have a Health Care Proxy (Any Setting)

A patient without medical decision-making capacity
is still presumed competent to appoint a health care agent,
unless such person has been adjudged incompetent or
otherwise adjudged not competent to appoint a health care
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person has been appointed by the Mental Hygiene Law or Surro-

The health care agent named in the health care proxy
can consent to medical orders relating to life-sustaining treatment. If the patient’s wishes are reasonably known, the health care agent must make decisions in accordance with those wishes. When there is evidence of the patient’s wishes, the health care agent should still be asked to consent to the medical orders and given the opportunity to provide additional evidence of the patient’s wishes. So
long as the health care agent represents that he or she is acting in accordance with the patient’s wishes, the health care provider should generally follow the decisions of the health care agent, unless a court has determined otherwise
under PHL section 2991.

Under current law, if the principal’s wishes regarding the administration of artificial nutrition and hydration are not reasonably known and cannot with reasonable
degree be ascertained, the health care agent does not have
authority to make decisions regarding these measures. Health care providers must assume that patients’ wishes
regarding the administration of artificial nutrition and hydration are reasonably known when health care prac-
tices state that the patients have discussed their wishes with their health care agents and know their wishes
about artificial nutrition and hydration. Even if the pa-
tient’s wishes regarding artificial nutrition and hydration
are not known, the person named as health care agent may
still have authority to make the patient’s wishes and be
ingsh

Health care agents can consent to decisions to with-
hold or withdraw life-sustaining treatment if the decision
is made by the patient and the decision is consistent with
the patient’s wishes, if known, or in the patient’s best interests,
and two physicians determine that “treatment ‘serves the patient no medical benefit because the patient will die imminently, even if the treatment is provided,’” and “the provision of life-sustaining treatment would violate accepted medical standards.” Before FHCA,
a general hospital or nursing home could issue a DNR
order for a patient for whom no surrogate was available if
the physician was “medically futile,” a term that does not
appear in FHCA. Although the law now does not use different
terms, there was still a difference in this fourth category
where a DNR order legally could have been issued before
FHCA but could not be issued under FHCA.

5. Adult Patients Outside of a General Hospital or
Nursing Home Without Medical Decision-Making Capacity Who Do Not Have a Health Care Proxy

Non-hospital DNR and DNI orders are now governed
by the new PHL Article 29-CCC, which is derived from
former PHL section 2977. One difference between PHL
Article 29-CCC and former PHL section 2977 is that now
hospitals and nursing homes have to determine whether any of a patient’s conditions can be considered “irreversible or incurable.” Presumably,
this term was not intended to include conditions that are
literally irreversible and incurable, but are in no way
dependent on death. On the other hand, consider the patient who is over 100 years old and has lost medical decision-making
capacity, but has no “irreversible or incurable” condition
(other than the frailty that naturally accompanies old age).
The application of the law to this patient is not entirely
clear.

Although the law defines CPR as a type of life-sust-
ing treatment, it distinguishes between DNR and other
orders to withhold or withdraw life-sustaining treat-
ment, with a significant difference between
dNR orders and other orders to withhold or
withdraw life-sustaining treatment in FHCA is that
the ethics committee review is not automatically required to issue a DNR order. The standard is that the treatment is not
"in the patient’s best interests and incurable condition" standard, whereas ethics review
committee approval is required in a nursing home to issue
other orders to withhold or withdraw life-sustaining treat-
ment under that standard.

4. Adult General Hospital or Nursing Home Patients
Patients Without Medical Decision-Making Capacity Who Do Not Have a Health Care Proxy, and for Whom No Surrogate or FHCA Substitute Decision Maker Is Available

In limited cases, facilities may withhold or withdraw
life-sustaining treatment from patients who lack medical
decision-making capacity, have no health care agent, and
for whom no surrogate is available. In these cases, treat-
ment is being withheld or withdrawn without consent. A
court of competent jurisdiction may make this decision.
Alternatively, FHCA provides that the facility may withhold
or withdraw life-sustaining treatment if the decision is
consistent with the patient’s wishes, if known, or in the
patient’s best interests, and two physicians determine that
treatment “serves the patient no medical benefit because
the patient will die imminently, even if the treatment is
provided,” and “the provision of life-sustaining treatment
would violate accepted medical standards.” Before FHCA,
a general hospital or nursing home could issue a DNR
order for a patient for whom no surrogate was available if
the physician was "medically futile," a term that does not
appear in FHCA. Although the law now uses different
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6. Minor Patients

