Family Health Care Decisions Act

New York's Family Health Care Decisions Act (FHCDA)(Chapter 8 of the Laws of 2010, adding Public Health Law Ch. 29-CC and 29-CCC) allows a patient's family member or close friend to make health care decisions for a patient who is in a hospital or nursing home, or to decisions regarding hospice care without regard to where the decision is made or where the care is provided, if the patient lacks decisional capacity and did not leave prior instructions or sign a health care proxy. This "surrogate" decisionmaker would also be empowered to direct the withdrawal or withholding of life-sustaining treatment (including consenting to a DNR order), when standards listed in the statute are satisfied. The key provisions of the FHCDA became effective on June 1, 2010. This article describes amendments through Dec. 2020 that added provisions for **hospice patients** and expanded the types of medical practitioners who can make decisions to include nurse practitioners and physican assistants, in addition to physicians. Later amendments also require the attending practitioner shall make reasonable efforts to determine whether the patient has a health care proxy.

Where does the law apply?

The law ONLY applies to patients in hospitals, nursing homes, and to those receiving hospice care who have lost the capacity to make medical treatment decisions and who have not appointed an agent under a health care proxy. PHL Â§ 2994-b(1). There are other laws that govern people whose treatment is governed by the state Office of Mental Health (OMH) or NYS Office for People with Developmental Disabilities (formerly OMRDD). PHL Â§ 2994-b(3). Private hospitals (as opposed to general hospitals) and individual health care providers are not required to honor decisions made by surrogates pursuant to FHCDA, and may make "conscience objections" based upon sincerely held religious beliefs or moral convictions. PHL Â§ 2994-n.

How is lack of capacity determined?

For a surrogate to be allowed by make medical treatment decisions on the patient's behalf, the facility must first make a determination of patient incapacity, following the procedures outlined below. **All adults are presumed to have decision-making capacity unless determined otherwise**, or unless there has been a legal guardian or court order. PHL Â§ 2994-c(1). The law contains special rules for patients who are minors. PHL Â§ 2994-e.

The **initial determination** of incapacity must be made by an attending physician or other authorized practitioner to a reasonable degree of medical certainty. The determination must include an assessment of the cause and extent of the patient's incapacity and the likelihood that they will regain capacity. PHL Â§ 2994-c(2). An attending practitioner must confirm the patient's continued lack of capacity for future treatment decisions after the initial determination. PHL Â§ 2994-c(7).

A **concurring determination** of incapacity, including the same considerations as required for the initial determination, is required in the following situations (PHL Â§ 2994-c(3)):

- In a nursing home, a social worker or other health practitioner must independently confirm that the patient lacks decision-making capacity
- In a hospital, the concurring determination of a social worker or other health practitioner is only required when the surrogate's decision involves the withdrawal or withholding of life-sustaining treatment.
- In a hospital or nursing home where the patient is receiving hospice care, the health or social services practitioner must be employed by or otherwise formally affiliated with the hospital or nursing home.

If the concurring determination disagrees with the initial determination, then the matter must be referred to the ethics review committee at the facility. PHL Â§ 2994-c(3)(d).

The attending physician making the initial determination of incapacity must have additional credentials in some situations (PHL Â§ 2994-c(3)(c)):

- If the patient lacks capacity due to **mental illness**, the attending practitioner must be board-certified or -eligible by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry
- If the patient lacks capacity due to **mental retardation or developmental disability**, the attending physician (or another professional making an independent determination) must be employed by a Developmental Disabilities Service Office (DDSO) named in section 13.17 of the mental hygiene law, or have been employed for a minimum of two years to render care and service in a facility operated or licensed by OPWDD, or have been approved by the commissioner of OPWDD under regulations requiring specialized training or three years experience in treating developmental disabilities.

Prior to seeking or relying upon a health care decision by a surrogate for a patient under this article, the attending practitioner shall make reasonable efforts to determine whether the patient has a health care agent appointed pursuant to a valid Health Care Proxy under article 29-C. If so, health care decisions for the patient shall be governed by the Health Care Proxy law, and shall have priority over decisions by any other person except the patient. PHL Â§ 2994-b)

Once a determination of incapacity has been made, the facility must give notice as follows (PHL Â§ 2994-c(4)):

- to the **patient**, where there is any indication of the patient's ability to comprehend the information
- to at least one person on the **surrogate** list highest in order of priority listed when persons in prior classes are not reasonably available, willing, and competent to act
- if the patient was transferred from a mental hygiene facility, to the director of the mental hygiene facility and to the mental hygiene legal service under article 47 of the

mental hygiene law.

