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MENTAL HYGIENE LAW, ARTICLE 81
GUARDIANSHIP AND THE FAMILY HEALTH CARE DECISIONS ACT

I. The Guardianship Statute

In 1983, the New York State legislature enacted Article 81 of the Mental Hygiene Law to replace Articles 77 and 78, the conservator and committee laws that had been in place to deal with persons who were unable to care for themselves.

Article 81 created a proceeding for the appointment of a Guardian for Personal Needs and Property Management. Guardianship is a remedy of last resort. Compared with its predecessor statutes, Article 81 is an enlightened approach to meeting the needs of incapacitated persons. There are built in due process and accountability safeguards and the law was designed to be flexible and to permit the Court to tailor the outcome to meet the needs of the individual without having to resort to a "one size fits all" approach.

Article 81 relies on a functional determination of incapacity, and the person for whom a guardian is ultimately appointed is declared an "Incapacitated Person" rather than an "Incompetent" person. The law lays out a detailed procedure designed to protect the rights of the individual for whom a guardian is sought by requiring that the Court make a determination that the appointment of a guardian is, in fact, the least restrictive form of intervention required to keep the person safe. Further, the law permits the appointment of a Guardian for personal needs or property management, or both, and requires that the powers awarded to the Guardian be narrowly tailored to protect the individual without giving the Guardian more powers than are necessary. Since the powers vary from case to case, it is very important that the Guardian and anyone assisting the Guardian, read the Order carefully to make sure that the Guardian exercises only those powers that have been granted by the Court.

The law states that the Court shall appoint a Court Evaluator at the time of the issuance of the order to show cause. The Court Evaluator is tasked with serving as the eyes and ears of the Court to investigate the allegations of incapacity and protect the rights of the individual during the proceeding. The Court Evaluator prepares a report and presents his/her findings at the hearing. The law also provides for the appointment of Counsel for the alleged incapacitated person if the person so wishes.

The law requires that a hearing be held at which the subject of the proceeding is entitled to appointed counsel. Petitioner must prove, by clear and convincing evidence, that the alleged incapacitated person is incapacitated and in need of a guardian. Proof must be offered that the person is likely to suffer harm because s/he is unable to provide for his/her personal needs and/or property management and "cannot adequately understand and appreciate the nature and consequences of such inability." (MHL §81.02(b)).

II. What Triggers the Need for a Guardian

When a person does not have advance directives, or when those directives are not viable for one reason or another, it may be necessary to bring a Guardianship proceeding. Oftentimes, the need for a guardian is triggered by the need to sell or transfer the property of person who never executed a power of attorney. For example, a "well" individual may seek to do Medicaid planning after his/her spouse has developed advanced dementia and can no longer sign a contract or execute a power of attorney. In such cases, a Guardianship proceeding will be necessary if assets need to be transferred or a house needs to be sold.

Sometimes the need is triggered by disagreements among children, or between a spouse and the children of the individual, over what the person needs and how best to care for him or her. Sometimes there are advance directives in place but other friends or family members are concerned that the designated agents are taking advantage of the individual or are not providing appropriate care.

Sometimes the need for a Guardian is triggered because the person does not understand or accept the fact that s/he needs assistance. S/he may be the victim of a scam artist or be refusing to move out of a house that poses an immediate danger to the person because of his or her incapacity.

The reasons are myriad. Having proper advance directives that name appropriate reliable agents can often, though not always, mitigate the need for a Guardianship proceeding.

III. The Guardian and End of Life Decision Making

Prior to 2010, Article 81 listed, amount the powers that a Court might grant to a Guardian for personal needs, the power to:

> consent to or refuse generally accepted routine or major medical or dental treatment; the guardian shall make treatment decisions consistent with the findings under section 81.15 of this article and in accordance with the

patient's wishes, including the patient's religious and moral beliefs, or if the patient's wishes are not known and cannot be ascertained with reasonable diligence, in accordance with the person's best interests, including a consideration of the dignity and uniqueness of every person, the possibility and extent of preserving the person's life, the preservation, improvement or restoration of the person's health or functioning, the relief of the person's suffering, the adverse side effects associated with the treatment, any less intrusive alternative treatments, and such other concerns and values as a reasonable person in the incapacitated person's circumstances would wish to consider. (MHL, section 81.22(a)(8)) (prior to the 2010 changes)

The statute also provided that:

> Nothing in this article shall be construed either to prohibit a court from granting, or to authorize a court to grant, to any person the power to give consent for the withholding or withdrawal of life sustaining treatment, including artificial nutrition and hydration. When used in this article, life sustaining treatment means medical treatment which is sustaining life functions and without which, according to reasonable medical judgment, that patient will die within a relatively short time period. (MHL, section 81.29(e)) (prior to the 2010 changes)

IV. The 2010 Family Health Care Decisions Act, Public Health Law, Article 29-CC changes to the Article 81 Guardianship Statute

The Family Health Care Decisions Act ("FHCDA") was enacted in 2010 to provide a mechanism that enables health care decision making for persons who lost capacity to make their own decisions but have not appointed a health care agent pursuant to Public Health Law §2981, the Health Care Proxy Statute. Unfortunately, it currently only applies to persons in general hospitals (as opposed to psychiatric hospitals), nursing homes, and those enrolled in hospice.

The FHCDA provides a list of the individuals, in descending order, who may serve as a surrogate to make medical decisions for the patient who has lost capacity. At the very top of the list is an Article 81 guardian "authorized to decide about health care". In an effort to coordinate the FHCDA with Article 81, the legislature changed sections 81.22 and 81.29 of the MHL.

The legislature eliminated subsection (e) from Section 81.29 (see above) and altered Section 81.22, subsection 8 to read as follows:

8. (i) for decisions in hospitals as defined by subdivision eighteen of section

twenty-nine hundred ninety-four-a of the public health law, act as the patient's surrogate pursuant to and subject to article twenty-nine-CC of the public health law, and (ii) in all other circumstances, to consent to or refuse generally accepted routine or major medical or dental treatment, subject to the decision-making standard in subdivision four of section twenty-nine hundred ninety-four-d of the public health law;

PHL §2994-d(4) fairly tracks the language that had existed in MHL §81.22(a)(8):

Decision-making standards.
(a) The surrogate shall make health care decisions:
(i) in accordance with the patient's wishes, including the patient's religious and moral beliefs; or
(ii) if the patient's wishes are not reasonably known and cannot with reasonable diligence be ascertained, in accordance with the patient's best interests. An assessment of the patient's best interests shall include: consideration of the dignity and uniqueness of every person; the possibility and extent of preserving the patient's life; the preservation, improvement or restoration of the patient's health or functioning; the relief of the patient's suffering; and any medical condition and such other concerns and values as a reasonable person in the patient's circumstances would wish to consider.
(b) In all cases, the surrogate's assessment of the patient's wishes and best interests shall be patient-centered; health care decisions shall be made on an individualized basis for each patient, and shall be consistent with the values of the patient, including the patient's religious and moral beliefs, to the extent reasonably possible.

With regard to end of life decision making, PHL § 2994-d (5) of the FHCDA is very explicit about how, and under what circumstances, a surrogate may make a decision to withhold or withdraw life sustaining treatment:

5. Decisions to withhold or withdraw life-sustaining treatment. In addition to the standards set forth in subdivision four of this section, decisions by surrogates to withhold or withdraw life-sustaining treatment (including decisions to accept a hospice plan of care that provides for the withdrawal or withholding of life-sustaining treatment) shall be authorized only if the following conditions are satisfied, as applicable:

(a)(i) Treatment would be an extraordinary burden to the patient and

an attending physician determines, with the independent concurrence of another physician, that, to a reasonable degree of medical certainty and in accord with accepted medical standards, (A) the patient has an illness or injury which can be expected to cause death within six months, whether or not treatment is provided; or (B) the patient is permanently unconscious; or

(ii) The provision of treatment would involve such pain, suffering or other burden that it would reasonably be deemed inhumane or extraordinarily burdensome under the circumstances and the patient has an irreversible or incurable condition, as determined by an attending physician with the independent concurrence of another physician to a reasonable degree of medical certainty and in accord with accepted medical standards.