FHDO defines a minor as an unmarried individual under eighteen years of age. In general, a parent or legal guardian may consent to medical services for a minor. Under PHL section 2504 and common law, parents can consent to medical orders issued by a physician that withdraw or withdraw life-sustaining treatment from their children, if it is determined that a child’s decision to withdraw or withdraw life-sustaining treatment from a terminally ill child could be construed as neglect under the Family Court Act. However, in cases involving terminally ill children and burdensome medical interventions, courts have considered parental consent to a physician’s order to withdraw or withdraw life-sustaining treatment, while providing palliative care to optimize the child’s quality of life, a reasonable decision, not an abandonment or medical neglect of the child. Indeed, the New York State Legislature has recently affirmed the legitimacy of palliative care in appropriate circumstances.

FHDO provides specific procedures that must be followed when a parent or guardian of a minor makes decisions about life-sustaining treatment in a general hospital or nursing home. Most of the provisions for a health care decision for an adult patient by a surrogate also apply to a decision by a parent or a child who lacks capacity, except that the decision only takes into account the child’s wishes as appropriate under the circumstances. The attending physician and the parent or a minor patient can discuss the medical treatment acuity, and if so, the minor must consent to the decision. Only one parent’s consent is required, but health care providers must make diligent efforts to notify a second parent who has maintained a different relationship with the minor. The second parent so notified has an opportunity to object to the decision before it is implemented.

FHDO does not address parental consent to the withholding or withdrawal of life-sustaining treatment outside the hospital or the nursing home setting. However, the common law provides some guidance. Before the enactment of FHDO, in Matter of AB, the court held that the most relevant statute should govern decisions by parents to withdraw or withdraw life-sustaining treatment from minor children. Accordingly, the court applied the standards in section 1750-b of the Surrogate’s Court Procedure Act, which governs surrogate decision making for persons with developmental disabilities. Now that FHDO provides a statutory framework for decisions made by parents for children in general hospitals and nursing homes, that framework should be applied to similar decisions on behalf of children in the community. Just as Matter of AB used the standards in SCPA section 1750-b, the most relevant statute in effect at that time, decisions by parents or legal guardians of minors in the community to withdraw or withdraw life-sustaining treatment should incorporate the FHDO procedures and standards. Thus, physicians should follow FHDO and not override the surrogate decision to withdraw or withdraw life-sustaining treatment from children in the community under circumstances in which those orders would be permitted in nursing homes or hospitals.

Since the standards for nursing homes are the most stringent (specifically regarding the need for ethics committee review when decisions other than DNR are made for a patient who is neither terminally ill nor permanently unconscious), those standards should be used in the community as well. Note that in cases where ethics review committee review is needed in the community, the physician will have to find an ethics review committee willing to review the case even though the patient is neither a hospital inpatient nor a nursing home resident. In these cases, the physician would presumably have privileges at a local hospital, and that hospital’s ethics review committee may be willing to review the case.

FHDO also gives an “emancipated minor” authority to decide about life-sustaining treatment in a general hospital or nursing home. An emancipated minor is a minor who is the parent of a child or is age 16 or older and living independently. Emancipated minors are other instances in which a minor may consent to health care without a parent’s permission or knowledge, neither FHDO nor any other New York statute gives minors living independently general authority to make health care decisions for themselves. Also, it should be noted that FHDO does not allow surrogates on the surrogate list to make decisions for emancipated minors with lack of capacity; it only provides for health care decisions for emancipated minors by surrogate. Under FHDO, however, a person under 18 years old who is married is an “adult.”