If the patient objects to a determination of incapacity, or to the selection of surrogate, or to the specific health care decision made by a surrogate, then **the patient's objection shall prevail**, unless (PHL Â§ 2994-c(6)):

- a court of competent jurisdiction has determined that the patient lacks decision-making capacity or the patient is or has been adjudged incompetent for all purposes and, in the case of a patient's objection to treatment, makes any other finding required by law to authorize the treatment, or
- another legal basis exists for overriding the patient's decision.

Who can be a surrogate under FHCDA?

Once a patient has been determined to lack capacity to make health care decisions, under procedures specified in the statute, a "surrogate" is chosen to make all health care decisions, in the following order of priority (PHL Â§ 2994-d(1)):

A hospital or nursing home will be authorized under FHCDA to make decisions regarding major medical treatment under the following circumstances (**Also see this helpful chart by the NYSBA**)

1. **Legal guardian** appointed under Article 81 (the act amends Article 81 to authorize guardian of a person to act as a surrogate under the FHCDA and repeals old Article 81 provision restricting a guardian from making life-sustaining treatment decisions).
2. **Spouse or domestic partner** defined to include person who is either (PHL Â§ 2994-a(7)):

    - formally registered as a domestic partner in any state, city, or foreign jurisdiction, or by either partner's domestic employer, or
    - a beneficiary of or covered by the other person's health insurance or employee benefits, or
    - dependent or mutually interdependent on the other person for support, as evidenced on the totality of circumstances indicating a mutual intent to be domestic partners, including jointly owned or leased property, shared income or expenses, children in common, signs of intent to marry or become domestic partners, or the length of the two parties' relationship.
3. **Adult child**
4. **Parent**
5. **Brother or sister**
6. **Close friend**, age 18 or over, or a relative other than those listed above, who presents a signed statement to the treating physician stating that s/he is in regular contact with the patient so as to be familiar with the patient's activities, health, religious and moral beliefs. PHL Â§ 2994-a(4).

If no one in the above persons can be identified or found, then the law establishes a procedure for the facility to follow in making health care decisions on the patient's behalf. PHL Â§ 2994-g. The procedure depends upon what type of treatment is at issue:

- **Routine medical treatment**, defined as procedures for which providers do not ordinarily seek specific consent from the patient or representative
    - An attending physician shall be authorized to decide about routine medical treatment for an adult patient who has been determined to lack decision-making capacity
- **Major medical treatment**, defined as procedures which involve:
    - **general anesthetic**; or
    - **significant risk**; or
    - **significant invasion of bodily integrity** requiring an incision, producing substantial pain, discomfort, debilitation or having a significant recovery period; or
    - **physical restraints**, except in an emergency; or
    - **psychoactive medications** (except when used post-op, acutely for less than 48 hours, or emergency)
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    - An attending physician shall make a recommendation in consultation with hospital staff directly responsible for the patient's care;
    - In a general hospital, at least one other physician designated by the hospital must independently concur that the recommendation is appropriate;
    - In a nursing home, and for a hospice patient not in a general hospital, the medical director of the facilityor hospice, or a physician, nurse practitioner or physician assistant designated by the medical director or hospice, must independently concur that the recommendation is appropriate. PHL Â§ 2994-g.
- **Withholding or withdrawal of life-sustaining treatment**, defined as any 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. CPR is presumed to be life-sustaining treatment without the necessity of a determination by an attending physician.