(b) In a residential health care facility, a surrogate shall have the authority to refuse life-sustaining treatment under subparagraph (ii) of paragraph (a) of this subdivision only if the ethics review committee, including at least one physician who is not directly responsible for the patient's care, or a court of competent jurisdiction, reviews the decision and determines that it meets the standards set forth in this article. This requirement shall not apply to a decision to withhold cardiopulmonary resuscitation.

(c) In a general hospital, if the attending physician objects to a surrogate's decision, under subparagraph (ii) of paragraph (a) of this subdivision, to withdraw or withhold nutrition and hydration provided by means of medical treatment, the decision shall not be implemented until the ethics review committee, including at least one physician who is not directly responsible for the patient's care, or a court of competent jurisdiction, reviews the decision and determines that it meets the standards set forth in this subdivision and subdivision four of this section.

(d) Providing nutrition and hydration orally, without reliance on medical treatment, is not health care under this article and is not subject to this article.

Under the old law Judges sitting in the Guardianship Parts were told that they were neither prohibited from, nor authorized to, grant a guardian the power to withhold or withdraw life sustaining treatment for their ward (§81.29(e)). Now they are told, clearly, that an Article 81 Guardian with health care decision making powers is the first in line to

be a surrogate who has the power to make decisions pursuant to PHL 2994-d, including decisions to withhold or withdraw life sustaining treatment in hospitals in conjunction with two physicians and under very circumscribed conditions and in nursing homes, with the input of the ethics review committee.

But the Judges, at least here in Nassau County, are not comfortable with delegating the power to make decisions to withhold or withdraw life sustaining treatment absent clear and convincing evidence of the incapacitated person's wishes. As of now, it appears that the Judges in Nassau County want a guardian to come back to Court to get permission to make decisions to withhold or withdraw life sustaining treatment uUnless there was clear and convincing evidence of the incapacitated person's wishes, such as a health care proxy or living will, presented at the hearing. One of the Nassau County Judges puts the following decision on the record when appointing a Guardian for personal needs if there were no health care advance directives presented:

> The Guardian shall have the right to consent to or refuse generally accepted routine or major medical or dental treatment in accordance with MHL 81.22(a)(8). The incapacitated person's wishes are not known. Relative to any other healthcare type of treatment, there is no evidence of his/her wishes or desires. There is no healthcare proxy or living will, as far as the Court is aware of so, consequently, the guardian shall have no authority to consent to the withholding or withdrawing of life sustaining treatment or to the implementation of either a Do-Not-Resuscitate or Do-Not-Intubate order without further order of the Court.

Thus, as indicated above, it is very important that the Guardian, and anyone assisting the Guardian, read the Order carefully to make sure that the Guardian knows and understands the powers that have been granted.

Practice Tip

If you are involved in a Guardianship proceeding and the alleged incapacitated person has made his/her wishes known with regard to the withholding or withdrawing of life sustaining treatment, whether in a Health Care Proxy form, a Living Will, or even in conversations with family members, it is very important that the evidence thereof be presented at the Hearing and that the Judge be encouraged to incorporate same into the Order to the extent of permitting the Guardian to make such decisions on behalf of the incapacitated person, in accordance with said person's wishes.

Effective:[See Text Amendments]

McKinney's Consolidated Laws of New York Annotated Currentness
Mental Hygiene Law (Refs & Annos)
Chapter 27. Of the Consolidated Laws (Refs & Annos)
Title E. General Provisions (Refs & Annos)
Article 81. Proceedings for Appointment of a Guardian for Personal Needs or Property Management (Refs & Annos)

→→ § 81.01 Legislative findings and purpose

The legislature hereby finds that the needs of persons with incapacities are as diverse and complex as they are unique to the individual. The current system of conservatorship and committee does not provide the necessary flexibility to meet these needs. Conservatorship which traditionally compromises a person's rights only with respect to property frequently is insufficient to provide necessary relief. On the other hand, a committee, with its judicial finding of incompetence and the accompanying stigma and loss of civil rights, traditionally involves a deprivation that is often excessive and unnecessary. Moreover, certain persons require some form of assistance in meeting their personal and property management needs but do not require either of these drastic remedies. The legislature finds that it is desirable for and beneficial to persons with incapacities to make available to them the least restrictive form of intervention which assists them in meeting their needs but, at the same time, permits them to exercise the independence and self-determination of which they are capable. The legislature declares that it is the purpose of this act to promote the public welfare by establishing a guardianship system which is appropriate to satisfy either personal or property management needs of an incapacitated person in a manner tailored to the individual needs of that person, which takes in account the personal wishes, preferences and desires of the person, and which affords the person the greatest amount of independence and self-determination and participation in all the decisions affecting such person's life.

CREDIT(S)

(Added L.1992, c. 698, § 3.)

HISTORICAL AND STATUTORY NOTES

Former Sections

Former § 81.01, L.1972, c. 251; amended L.1973, c. 676, § 3; L.1975, c. 667, § 7, which stated the legislature's findings and declaration of purpose in establishing a program of care and treatment of narcotic addicts and other drug dependent persons, was repealed by L.1977, c. 978, § 14, eff. Apr. 1, 1978. See Mental Hygiene Law § 19.01.

SUPPLEMENTARY PRACTICE COMMENTARIES

by Rose Mary Bailly

2011

Guardianship reform moved forward this fall when the National Guardianship Network convened the Third National Guardianship Summit: *Standards of Excellence* at the University of Utah S.J. Quinney College of Law in Salt Lake City. *See Guardianship Summit 2011, http://www.guardianshipsummit.org/.* The National Guardianship Network is the collaborative effort of national organizations concerned about ongoing reform of guardianship laws. The Network includes the AARP Public Policy Institute, The American Bar Association Commission on Law and Aging, The American Bar Association Section of Real Property, Trust and Estate Law, The Alzheimer's Association, The American College of Trust and Estate Counsel, The Center for Guardianship Certification, The National Academy of Elder Law Attorneys, The National Center for State Courts, The National College of Probate Judges, and The National Guardianship Association. *See Guardianship Summit 2011, http://www.guardianshipsummit.org/.*

This *Summit* follows on the path of several previous efforts for guardianship reform. The 1988 Wingspread Conference was the first such effort. It was a multi-disciplinary guardianship symposium which issued 31 recommendations for change in guardianship appointments, focusing primarily on the procedure for the appointment of a guardian. These recommendations were prompted by the 1987 Associated Press report, *Guardians of the Elderly: An Ailing System* which revealed that guardianship appointments across the nation were replete with due process violations and systemic failures to address the needs of vulnerable adults. *See Guardianship Summit 2011, http://www.guardianshipsummit.org/.*

The second major step was the 2001 Wingspan Conference which expanded on the challenges identified in 1988. It issued recommendations for further reform in "law, practice, education and research." The Wingspan Conference produced 68 key recommendations in the areas of law, practice, education and research. This conference was followed by a 2004 convening of the National College of Probate Judges, the National Academy of Elder Law Attorneys and the National Guardianship Association which released a series of Action Steps, to implement the Wingspan recommendations. *See Guardianship Summit 2011, http://www.guardianshipsummit.org/.*