7. Patients with a Developmental Disability Who Lack Decision-Making Capacity and Who Do Not Have a Health Care Proxy

FHDO does not apply to decision making for patients with developmental disabilities who lack medical decision-making capacity. Surrogate decision making for patients with developmental disabilities who lack capacity is governed by the Surrogate’s Court Procedure Act (SCPA). Decisions to withhold or withdraw life-sustaining treatment may be made by surrogates as provided in SCPA section 1750-b and 14 NYCRR section 633.10. Decisions by surrogates pursuant to the SCPA may be recorded in the MOLST form. To assure compliance with this process, OPWDD requires that a special checklist be attached to the MOLST form.

8. Patients in a Psychiatric Unit of a General Hospital or a Psychiatric Institution Licensed by OMH Without Decision-Making Capacity Who Do Not Have a Health Care Proxy

FHDO applies to patients with mental illness in a “general hospital,” as defined by FHDO. FHDO, however, does not apply to decision making for patients in a psychiatric unit of a general hospital or a general hospital operated for the purpose of providing services for persons with mental illness pursuant to an operating certificate issued by OMH or a “hospital” as defined in Mental Hygiene Law section 1.03(10). DNR orders for such patients are still governed by the provisions of PHL Article 29-B. In compliance with Article 29-B and any other applicable laws, MOLST may be used for patients with mental illness in any setting.

Legal Requirements Checklists

As described above, decision-making standards and procedures for decisions to withhold or withdraw life-sustaining treatment vary depending on who makes the decision and where the decision is made. Accordingly, DOH has developed checklists that summarize these requirements in six different scenarios, along with general instructions and alerts. MOLST Checklist 1 through 5 set forth the appropriate process for the capacity determination, depending on whether a health care agent or an FHDO surrogate is the decision-maker. And, they direct the physician to notify the patient of the determination of incapacity if there is any indication that the patient is able to comprehend the determination. All summarize the statutory standards for medical decision-making capacity and informed consent to life-sustaining treatment orders. And, all of the checklists remind providers of the writs requirements and the need to notify the director of the patient’s convoluntary facility or mental hygiene facility and Mental Hygiene Legal Services, where applicable.

The DOH checklists also specify the unique requirements applicable to specific decision-makers and settings. For example, Checklist 2 (for adults with a health care proxy) alerts the provider to the two-physician capacity determination process for decisions by health care agents. It also points out the limits on the health care agent’s ability to consent to withdrawal of artificial nutrition or hydration. Checklist 3 includes both the patient-centered standards and clinical standards that must be met under FHDO to justify the withholding or withdrawal of life-sustaining treatment when a surrogate makes that decision. Checklist 5 also points out the required ethics committee determination for decisions to withhold or withdraw withdrawal of life-sustaining treatment when a patient lacks capacity and has neither a health care agent nor an FHDO surrogate: (i) a court proceeding; or (ii) a determination by two physicians that treatment offers the patient no medical benefit because it involves the painful or irreversible or incurable condition standard. Checklist 4 sets forth the two alternative processes for decisions to withhold or withdraw life-sustaining treatment by a patient who lacks capacity and has neither a health care agent nor an FHDO surrogate: (i) a court proceeding; or (ii) a determination by two physicians that treatment offers the patient no medical benefit because it involves the painful or irreversible or incurable condition standard.

Although the DOH checklists enumerate the process in detail the complex requirements for adults in the community who lack capacity and do not have a health care proxy. Checklist 5 makes clear that the authority of the FHDO surrogate in the community is limited to DNR/DNI decisions. It also indicates that decisions concerning other life-sustaining treatment may be made based on clear and convincing evidence of the patient’s wishes. “Clear and convincing evidence” is defined in the glossary accompanying the general instructions.

Finally, the DOH checklist for minor patients applies to patients under age 18 who are not married. However,
6. Minor Patients

FHICDA defines a minor as an unmarried individual under eighteen years of age. In general, a parent or legal guardian may consent to medical services for a minor. Under FHICDA, section 2504 and common law, parents can consent to medical orders issued by a physician who with- hold or withdraw life-sustaining treatment from their chil- dren. The court ordered that the decision to withhold or withdraw life-sustaining treatment from a terminally ill child could be construed as neglect under the Family Court Act. However, in cases involving terminally ill children and burdensome medical interventions, courts have considered parental consent to a physician’s order to withhold or withdraw life-sustaining treatment, while providing palliative care to optimize the patient’s quality of life, a reasonable decision, not an abandonment or medical neglect of the child. Indeed, the New York State Legisla- ture has recently affirmed the legitimacy of palliative care in appropriate circumstances.

FHICDA provides specific procedures that must be followed when a parent or guardian of a minor makes de- cisions about life-sustaining treatment in a general hospital or nursing home. Most of the provisions for a health care decision for an adult patient or a surrogate also apply to a decision by a parent or a child who lacks capacity, except that the decision only takes into account the child’s wishes as appropriate under the circumstances. The attending physician and the minor’s parent must act in the minor’s best interests, and if so, the minor must consent to the decision. Only the minor’s consent is required, but health care providers must make diligent efforts to notify a second parent who has maintained sufficient relationship with the minor. The second parent so notified has an opportunity to object to the decision before it is implemented.

FHICDA does not address parent consent to the withholding or withdrawing of life-sustaining treatment outside of the hospital or nursing home setting. However, the common law provides some guidance. Before the enactment of FHICDA, in Matter of AB, the court held that the most relevant statute should govern decisions by parents to withdraw or withhold life-sustaining treatment from minor children. Accordingly, the court applied the standards in section 1750-b of the Surrogate’s Court Pro- cedure Act, which governs surrogate decision making for persons with developmental disabilities. Now that FHICDA provides a statutory framework for decisions made by parents for children in general hospitals and nursing homes, that framework should be applied to the adult decisions on behalf of children in the community. Just as Matter of AB used the standards in SCPA section 1750-b, the most relevant statute in effect at that time, decisions

by parents or legal guardians of minors in the community to withhold or withdraw life-sustaining treatment should incorporate the FHICDA procedures and standards. Thus, physicians should consider the patient’s condition to withdraw or with- draw life-sustaining treatment from children in the commu- nity under circumstances in which those orders would be permitted in nursing homes or hospitals.

Since the standards for nursing homes are the most stringent (specifying the need for ethics com- mittee review when decisions other than DNR are made for a patient who is neither terminally ill nor permanently unconscious), those standards should be used in the community as well. Note that in cases where ethics review committee review is needed in the community, the physi- cian will have to find an ethics review committee willing to review the case even though the patient is not a hospital inpatient nor a nursing home resident. In these cases, the physician would presumably have privileges at a local hospital, and that hospital’s ethics review committee may be willing to review the case.

FHICDA also gives an “emancipated minor” authority to decide about life-sustaining treatment in a general hospital or nursing home. An emancipated minor is a minor who is the parent of a child or is age 16 or older and living independently. There are other instances in which a minor may consent to health care without a parent’s permission or knowledge, neither FHICDA nor any other New York statute gives minors living indepen- dently general authority to make health care decisions for themselves. Also, it should be noted that FHICDA does not allow surrogates on the surrogate list to make decisions for emancipated minors with lack of capacity; it only provides for health care decisions for emancipated minors by surrogate. Under FHICDA, however, a person under 18 years old who is married is an “adult.”

7. Patients with a Developmental Disability Who Lack Decision-Making Capacity and Who Do Not Have Health Care Proxy

FHICDA does not apply to decision making for patients with developmental disabilities who lack medical decision-making capacity. Surrogate decision making for patients with developmental disabilities who lack capacity is governed by the Surrogate’s Court Procedure Act (SCPA). Decisions to withhold or withdraw life-sustaining treat- ment may be made by surrogates as provided in SCPA section 1750-b and 14 NYCRR section 653.10. Decisions by surrogates pursuant to the SCPA may be recorded in the MOLST form. To assure compliance with this process, OPWDD requires that a special checklist be attached to the MOLST form.

8. Patients in a Psychiatric Unit of a General Hospital Without Decision-Making Capacity Who Do Not Have a Health Care Proxy

FHICDA applies to patients with mental illness in a “general hospital,” as defined by FHICDA. FHICDA, however, does not apply to decision making for patients in a psychiatric unit of a general hospital. Therefore, the hospital must operate for the purpose of providing services for persons with mental illness pursuant to an operating certificate issued by OMH or a “hospital” as defined in Mental Hygiene Law section 1.03(10). DNR orders for such patients are still governed by the provisions of PHL Article 29-A. In compliance with Article 29-A and any other applicable laws, MOLST may be used for patients with mental illness in any setting.