The 2011 Summit wasconvened in recognition of the fact that the passage of time has produced "demographic shifts in aging and disability, striking developments in information technology, marked medical advances" as well as continued media attention about "guardian malfeasance as well as inefficiencies in the system." Notwithstanding the potentially broad scope of issues, the Summit "will focus intensively on post-appointment guardian performance and decision-making." *See Guardianship Summit 2011, http://www.guardianshipsummit.org/.*

The summit's agenda is timely because Recent reports by the U.S. Government Accounting office have identified the potential for problems posed by the absence of effective accountability, particularly in lengthy guardianship appointments. *See* 2011 U.S. Government Accounting Office Report # GAO-11-678, *Incapacitated Adults: Oversight of Federal Fiduciaries and Court Appointed Guardians Needs Improvement* (recommending that the Department of Health and Human Services fund evaluations of

guardianship monitoring procedures and that the Social Security Administration develop legislative proposals that would allow it to share with state courts information about their beneficiaries and representative payees.), available at http://www.gao.gov/products/GAO-11-678.; 2010 U.S. Government Accounting Office Report # GAO-10-1046, *Guardianship: Cases of Financial Exploitation, Abuse, and Neglect*, (detailing certain abuses by guardians who were seemingly appointed without adequate credentials although the GAO report does not purport to project its results to "the overall population of guardians or state certification programs [for qualifying as a guardian]."), available at http://www.gao.gov/new.items/d101046.pdf.*See also* 2011 U.S. Government Accounting Office Report# GAO-11-208, *Elder Justice: Stronger Federal Leadership Could Enhance National Response to Elder Abuse, available at http://www.gao.gov/new.items/d11208.pdf*

More information on the Summit can be found at its website, *http://www.guardianshipsummit.org/*, and its blog on guardianship practices and standards, http://www.guardianshipsummit.org/blog/.

2010

When article 81 was enacted, it did not repeal article 17A of the surrogate's court procedure act, guardianship for individuals who have been diagnosed with mental retardation or a developmental disability, or traumatic brain injury. Under article 17A a person with a diagnosis of mental retardation is defined as "a person certified by one licensed physician and one licensed psychologist, or by two licensed physicians as incapable to manage him or herself and/or his or her affairs by reason of mental retardation and that the condition is permanent or likely to continue indefinitely." N.Y. Surr. Ct. Proc. Act § 1750. A developmentally disabled person is defined as "a person certified by one licensed physician and one licensed psychologist, or by two licensed physicians "as having an impaired ability to understand and appreciate the nature and consequences of decisions which result in such person being incapable of managing himself or herself and/or his or her affairs by reason of developmental disability." N.Y. Surr. Ct. Proc. Act 1750-a.

The statute further provides that the developmental disability must be caused by "cerebral palsy, epilepsy, neurological impairment, autism or traumatic head injury," or "any other condition of a person found to be closely related to mental retardation because such condition results in similar impairment of general intellectual functioning or adaptive behavior to that of mentally retarded persons" or "dyslexia resulting from a disability or mental retardation that originated before the person's twenty second birthday." N.Y. Surr. Ct. Proc. Act § 1750-a (1)-(3). There is no age restriction for a person with a traumatic head injury. N.Y. Surr. Ct. Proc. Act § 1750-a (4).

As with article 81, the statute outlines a procedure for the appointment of an article 17A guardian. A parent, any interested person eighteen years of age or older on behalf of an individual for whom the guardian is sought, including a corporation authorized to serve as a guardian, or the individual with the diagnosis can petition for the appointment of a guardian so long as he or she is 18 or older. N.Y. Surr. Ct. Proc. Act § 1751. Forms for the application are available through the Surrogate's Court.

The court may appoint a guardian, N.Y. Surr. Ct. Proc. Act §§ 1750, 1750-a, or a limited guardian for property other than wages and earnings. N.Y. Surr. Ct. Proc. Act § 1756.

The court may also appoint a standby guardian of the person or property or both, or an alternate and/or successive alternates to the standby guardian, to act in the event of the death or incapacity of the standby guardian or his or her renunciation of the appointment. N.Y. Surr. Ct. Proc. Act § 1757.

The 17A guardianship continues permanently, or until terminated by the court. N.Y. Surr. Ct. Proc. Act § 1759.

Under article 17A, a guardian may make health care decisions, including end-of-life decisions, if there has been a determination that the individual lacks the capacity to do so. N.Y. Surr. Ct. Proc. Act § 1750-b(1). The statute also permits family members, in the absence of a guardianship appointment to make end-of-life decisions. N.Y. Surr. Ct. Proc. Act § 1750-b(1)(a). By reason of this health care authority, article 17A health care decisions are excepted out of the coverage of the Family Health Care Decisionsmaking Act, Laws of 2010, Chapter 8, adding Pub. Health Law, art. 29-CC.

Several recent cases have engaged in a comparison of the relative merits of article 81 and article 17A. *See In re Mark C.H.*, 28 Misc.3d 765, 906 N.Y.S.2d 419 (N.Y. Sur. Ct. N.Y. Co. 2010); *In re Guardianship of Yvette A.*, 27 Misc.3d 945, 898 N.Y.S.2d 420 (N.Y.Sur. Ct. N. Y. Co. 2010); *In re Guardianship of John J.H.*, 27 Misc.3d 705, 896 N.Y.S.2d 662 (N.Y.Sur.Ct. N.Y. Co. 2010); *Matter of Chaim A.K.*, 26 Misc.3d 837, 885 N.Y.S.2d 582 (N.Y.Sur. Ct., N.Y. County 2009). *See also In re Guardianship of Jon Z*, 907 N.Y.S.2d 595, 2010 WL 3667005 (N.Y.Sur. Ct. Broome Co. 2010).

On the one hand, the court in *In re Guardianship of Yvette A.* concluded that sections 1755 and 1758, which authorize the guardianship court respectively to modify the order appointing the guardian and to retain jurisdiction over the guardianship "to entertain and adjudicate such steps and proceedings relating to such guardian, ... as may be deemed necessary or proper for the welfare of such mentally retarded ... person" provide a sufficient basis for tailoring an article 17A guardianship in the same manner as is permissible under article 81 of the mental hygiene law.

On the other hand, article 17A has been criticized because it does not allow for authority to grant plenary gifting authority, *In re Guardianship of John J.H.*, 27 Misc.3d 705, 896 N.Y.S.2d 662 (N.Y.Sur.Ct. N.Y. Co. 2010); it does not take into account situations where the individual subject to the article 17A proceeding has a dual diagnosis of mental illness and mental retardation and lacks the flexibility to address the unique needs of an individual, *Matter of Chaim A.K.*, 26 Misc.3d 837, 885 N.Y.S.2d 582 (Sur.Ct. N.Y. County 2009); and it fails to provide meaningful periodic review of the guardian's supervision raising concerns of constitutional dimension, *In re Mark C.H.*, 28 Misc.3d 765, 906 N.Y.S.2d 419 (N.Y.Sur. Ct. N.Y. Co. 2010). These critical decisions uniformly have expressed the view that article 81 reflects a more enlightened view of guardianship and the desire that reform of article 17A be undertaken in light of developments involving the care, treatment and understanding of individuals with various developmental disabilities as well as new legal theories and case law relating to the rights of such individuals which

have been recognized for more than 20 years.

It is undeniable that article 17A and article 81 are quite different in their approach to guardianship. Whether the legislature will respond to the calls for reform of article 17A remains to be seen.