Legal Requirements Checklists

As described above, decision-making standards and procedures for decisions to withhold or withdraw life- sustaining treatment vary depending on who makes the decision and where the decision is made. Accordingly, DOH has developed checklists that summarize these requirements in six different scenarios, along with general instructions and a reference to the relevant section of the CRP.

- MOLST Checklist 1—Adult with capacity (any setting)
- MOLST Checklist 2—Adult with health care proxy (any setting)
- MOLST Checklist 3—Adult with FHICDA surrogate (hospital and nursing home)
- MOLST Checklist 4—Adult without FHICDA sur- rogate (hospital or nursing home)
- MOLST Checklist 5—Adult without capacity in the community
- MOLST Checklist for Minor Patients and Glossary (any setting)

These checklists are not mandatory; they are intended as a tool for health care providers as complying with the complex laws governing decisions concerning life- sustaining treatment when completing MOLST forms.

In addition, OPWDD has developed a checklist for people with developmental disabilities who lack medical decision-making capacity and do not have a health care proxy. This checklist is mandatory and must be attached to the MOLST form. The use of this checklist assures that any medical decisions involving the withholding or withdrawing of life-sustaining treatment from individuals with developmental disabilities comply with the process set forth in the Surrogate’s Court Procedure Act.

The DOH checklists for adults share a number of common elements. For example, they remind providers to ask patients about executing a health care proxy, if the patient has not done so. The proxy may also set forth one DOH. Checklists 2 through 5 set forth the appropriate process for the capacity determination, depending on whether a health care agent or an FHICDA surrogate is the decision-maker. And, they direct the physician to notify the patient of the determination of incapacity if there is any indication that the patient is able to comprehend the determination. All summarize the standards for medical decision-making capacity and informed consent to life-sustaining treatment orders. And, all of the checklists remind providers of the witnesses requirements and the need to notify the director of the patient’s convalescent facility or mental hygiene facility and Mental Hygiene Legal Services, where applicable.

The DOH checklists also specify the unique requirements applicable to specific decision-makers and settings. For example, Checklist 2 (for adults with a health care proxy) alerts the provider to the two-physician capacity determination process for decisions by health care agents. It also points out the limits on the health care agent’s ability to consent to withdrawal of artificial hydration or nutrition. Checklist 3 includes both the patient-centered standards and clinical standards that must be met under FHICDA to justify the withholding or withdrawal of life-sustaining treatment when a sur- rogate makes that decision. Checklist 5 also points out the required ethics committee determination for decisions to withdraw or withhold life-sustaining treatment from a patient who lacks capacity and has neither a health care agent nor an FHICDA surrogate: (i) a court proceeding; or (ii) a determination by two physicians that treatment offers the patient no medical benefit because of the patient’s condition, even if the treatment is provided, and the provision of life-sustaining treatment would violate accepted medical standards.

DOH Checklist 5 delineates in detail the complex requirements for adults in the community who lack capacity and do not have a proxy. Check List 5 makes clear that the authority of the FHICDA surrogate in the community is limited to DNR/MDN decisions. It also indicates that decisions concerning other life-sustaining treatment may be made based on clear and convincing evidence of the patient’s wishes. “Clear and convincing evidence” is defined in the glossary accompanying the general instructions.

Finally, the DOH checklist for minor patients applies to patients under age 18 who are not married. However,
it also notes that special considerations and requirements apply to decisions concerning life-sustaining treatment for emancipated minors. The checklist does not go into detail about the various considerations that apply to life-sustaining treatment by or concerning emanci- pated minors. Instead, it directs physicians to consult with counsel regarding such matters. As discussed above, the checklist for minor patients imports into the community setting the HFICDA requirements for withholding or withdrawing life-sustaining treatment, other than DNR, in a nursing home. It requires physicians committee review for such decisions, if the patient is neither terminally ill nor permanently unconscious. The checklist sets forth the requirements to assess the minor's capacity and secure his or her consent, if he or she has capacity. It also describes the requirements concerning notification and participation of a non-consenting parent.

It is undoubtedly challenging for busy health care providers to juggle all of these different checklists with disparate requirements. However, the checklists merely reflect the complexity of the law. And, that complexity is largely driven by a desire to protect the rights of vulnerable patients—a paramount consideration in our society. Clearly, health care providers should appreciate and consider the legal and ethical implications when issuing an order to "allow natural death."

Conclusion
MOLST and HFICDA together provide an opportunity to honor the wishes of patients and to improve the quality of end-of-life care. Widespread completion of health care proxies and MOLST forms by patients with capacity will reduce the need for decision making by HFICDA surrogates for patients approaching the end of life and will provide guidance for surrogates when needed. MOLST empowers patients in two ways. It provides a structured framework for discussions between clinicians and patients and their families about end-of-life options, so that patients have the information they need to make informed decisions. And, it provides a vehicle for patients to make clear their wishes concerning life-sustaining treatment. MOLST enables patients to communicate across care settings their desire to receive life sustaining treatment. It also makes it possible to have a nurse to spend his or her last days comfortably at home, instead of in a hospital receiving futile and invasive interventions.

Endnotes
1. See 42 U.C.S. §§ 1305(c), 1306(e).
3. According to a 1999 Harvard Public Opinion Poll, 71 percent of Americans would prefer to die at home. A 2002 Harris Interactive Poll found that 95 percent of Americans believe that people who have a terminal illness "generally should be allowed by law to end their own life if they wish to do so." (Netherlands, France, and Canada have similar laws.)
8. See PHL § 294-c(6).
9. See PHL § 294-c(8).
10. See PHL § 294-c(8).
11. See PHL § 294-c(8).
12. See PHL § 294-c(8).
13. See PHL § 294-c(8).
14. See PHL § 294-c(8).
15. See PHL § 294-c(8).
16. See PHL § 294-c(8).
17. The current version of the MOLST is available online at: http://www.molst.org/aboutmolst/aboutmolst.html.
18. Implementation of the Family Health Care Decisions Act
it also notes that special considerations and requirements apply to decisions concerning life-sustaining treatment for emancipated minors. The checklist does not go into detail about the various considerations that apply to life-sustaining treatment decisions by or concerning emancipated minors. Instead, it directs physicians to consult with counsel regarding such decisions. As discussed above, the checklist for minor patients imports into the community setting the FICHDCA requirements for withholding or withdrawing life-sustaining treatment, rather than in a nursing home. It requires a committee review for such decisions, if the patient is neither terminally ill nor permanently unconscious. The checklist sets forth the requirements to assess the minor’s capacity and secure his or her consent, if he or she has capacity. It also describes the requirements concerning notification and participation of a non-consenting parent.

It is undoubtedly challenging for busy health care providers to juggle all of these different checklists with disparate requirements. However, the checklists merely reflect the complexity of the law. And, that complexity is largely driven by a desire to protect the rights of vulnerable patients—a paramount consideration in our society. Clearly, health care providers should appreciate and consider the legal and ethical implications when issuing an order to “allow natural death.”

Conclusion
MOLST and FICHDCA together provide an opportunity to honor the wishes of patients and to improve the quality of end-of-life care. Widespread completion of health care proxies and MOLST forms by patients with capacity will reduce the need for decision-making by FICHDCA surrogates for patients approaching the end of life and will provide guidance for surrogates when needed. MOLST empowers patients in two ways. It provides a structured framework for discussions between clinicians and patients and their families about end-of-life options, so that patients have the information they need to make informed decisions. And, it provides a vehicle for patients to make clear their wishes concerning life-sustaining treatment. MOLST enables patients to communicate across care settings their desires to receive life-sustaining treatment. It also makes it possible for a hospital to spend his or her last days comfortably at home, instead of in a hospital receiving futile and invasive interventions.