2007

Choice of Guardianship or guardian ad litem

In re Smith-Guzman, 11 Misc.3d 1092, 819 N.Y.S.2d 851 (Sup. Ct. Kings Co. 2006) involved whether petitioners made the right choice between guardianship and a guardian ad litem. Co-petitioners sought appointment as guardians ad litem for a brain injured woman on the grounds that they intended to prosecute a personal injury action on her behalf for medical malpractice and that their appointment as guardians ad litem was more effective than their appointment as article 81 guardians. One co-petitioner was the woman's spouse and the other was the personal injury lawyer. The court found that while the spouse would normally fall within the category of persons who could be appointed, his application was facially defective because his application was not accompanied by an affidavit that his consent to the appointment had been translated into his native language to ensure that he understood the meaning of the document. The court also denied the application of the lawyer because although she intended to waive compensation for acting as guardian ad litem, she fully intended to collect a fee for litigating the personal injury action. The court perceived that fee as compensation as guardian ad litem. In order to qualify for that appointment the attorney must be named on the list maintained for fiduciary appointments by the Office of Court Administration in accordance with Part 36 rules, and she was not on the list. The court went on to note that the appointment of an article 81 guardian was more appropriate. As the individual was in a persistent vegetative state it was unlikely that she would participate in the settlement of the case which would require the appointment of an article 81 guardian and the lack of a guardian ad litem' authority to conclude a settlement could very well inhibit settlement negotiations. Moreover, the guardian could also be granted powers with respect to medical treatment.

The same choice was discussed in *In re Feminella*, 14 Misc.3d 476, 824 N.Y.S.2d 705 (Sup. Ct. Nassau Co. 2006). There the individual alleged to be incapacitated had no assets other than the potential recovery of damages from a negligence action. The court held that it was appropriate to appoint a guardian ad litem pursuant to CPLR 1202 rather than to require an article 81 proceeding which is expensive and the cost of which cannot "be recouped from an alleged incapacitated person who has no assets and these expenses may be imposed upon a petitioner." The court distinguished *In re Smith-Guzman*, because unlike co-petitioners in that case, here the persons seeking to be guardians ad litem were also the individual's power of attorney and health care proxy . However, the court found that the applications were procedurally defective and dismissed them.

Specialized Guardianship Part

The Office of Court Administration has established a specialized guardianship part in Suffolk County

which is characterized as "the only one of its kind in the nation." *Laura Lane, Justice for the Weakest,* N.Y. L. J. 20 (col. 2)(Sept. 26, 2006). A discussion of the court's goals is contained in the article published in the New York State Bar Journal.

PRACTICE COMMENTARIES

by Rose Mary Bailly

In 1993, as the result of a three year study by the New York State Law Revision Commission, Article 81 of the Mental Hygiene Law was enacted, creating a proceeding called a "guardian for personal needs and/or property management" to replace New York's conservatorship and committee laws, Articles 77 and 78.

Article 81 brought major changes to New York's law regarding the appointment of a surrogate decision-maker for persons unable to make decisions for themselves. The most significant change is that a guardianship proceeding under Article 81 focuses on the functional ability of the person alleged to be in need of a guardian and his or her appreciation of the harm she or he may face as a result of any functional limitations. Although the underlying cause of a person's behavior, e.g., mental illness, mental disability, alcoholism, remains important, particularly as to prognosis, the new guardianship law places more emphasis on how the person carries out daily activities and compensates for any functional limitations in so doing.

The Legislature recognized that the legal remedy of guardianship should be the last resort for addressing an individual's needs because it deprives the person of so much power and control over his or her life. It also recognized that even when guardianship must be invoked, the authority granted to the guardian should be tailored to the individual's specific needs rather than a "one size fits all" power, and the authority of the guardian should be limited by those needs.

The guardianship law implemented many reforms that have been recognized on a national level as appropriate and incorporated into the guardianship laws of other states. The spirit of these reforms was reflected in a series of recommendations for the reform of guardianship promulgated by the 1995 White House Conference on Aging. These 1995 WHCoA Recommendations on improving guardianship have already been incorporated in New York's Law:

· Procedural due process protection in guardianship, including the right of the proposed ward to adequate notice, representation by counsel, to be present and offer evidence and otherwise participate at hearings

· Functional determination of incapacity rather than a strict medical diagnosis

· Limited guardianships and the use of the least restrictive level of guardianship

· Court programs that ensure accountability of guardians in financial transactions and personal decisions

· Education and training efforts for guardians and others about guardianship

· Recognition by the court of legally executed advance directives at a time when the proposed ward had capacity. *Official 1995 White House Conference on Aging, Proposed Report: From Resolutions to Results 75-76 (August 3, 1995).*

Early cases interpreting the statute aptly illustrated the legislature's intent and how the statute can work effectively. *See, e.g., Matter of Presbyterian Hospital of the City of New York (Early)* (Sup. Ct. N.Y.Co.) N.Y.L.J., July 2, 1993, p. 22, col. 2. In *Matter of Presbyterian Hospital of the City of New York,* the hospital petitioned for the appointment of a guardianship for an 80 year old blind woman who suffered from diabetes and had undergone emergency surgery. The hospital wished to transfer her to a residential health care facility claiming that she required 24 hour care and failed to appreciate her inability to care for herself. A hospital psychiatrist testified that her failure to appreciate the consequence of her inability to meet her personal needs was "an adjustment disorder with maladaptive denial." The woman vehemently opposed nursing home placement and unfamiliar home health attendants coming into her apartment. The evidence at the hearing established that the woman had an informal arrangement with a neighbor who cared for her and with another friend. The neighbor cared for her five days a week: cooking her meals, doing her laundry and shopping and other chores, and preparing her insulin so that the woman could administer it to herself. The neighbor also assisted her in paying her bills by preparing checks for the woman's signature. Another friend managed the woman's savings account and transferred money into it as needed. The court found that this arrangement demonstrated that the woman appreciated her functional limitations and had taken steps to provide for her personal care. The court ultimately decided that there was no justification for substituting this arrangement for a guardian.

Matter of Robert B. Saunderson, II, (Sup. Ct. Suffolk Co.) N.Y.L.J., April 12, 1994 p. 25 col. 6., is an interesting analysis of using the least restrictive alternative to address the needs of persons who require assistance. Robert Saunderson, II, recovered a medical malpractice award of $1,300,000 for brain injuries suffered at birth. The infant's compromise order directed that his father apply for appropriate letters of guardianship prior to the son's 18th birthday so that the funds could be invested and utilized. In this proceeding, the father sought to have the funds placed in a trust for the benefit of his son and sought to avoid the appointment of a guardian and any finding that the son was incapacitated as that term is defined in Article 81. The court approved the trust and declined to appoint a guardian because the son understood his limitations and was not incapacitated.

The petitioners subsequently amended the application to seek a guardian for health care decisions. They were concerned that health care professionals might question the son's decisions in light of his disability. The court found that the son had not consented to such an appointment so it adjourned the proceedings and ordered a hearing to be held with the son present to determine his consent to the appointment. Subsequently, petitioners moved to vacate the portion of the order requiring the hearing on the grounds that the son had agreed to execute a health care proxy and submitted affidavits from the son and the petitioners and a copy of the executed health care proxy. The court noted that its approval of the health care proxy was not necessary and vacated that portion of the order requiring a hearing declaring that there was no need of fur-

ther judicial intervention. Other cases that demonstrate the flexibility of the guardianship law to address the specific concerns that are as this section indicates "unique to the individual" appear throughout these commentaries.

The enactment of The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, and the regulations promulgated by the Department of Health and Human Service ("Standards for Privacy of Individually Identifiable Health Information" known as the "Privacy Rule") established national standards for an individual's rights regarding his or her health information. In so doing, they have had a profound effect on how health care professionals and attorneys view requests for medical information. The standard for determining whether an Article 81 guardian should be appointed is not based on the medical condition of the alleged incapacitated person and Article 81 provides that the court cannot require medical information to be included in any supporting papers accompanying the order to show cause. *See* 2004 Laws of New York, c. 438, § 5. Nevertheless, medical information may be needed at some point in the proceeding. These Commentaries will note where HIPAA has an impact on a particular practice under Article 81. For a detailed discussion of the inter-relationship of HIPAA and Article 81, *See Rose Mary Bailly & Barbara Hancock, Incapacity and the Privacy Rule: With a Nip and a Tuck They Might Fit*, 9 NYSBA Health Law Journal 32 (Spring 2004).