Endnotes
3. See 42 U.S.C. §§ 1395c(f), 1396w.
5. According to a 1999 Harvard Public Opinion Poll, 71 percent of Americans would prefer to die at home. A 2002 Harris Interactive Poll found that 85 percent of Americans believe that people who have a terminal illness should have the right to end-of-life care at home. Both surveys are available at http://www.poll360.COM/Pages/1999-Harvard-Public- Opinion-About-Life-Dying-COH.html.
9. Id. at 28.
10. L. of 2010, ch. 8 § 2.
12. Id. at 28.
15. As discussed more fully below, if the patient lacks decision-making capacity, an appropriate FICHDCA surrogate can provide consent to MOLST orders, based on specified standards, on behalf of a patient who is deemed incompetent. In the community, surrogates may consent only to DNR and DNI orders.
17. See PHIL § 2994-4(f) (orders pertaining to a patient admitted to a mental hygiene facility are governed by Article 29-b).
18. PHIL §§ 2994-4(a) and 2994-4(f).
19. PHIL § 2994-9(c).
20. PHIL § 2994-9(d), (e).
21. PHIL § 2994-9(c).
22. PHIL § 2994-9(d).
23. PHIL § 2994-9(e).
24. PHIL § 2994-9(f).
25. PHIL § 2994-10(c).
27. See 2010, ch. 331, adding PHIL § 2997-c.
28. PHIL §§ 2994-a(2), 2994-a(c).
29. See PHIL §§ 2994-1(a), 2994-1(m).
30. See PHIL §§ 2994-2(c), 2994-2(m).
31. See PHIL § 2994-1(a), 2994-1(m).
32. PHIL §§ 2994-2(c), 2994-2(m).
33. Former PHIL § 2994(c) was repealed by 1L. 2010, ch. 8 § 20.
34. See PHIL §§ 2994(5)(c), 2994(5)(d).
35. PHIL §§ 2994-1(c), 2994-1(c).
37. PHIL § 2994-4(a).
38. PHIL § 2994-4(b).
39. PHIL § 2994-4(c).
40. PHIL § 2994-4(d).
41. PHIL § 2994-4(e).
42. Matter of by Her Mother, CO, 196 Misc.2d 491, 591 F.P.S. Pursuant to Matter of Hayman and Public Health Law § 2994-2(c), CD is authorized to make this choice for her daughter”). Unlike former PHIL section 2997-c, PHIL section 2994-1 contains no specific provisions regarding consent by a person to a nonterminal DNR order for a minor child. There is nothing, however, in the legislative history of L. 2010, ch. 8, to suggest any intent to take away the ability of the parent or legal guardian of a minor to consent to a nonterminal DNR order.
43. See Matter of Hayman, 67 NY2d 548, 496.
44. See 2010, ch. 331, adding PHIL § 2997-c.
45. PHIL §§ 2994-2(a), 2994-2(m).
46. PHIL §§ 2994-2(a), 2994-2(m).
47. PHIL §§ 2994-2(a), 2994-2(m).
48. PHIL § 2994-4(e).
49. PHIL § 2994-4(f).
50. Memo from Eileen Zelbst to DEO Directors, Volunteer Provider Agency Board, Director of Medical Control, MOLST (January 21, 2011), http://www.concertoncarestate.org/health/hp_MOLST.
51. PHIL §§ 2994-1(b), 2994-1(c).
53. The checklists are available on the DOH website: http://www.nyshealth.gov/professionals/patients/patient_rights_med/.
54. The OPWDD checklist is available at: http://www.concertoncarestate.org/health/hp_MOLST.
55. “Clear and convincing evidence” is evidence that the patient held a firm and settled commitment to the withholding of life-sustaining treatment in the event of circumstances like the patient’s current medical condition. The evidence may be in a written Will or, previous oral statements indicating the patient’s wishes, considering the circumstances under which such statements were made and to whom. In order to decide whether the evidence of the patient’s wishes is clear and convincing, consideration should be given to: whether the statements were general or specific; whether the statements were made prior to circumstances (for example, terminal illness, persistent vegetative state) that are similar to the patient’s current medical condition; the frequency, consistency, and seriousness of such statements; whether the statements tend to show that the patient held a firm and settled commitment to certain treatment decisions under circumstances like their own, the strength and durability of the patient’s religious and moral beliefs make a more recent change less likely unselfishly; and whether the statements were made to one person only or to more than one person close to the patient.

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