One concern raised periodically regarding Article 81 is that the statute's emphasis on due process afforded the person alleged to be incapacitated, the more adversarial process, and the involvement necessary to craft a tailored guardianship order increased the costs and the time involved in bringing a guardianship proceeding and thus may quickly dilute the assets of person in need of this type of relief. Article 81 proceedings can be expensive but the cost does not dilute the merit of proceeding in a manner that protects the alleged incapacitated person. *See Strauss, Before Guardianship, Abuse of Patient Rights behind Closed Doors*, 41 Emory L.J. 761, 763 (1992) ("... it is extremely difficult to budge the managers of our legal system from their fear that increased cost, administrative delay, and stress on the court system would result if all guardianship proceedings were made adversarial in nature. Why require this in all cases, they argue, when there are few situations that require the adversarial approach? Imperfect as the guardianship system may be in this regard, at least there is a mechanism for questioning decisions regarding an impaired older adult and the opposition of the protectee can be aired and considered.")

Although the enactment of Article 81 has had a profound impact on guardianship law in New York, it has not effected any change in Article 17-A of the Surrogate's Court Procedure Act which governs guardianship for persons with mental retardation or developmental disabilities. Article 17-A is markedly different from Article 81. The proceeding can only be brought in Surrogate's Court; it is limited to persons with mental retardation and developmental disabilities; the petition must be accompanied by certificates of one licensed physician and one licensed psychologist or two licensed physicians; the appointment can be made without a hearing or the presence of the person alleged to need a 17-A guardian; and it does not provide the same due process protections, the limited or tailored authority of the guardian, nor the detailed accountability of the guardian as Article 81. *See* SCPA Article 17-A. At one point a working group formed under the auspices of the New York State Office of Mental Retardation and Developmental Disabilities studied the possibility of revising Article 17-A in a manner that reflects the national trends in guardianship reform similar to those in Article 81 but no legislative proposals resulted.

There are resources to assist practitioners regarding Article 81. New York has an Office of Guardian and Fiduciary Services as part of the Office of Court Administration. This office was created as a result of the recommendations of the Commission on Fiduciary Appointments; it is a major development for New York. *See Summary of Recommendations, Report on the Commission of Fiduciary Appointments* (December 2001), available on line at www.courts.state.ny.us. The office's mandate is to provide statewide leadership for the judicial system in the area of guardianship and fiduciary appointments. It acts as a resource center for members of the Judiciary and the Bar as well as other professionals and agencies who interact in guardianship cases. The Statewide Coordinator for Fiduciary Services is James T. Fish. Its headquarters are located at 140 Grand Street, White Plains, New York. *See Guardian and Fiduciary Services,* http://www.nycourts.gov/ip/gfs/index.shtml.

The Guardianship Task Force established in the New York Appellate Division, Second Department has published a Best Practices Handbook which is available at the court's website: http://www.nycourts.gov/courts/ad2/pdf/BestPracticesHandbook_1.pdf. The Task Force also made specific recommendations regarding Court Examiners which will be discussed at Mental Hygiene Law § 81.31. The Task Force Report is available at the court's website: www.courts.state.ny.us/courts/ad2/pdf/Guardianship% 20Task% 20Force% 20Report % 20Recommendations% 2020041130.pdf.

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McKinney's Consolidated Laws of New York Annotated Currentness
Mental Hygiene Law (Refs & Annos)
Chapter 27. Of the Consolidated Laws (Refs & Annos)
Title E. General Provisions (Refs & Annos)
Article 81. Proceedings for Appointment of a Guardian for Personal Needs or Property Management (Refs & Annos)

→→ § 81.22 Powers of guardian; personal needs

(a) Consistent with the functional limitations of the incapacitated person, that person's understanding and appreciation of the harm that he or she is likely to suffer as the result of the inability to provide for personal needs, and that person's personal wishes, preferences, and desires with regard to managing the activities of daily living, and the least restrictive form of intervention, the court may grant to the guardian powers necessary and sufficient to provide for the personal needs of the incapacitated person. Those powers which may be granted include, but are not limited to, the power to:

1. determine who shall provide personal care or assistance;

2. make decisions regarding social environment and other social aspects of the life of the incapacitated person;

3. determine whether the incapacitated person should travel;

4. determine whether the incapacitated person should possess a license to drive;

5. authorize access to or release of confidential records;

6. make decisions regarding education;

7. apply for government and private benefits;

8. (i) for decisions in hospitals as defined by subdivision eighteen of section twenty-nine hundred ninety-four-a of the public health law, act as the patient's surrogate pursuant to and subject to article twenty-nine-CC of the public health law, and (ii) in all other circumstances, to consent to or refuse generally accepted routine or major medical or dental treatment, subject to the decision-making standard in subdivision four of section twenty-nine hundred ninety-four-d of the public health law;

9. choose the place of abode; the choice of abode must be consistent with the findings under section 81.15 of this article, the existence of and availability of family, friends and social services in the community, the care, comfort and maintenance, and where appropriate, rehabilitation of the incapacitated person, the needs of those with whom the incapacitated person resides; placement of the incapacitated person in a nursing home or residential care facility

as those terms are defined in section two thousand eight hundred one of the public health law, or other similar facility shall not be authorized without the consent of the incapacitated person so long as it is reasonable under the circumstances to maintain the incapacitated person in the community, preferably in the home of the incapacitated person.

(b) No guardian may:

1. consent to the voluntary formal or informal admission of the incapacitated person to a mental hygiene facility under article nine or fifteen of this chapter or to a chemical dependence facility under article twenty-two of this chapter;

2. revoke any appointment or delegation made by the incapacitated person pursuant to sections 5-1501, 5-1601 and 5-1602 of the general obligations law, sections two thousand nine hundred sixty-five and two thousand nine hundred eighty-one of the public health law, or any living will.

CREDIT(S)

(Added L.1992, c. 698, § 3. Amended L.1993, c. 32, § 12; L.1999, c. 558, § 37, eff. Oct. 5, 1999; L.2004, c. 438, § 17, eff. Dec. 13, 2004; L.2010, c. 8, § 25, eff. June 1, 2010.)

HISTORICAL AND STATUTORY NOTES

L.2010, c. 8 legislation

Subd. (a), par. 8. L.2010, c. 8, § 25, rewrote par. 8, which had read:

"8. consent to or refuse generally accepted routine or major medical or dental treatment subject to the provisions of subdivision (e) of section 81.29 of this article dealing with life sustaining treatment; the guardian shall make treatment decisions consistent with the findings under section 81.15 of this article and in accordance with the patient's wishes, including the patient's religious and moral beliefs, or if the patient's wishes are not known and cannot be ascertained with reasonable diligence, in accordance with the person's best interests, including a consideration of the dignity and uniqueness of every person, the possibility and extent of preserving the person's life, the preservation, improvement or restoration of the person's health or functioning, the relief of the person's suffering, the adverse side effects associated with the treatment, any less intrusive alternative treatments, and such other concerns and values as a reasonable person in the incapacitated person's circumstances would wish to consider;"

L.2010, c. 8, § 29, provides:

"This act shall take effect immediately [March 16, 2010]; provided that sections one through twenty-six of this act shall take effect on the first of June next succeeding the date on which this act shall have become a law; and provided further that effective immediately it shall be lawful for a hospital, as defined in subdivision 18 of section

2994-a of the public health law, as added by this act to adopt a policy that is consistent with the requirements of article 29-CC of the public health law as added by section two of this act or the mental hygiene law as amended by sections twenty-five and twenty-six of this act and for a health care provider to accept and carry out a health care decision in accordance with such requirements for a patient in a hospital that has adopted such policy."

L.2004, c. 438 legislation

Subd. (a), par. 8. L.2004, c. 438, § 17, inserted "subject to the provisions of subdivision (e) of section 81.29 of this article dealing with life sustaining treatment".

L.1999, c. 558 legislation

Subd. (b), par. 1. L.1999, c. 558, § 37, substituted "a chemical dependence" for "an alcoholism" and "twenty-two" for "twenty-one".

Derivation

Former § 77.19, L.1972, c. 251; amended L.1974, c. 623, § 3, and repealed by L.1992, c. 698, § 1.

Effective: June 1, 2010

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Article 81. Proceedings for Appointment of a Guardian for Personal Needs or Property Management (Refs & Annos)

→→ § 81.29 Effect of the appointment on the incapacitated person

(a) An incapacitated person for whom a guardian has been appointed retains all powers and rights except those powers and rights which the guardian is granted.

(b) Subject to subdivision (a) of this section, the appointment of a guardian shall not be conclusive evidence that the person lacks capacity for any other purpose, including the capacity to dispose of property by will.

(c) The title to all property of the incapacitated person shall be in such person and not in the guardian. The property shall be subject to the possession of the guardian and to the control of the court for the purposes of administration, sale or other disposition only to the extent directed by the court order appointing the guardian.

(d) If the court determines that the person is incapacitated and appoints a guardian, the court may modify, amend, or revoke any previously executed appointment, power, or delegation under section 5-1501, 5-1505, or 5-1506 of the general obligations law or section two thousand nine hundred sixty-five of the public health law, or section two thousand nine hundred eighty-one of the public health law notwithstanding section two thousand nine hundred ninety-two of the public health law, or any contract, conveyance, or disposition during lifetime or to take effect upon death, made by the incapacitated person prior to the appointment of the guardian if the court finds that the previously executed appointment, power, delegation, contract, conveyance, or disposition during lifetime or to take effect upon death, was made while the person was incapacitated or if the court determines that there has been a breach of fiduciary duty by the previously appointed agent. In such event, the court shall require that the agent account to the guardian. The court shall not, however, invalidate or revoke a will or a codicil of an incapacitated person during the lifetime of such person.

(e) Repealed by L.2010, c. 8, § 26, eff. June 1, 2010.

CREDIT(S)

(Added L.1992, c. 698, § 3. Amended L.2004, c. 438, § 21, eff. Dec. 13, 2004; L.2008, c. 176, § 1, eff. July 7, 2008; L.2010, c. 8, § 26, eff. June 1, 2010.)

HISTORICAL AND STATUTORY NOTES

L.2010, c. 8 legislation

Subd. (e). L.2010, c. 8, § 26, repealed subd. (e), which had read:

"(e) Nothing in this article shall be construed either to prohibit a court from granting, or to authorize a court to grant, to any person the power to give consent for the withholding or withdrawal of life sustaining treatment, including artificial nutrition and hydration. When used in this article, life sustaining treatment means medical treatment which is sustaining life functions and without which, according to reasonable medical judgment, that patient will die within a relatively short time period."

L.2010, c. 8, § 29, provides:

"This act shall take effect immediately [March 16, 2010]; provided that sections one through twenty-six of this act shall take effect on the first of June next succeeding the date on which this act shall have become a law; and provided further that effective immediately it shall be lawful for a hospital, as defined in subdivision 18 of section 2994-a of the public health law, as added by this act to adopt a policy that is consistent with the requirements of article 29-CC of the public health law as added by section two of this act or the mental hygiene law as amended by sections twenty-five and twenty-six of this act and for a health care provider to accept and carry out a health care decision in accordance with such requirements for a patient in a hospital that has adopted such policy."

L.2008, c. 176 legislation

Subd. (d). L.2008, c. 176, § 1 added the last sentence.

L.2004, c. 438 legislation

Subd. (d). L.2004, c. 438, § 21, substituted "5-1505, or 5-1506" for "5-1601, or 5-1602" and inserted "or if the court determines that there has been a breach of fiduciary duty by the previously appointed agent. In such event, the court shall require that the agent account to the guardian".

Derivation

Former § 77.25, L.1972, c. 251; amended L.1974, c. 623, §§ 6, 7; L.1982, c. 489, § 2; repealed L.1992, c. 698, § 1.

Former Sections

Former § 81.29, relating to care, custody and supervision of drug dependent persons, added L.1972, c. 251; amended L.1973, c. 275, § 8; L.1973, c. 676, § 3; L.1975, c. 667, § 7; was renumbered Mental Hygiene Law § 23.15 by L.1977, c. 978, § 15.

LAW REVISION COMMISSION COMMENTS

This section emphasizes the concept of tailoring the guardian's powers by indicating that the incapacitated person retains all the powers and rights that the guardian is not granted. Title in all property remains in the incapacitated person and is subject to the control of the guardian only to the extent provided in the order appointing the guardian. As indicated in section 81.22(b)(2) the guardian may not revoke powers of attorney, Do Not Resuscitate Orders, health care proxies, or living wills; however, the court may modify, amend or revoke any previously executed appointment, power or delegation, or any contract, conveyance, or disposition if the court finds that the person took such action while incapacitated.

This section also makes clear that Article 81 does not change the current law in New York regarding whether a guardian has the authority to make decisions regarding the withholding or withdrawal of life sustaining treatment nor does it impede the development of the law in this area. Under present New York law, the right to decline treatment is a personal one whose exercise has been denied to a third party when the patient is unable to do so unless a health care proxy or Do Not Resuscitate Order is in place or there is otherwise clear and convincing evidence of the patient's wishes regarding such treatment expressed while the patient was competent (*Matter of O'Connor*, 72 N.Y. 2d 517, 534 N.Y.S. 2d 886, 531 N.E. 2d 607 [1988]). The New York Task Force on Life and the Law has been and continues to study the role that third parties should play, if any, in these types of treatment decisions and whether legislation should address this subject. Most recently, in March 1992 it published recommendations and a legislative proposal regarding treatment decisions (see New York State Task Force on Life and the Law, When Others Must Choose, March 1992).

McKinney's Consolidated Laws of New York Annotated Currentness
Public Health Law
Chapter 45. Of the Consolidated Laws
Article 29-CC. Family Health Care Decisions Act

HISTORICAL AND STATUTORY NOTES

L.2010, c. 8 legislation

L.2010, c. 8, §§ 1, 28 and 29, provide:

"§1. Legislative intent. Under article 29-C of the public health law, competent adults have a powerful way to control their medical treatment even after they lose decision-making capacity, by appointing someone they trust to decide on their behalf. This legislation fills a gap that remains in New York law. It adds, inter alia, a new article 29-CC to the public health law, which establishes a decision-making process, applicable to decisions in general hospitals and nursing homes, whereby a surrogate is selected and empowered to make health care decisions for patients who lack capacity to make their own health care decisions and who have not otherwise appointed an agent to make health care decisions pursuant to article 29-C of the public health law or provided clear and convincing evidence of their treatment wishes.

"The legislature does not intend to encourage or discourage any particular health care decision or treatment, or to create or expand a substantive right of competent adults to decide about treatment for themselves, or to impair the right of patients to object to treatment under applicable law including court decisions. Further, the legislature does not intend to authorize a surrogate to deny to the patient personal services that every patient would generally receive, such as appropriate food, water, bed rest, room temperature and hygiene. This legislation establishes a procedure to facilitate responsible decision-making by surrogates on behalf of patients who do not have capacity to make their own health care decisions.

"This legislation affirms existing laws and policies that limit individual conduct of patients with or without capacity, including those laws and policies against homicide, suicide, assisted suicide and mercy killing."

"§ 28. Issues to be considered by the task force on life and the law; special advisory committee. The New York state task force on life and the law (referred to in this section as the 'task force'), a body created by executive order number 56 (issued December 20, 1984), shall consider and make regulatory and statutory recommendations relating to the family health care decisions act (article 29-CC of the public health law, referred to in this section as the 'FHCDA'), including the following:

"1. The task force shall consider whether the FHCDA should be amended to incorporate procedures, standards and practices for decisions about the withdrawal or withholding of life-sustaining treatment from patients with mental illness or mental retardation or developmental disabilities, and from patients residing in mental health facilities. The task force shall form a special advisory committee to advise the task force in its work under this subdivision. The special advisory committee shall consist of six task force members, selected by the chair of the task force, three per-

sons selected by the commissioner of the office of mental health, and three persons selected by the commissioner of the office of mental retardation and developmental disabilities. The special advisory committee shall solicit comments from a broader range of interested persons.

"2. The task force shall consider whether the FHCDA should be amended to apply to health care decisions in settings other than general hospitals and residential health care facilities."

"§ "29. This act shall take effect immediately [March 16, 2010]; provided that sections one through twenty-six of this act shall take effect on the first of June next succeeding the date on which this act shall have become a law; and provided further that effective immediately it shall be lawful for a hospital, as defined in subdivision 18 of section 2994-a of the public health law, as added by this act to adopt a policy that is consistent with the requirements of article 29-CC of the public health law as added by section two of this act or the mental hygiene law as amended by sections twenty-five and twenty-six of this act and for a health care provider to accept and carry out a health care decision in accordance with such requirements for a patient in a hospital that has adopted such policy."

LAW REVIEW AND JOURNAL COMMENTARIES

Reflecting on scope of guardianship petitions and appointments. Nancy Levitin & Moriah Adamo, 248 N.Y.L.J. 98 (Nov. 20, 2012).

McKinney's Public Health Law Ch. 45, Art. 29-CC, Refs & Annos, NY PUB HEALTH Ch. 45, Art. 29-CC, Refs & Annos

Current through L.2013, chapters 1 to 340.

END OF DOCUMENT

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Public Health Law (Refs & Annos)
Chapter 45. Of the Consolidated Laws (Refs & Annos)
Article 29-CC. Family Health Care Decisions Act (Refs & Annos)
→→ § 2994-a. Definitions

The following words or phrases, used in this article, shall have the following meanings, unless the context otherwise requires:

1. "Adult" means any person who is eighteen years of age or older or has married.

2. "Attending physician" means a physician, selected by or assigned to a patient pursuant to hospital policy, who has primary responsibility for the treatment and care of the patient. Where more than one physician shares such responsibility, or where a physician is acting on the attending physician's behalf, any such physician may act as an attending physician pursuant to this article.

3. "Cardiopulmonary resuscitation" means measures, as specified in regulations promulgated by the commissioner, to restore cardiac function or to support ventilation in the event of a cardiac or respiratory arrest. Cardiopulmonary resuscitation shall not include measures to improve ventilation and cardiac function in the absence of an arrest.

4. "Close friend" means any person, eighteen years of age or older, who is a close friend of the patient, or a relative of the patient (other than a spouse, adult child, parent, brother or sister), who has maintained such regular contact with the patient as to be familiar with the patient's activities, health, and religious or moral beliefs, and who presents a signed statement to that effect to the attending physician.

5. "Decision-making capacity" means the ability to understand and appreciate the nature and consequences of proposed health care, including the benefits and risks of and alternatives to proposed health care, and to reach an informed decision.

5-a. "Decisions regarding hospice care" means the decision to enroll or disenroll in hospice, and consent to the hospice plan of care and modifications to that plan.

6. "Developmental disability" means a developmental disability as defined in subdivision twenty-two of section 1.03 of the mental hygiene law.

7. "Domestic partner" means a person who, with respect to another person:

(a) is formally a party in a domestic partnership or similar relationship with the other person, entered into pursuant to the laws of the United States or of any state, local or foreign jurisdiction, or registered as the domestic partner of

the other person with any registry maintained by the employer of either party or any state, municipality, or foreign jurisdiction; or

(b) is formally recognized as a beneficiary or covered person under the other person's employment benefits or health insurance; or

(c) is dependent or mutually interdependent on the other person for support, as evidenced by the totality of the circumstances indicating a mutual intent to be domestic partners including but not limited to: common ownership or joint leasing of real or personal property; common householding, shared income or shared expenses; children in common; signs of intent to marry or become domestic partners under paragraph (a) or (b) of this subdivision; or the length of the personal relationship of the persons.

Each party to a domestic partnership shall be considered to be the domestic partner of the other party. "Domestic partner" shall not include a person who is related to the other person by blood in a manner that would bar marriage to the other person in New York state. "Domestic partner" also shall not include any person who is less than eighteen years of age or who is the adopted child of the other person or who is related by blood in a manner that would bar marriage in New York state to a person who is the lawful spouse of the other person.

8. "Emancipated minor patient" means a minor patient who is the parent of a child, or who is sixteen years of age or older and living independently from his or her parents or guardian.

9. "Ethics review committee" means the interdisciplinary committee established in accordance with the requirements of section twenty-nine hundred ninety-four-m of this article.

10. "General hospital" means a general hospital as defined in subdivision ten of section twenty-eight hundred one of this chapter excluding a ward, wing, unit or other part of a general hospital operated for the purpose of providing services for persons with mental illness pursuant to an operating certificate issued by the commissioner of mental health.

11. "Guardian of a minor" or "guardian" means a health care guardian or a legal guardian of the person of a minor.

12. "Health care" means any treatment, service, or procedure to diagnose or treat an individual's physical or mental condition. Providing nutrition or hydration orally, without reliance on medical treatment, is not health care under this article and is not subject to this article.

13. "Health care agent" means a health care agent designated by an adult pursuant to article twenty-nine-C of this chapter.

14. "Health care decision" means any decision to consent or refuse to consent to health care.

15. "Health care guardian" means an individual appointed by a court, pursuant to subdivision four of section twenty-

nine hundred ninety-four-r of this article, as the guardian of a minor patient solely for the purpose of deciding about life-sustaining treatment pursuant to this article.

16. "Health care provider" means an individual or facility licensed, certified, or otherwise authorized or permitted by law to administer health care in the ordinary course of business or professional practice.

17. "Health or social service practitioner" means a registered professional nurse, nurse practitioner, physician, physician assistant, psychologist or licensed clinical social worker, licensed or certified pursuant to the education law acting within his or her scope of practice.

17-a. "Hospice" means a hospice as defined in article forty of this chapter, without regard to where the hospice care is provided.

18. "Hospital" means a general hospital, a residential health care facility, or hospice.

19. "Life-sustaining treatment" means any medical treatment or procedure without which the patient will die within a relatively short time, as determined by an attending physician to a reasonable degree of medical certainty. For the purpose of this article, cardiopulmonary resuscitation is presumed to be life-sustaining treatment without the necessity of a determination by an attending physician.

20. "Mental hygiene facility" means a facility operated or licensed by the office of mental health or the office of mental retardation and developmental disabilities as defined in subdivision six of section 1.03 of the mental hygiene law.

21. "Mental illness" means a mental illness as defined in subdivision twenty of section 1.03 of the mental hygiene law, and does not include dementia, such as Alzheimer's disease, or other disorders related to dementia.

22. "Minor" means any person who is not an adult.

23. "Order not to resuscitate" means an order not to attempt cardiopulmonary resuscitation in the event a patient suffers cardiac or respiratory arrest.

24. "Parent", for the purpose of a health care decision about a minor patient, means a parent who has custody of, or who has maintained substantial and continuous contact with, the minor patient.

25. "Patient" means a person admitted to a hospital.

26. "Person connected with the case" means the patient, any person on the surrogate list, a parent or guardian of a minor patient, the hospital administrator, an attending physician, any other health or social services practitioner who is or has been directly involved in the patient's care, and any duly authorized state agency, including the facility director or regional director for a patient transferred from a mental hygiene facility and the facility director for a pa-

tient transferred from a correctional facility.

27. "Reasonably available" means that a person to be contacted can be contacted with diligent efforts by an attending physician, another person acting on behalf of an attending physician, or the hospital.

28. "Residential health care facility" means a residential health care facility as defined in subdivision three of section twenty-eight hundred one of this chapter.

29. "Surrogate" means the person selected to make a health care decision on behalf of a patient pursuant to section twenty-nine hundred ninety-four-d of this article.

30. "Surrogate list" means the list set forth in subdivision one of section twenty-nine hundred ninety-four-d of this article.

CREDIT(S)

(Added L.2010, c. 8, § 2, eff. June 1, 2010. Amended L.2011, c. 167, § 1, eff. Sept. 18, 2011.)

HISTORICAL AND STATUTORY NOTES

L.2011, c. 167 legislation

Subd. 5-a. L.2011, c. 167, § 1, added subd. 5-a.

Subd. 17-a. L.2011, c. 167, § 1, added subd. 17-a.

Subd. 18. L.2011, c. 167, § 1, substituted a comma for "or" following "hospital" and inserted ", or hospice".

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Public Health Law (Refs & Annos)
Chapter 45. Of the Consolidated Laws (Refs & Annos)
Article 29-CC. Family Health Care Decisions Act (Refs & Annos)
→→ § 2994-d. Health care decisions for adult patients by surrogates

1. Identifying the surrogate. One person from the following list from the class highest in priority when persons in prior classes are not reasonably available, willing, and competent to act, shall be the surrogate for an adult patient who lacks decision-making capacity. However, such person may designate any other person on the list to be surrogate, provided no one in a class higher in priority than the person designated objects:

(a) A guardian authorized to decide about health care pursuant to article eighty-one of the mental hygiene law;

(b) The spouse, if not legally separated from the patient, or the domestic partner;

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

(d) A parent;

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

(f) A close friend.

2. Restrictions on who may be a surrogate. An operator, administrator, or employee of a hospital or a mental hygiene facility from which the patient was transferred, or a physician who has privileges at the hospital or a health care provider under contract with the hospital may not serve as the surrogate for any adult who is a patient of such hospital, unless such individual is related to the patient by blood, marriage, domestic partnership, or adoption, or is a close friend of the patient whose friendship with the patient preceded the patient's admission to the facility. If a physician serves as surrogate, the physician shall not act as the patient's attending physician after his or her authority as surrogate begins.

3. Authority and duties of surrogate. (a) Scope of surrogate's authority.

(i) Subject to the standards and limitations of this article, the surrogate shall have the authority to make any and all health care decisions on the adult patient's behalf that the patient could make.

(ii) Nothing in this article shall obligate health care providers to seek the consent of a surrogate if an adult patient has already made a decision about the proposed health care, expressed orally or in writing or, with respect to a decision to withdraw or withhold life-sustaining treatment expressed either orally during hospitalization in the presence

of two witnesses eighteen years of age or older, at least one of whom is a health or social services practitioner affiliated with the hospital, or in writing. If an attending physician relies on the patient's prior decision, the physician shall record the prior decision in the patient's medical record. If a surrogate has already been designated for the patient, the attending physician shall make reasonable efforts to notify the surrogate prior to implementing the decision; provided that in the case of a decision to withdraw or withhold life-sustaining treatment, the attending physician shall make diligent efforts to notify the surrogate and, if unable to notify the surrogate, shall document the efforts that were made to do so.

(b) Commencement of surrogate's authority. The surrogate's authority shall commence upon a determination, made pursuant to section twenty-nine hundred ninety-four-c of this article, that the adult patient lacks decision-making capacity and upon identification of a surrogate pursuant to subdivision one of this section. In the event an attending physician determines that the patient has regained decision-making capacity, the authority of the surrogate shall cease.

(c) Right and duty to be informed. Notwithstanding any law to the contrary, the surrogate shall have the right to receive medical information and medical records necessary to make informed decisions about the patient's health care. Health care providers shall provide and the surrogate shall seek information necessary to make an informed decision, including information about the patient's diagnosis, prognosis, the nature and consequences of proposed health care, and the benefits and risks of and alternative to proposed health care.

4. Decision-making standards. (a) The surrogate shall make health care decisions:

(i) in accordance with the patient's wishes, including the patient's religious and moral beliefs; or

(ii) if the patient's wishes are not reasonably known and cannot with reasonable diligence be ascertained, in accordance with the patient's best interests. An assessment of the patient's best interests shall include: consideration of the dignity and uniqueness of every person; the possibility and extent of preserving the patient's life; the preservation, improvement or restoration of the patient's health or functioning; the relief of the patient's suffering; and any medical condition and such other concerns and values as a reasonable person in the patient's circumstances would wish to consider.

(b) In all cases, the surrogate's assessment of the patient's wishes and best interests shall be patient-centered; health care decisions shall be made on an individualized basis for each patient, and shall be consistent with the values of the patient, including the patient's religious and moral beliefs, to the extent reasonably possible.

5. Decisions to withhold or withdraw life-sustaining treatment. In addition to the standards set forth in subdivision four of this section, decisions by surrogates to withhold or withdraw life-sustaining treatment (including decisions to accept a hospice plan of care that provides for the withdrawal or withholding of life-sustaining treatment) shall be authorized only if the following conditions are satisfied, as applicable:

(a)(i) Treatment would be an extraordinary burden to the patient and an attending physician determines, with the independent concurrence of another physician, that, to a reasonable degree of medical certainty and in accord with

accepted medical standards, (A) the patient has an illness or injury which can be expected to cause death within six months, whether or not treatment is provided; or (B) the patient is permanently unconscious; or

(ii) The provision of treatment would involve such pain, suffering or other burden that it would reasonably be deemed inhumane or extraordinarily burdensome under the circumstances and the patient has an irreversible or incurable condition, as determined by an attending physician with the independent concurrence of another physician to a reasonable degree of medical certainty and in accord with accepted medical standards.

(b) In a residential health care facility, a surrogate shall have the authority to refuse life-sustaining treatment under subparagraph (ii) of paragraph (a) of this subdivision only if the ethics review committee, including at least one physician who is not directly responsible for the patient's care, or a court of competent jurisdiction, reviews the decision and determines that it meets the standards set forth in this article. This requirement shall not apply to a decision to withhold cardiopulmonary resuscitation.

(c) In a general hospital, if the attending physician objects to a surrogate's decision, under subparagraph (ii) of paragraph (a) of this subdivision, to withdraw or withhold nutrition and hydration provided by means of medical treatment, the decision shall not be implemented until the ethics review committee, including at least one physician who is not directly responsible for the patient's care, or a court of competent jurisdiction, reviews the decision and determines that it meets the standards set forth in this subdivision and subdivision four of this section.

(d) Providing nutrition and hydration orally, without reliance on medical treatment, is not health care under this article and is not subject to this article.

(e) Expression of decisions. The surrogate shall express a decision to withdraw or withhold life-sustaining treatment either orally to an attending physician or in writing.

CREDIT(S)

(Added L.2010, c. 8, § 2, eff. June 1, 2010. Amended L.2011, c. 167, § 4, eff. Sept. 18, 2011.)