  A hospital or nursing home will be authorized under FHCDA to make decisions regarding withholding or withdrawal of life-sustaining treatment under the following circumstances:
    - Pursuant to court order; or
    - If the attending physician, with independent concurrence of a second physician designated by the hospital, determines to a reasonable degree of medical certainty that:
        - life-sustaining treatment offers the patient no medical benefit

7. because the patient will die imminently, even if the treatment is provided; and
   - the provision of life-sustaining treatment would violate accepted medical standards

♦ **Decisions regarding hospice care**. An attending practitioner shall be authorized to make decisions regarding hospice care and execute appropriate documents for such decisions (including a hospice election form) for an adult patient under this section who is hospice eligible under these rules under PHL Â§ 2994-g, subd. 5-a:

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(a) The attending practitioner shall make decisions in consultation with staff directly responsible for the patient's care, and decisions shall be based on the standards for surrogate decisions set forth in PHL Â§ 2994-d(4) and 5);

(b) There is a concurring opinion as follows:

(i) in a general hospital, at least one other practitioner designated by the hospital must independently determine that he or she concurs that the recommendation is consistent with such standards for surrogate decisions;

(ii) in a residential health care facility, the medical director of the facility, or a practitioner designated by the medical director, must independently determine that he or she concurs that the recommendation is consistent with such standards for surrogate decisions; provided that if the medical director is the patient's attending practitioner, a different practitioner designated by the facility must make this independent determination; or

(iii) in settings other than a general hospital or residential health care facility, the medical director of the hospice, or a physician designated by the medical director, must independently determine that he or she concurs that the recommendation is medically appropriate and consistent with such standards for surrogate decisions; provided that if the medical director is the patient's attending physician, a different physician designated by the hospice must make this independent determination; and

(c) The ethics review committee of the general hospital, residential health care facility or hospice, as applicable, including at least one physician, nurse practitioner or physician assistant who is not the patient's attending practitioner, or a court of competent jurisdiction, must review the decision and determine that it is consistent with such standards for surrogate decisions.

What decisions are governed by the FHCDA?

The new law provides for a surrogate to make all health care decisions in a hospital or nursing home that the adult patient could make for him or herself prior to losing capacity. PHL Â§ 2994-d(3)(a)(i). **Providing nutrition and hydration orally, without reliance on medical treatment, is not a health care decision covered by the FHCDA.** PHL Â§ 2994-d(5)(d).

The surrogate's authority does not apply if (PHL Â§ 2994-d(3)(a)(ii)):

- the **patient has already made a decision** about the proposed health care, expressed orally or in writing or,
- the patient has made a decision to withdraw or withhold life-sustaining treatment:
    - ♦ expressed 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
    - ♦ expressed in writing

Once the surrogate's authority is triggered, the surrogate must make health care decisions (PHL Â§ 2994-d(4)):

- **in accordance with the patient's wishes**, including the patient's religious and moral beliefs; or
- if the patient's wishes are not reasonably known and cannot with reasonable diligence be ascertained, in accordance with the **patient's best interests**. 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.

If the treatment decision involves the withdrawal or with-holding of life-sustaining treatment, (including decisions to accept a hospice plan of care that provides for the withdrawal or withholding of life-sustaining treatment) the law imposes additional conditions on the surrogate's authority (PHL Â§ 2994-d(5)):

- Treatment would be an extraordinary burden to the patient and an attending practitioner determines, with the independent concurrence of another practitioner, that, to a reasonable degree of medical certainty and in accord with accepted medical standards,

    - ♦ the patient has an illness or injury which can be expected to cause death within six months, whether or not treatment is provided; or
    - ♦ the patient is permanently unconscious; or
  - 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 practitioner with the independent concurrence of another physician to a reasonable degree of medical certainty and in accord with accepted medical standards.

For decisions to withdraw or with-hold life-sustaining treatment, the law further requires a referral to the facility's ethics review committee in two situations:

- If the surrogate wants to refuse life-sustaining treatment in a nursing home (not including CPR) (PHL Â§ 2994-d(5)(b))
- If the attending physician at a hospital objects to a surrogate's decision to withdraw or with-hold nutrition and hydration provided by means of medical treatment (PHL Â§ 2994-d(5)(c))

How does FHCDA affect Do Not Resuscitate (DNR) Orders?

FHCDA has largely replaced those sections of Public Health Law 29-B that granted a surrogate with a close relationship to an incapacitated patient authority to consent to a "do not resuscitate" (DNR) order regarding the use of cardio-pulmonary resuscitation. The authority to consent to a DNR order for an incapacitated patient now adheres to the surrogacy order of priority and the standards and procedures used throughout the other sections of the FHCDA. The changes are minor, such as permitting a friend to enter a DNR order after writing a statement describing their closeness to the patient rather than signing an affidavit attesting to knowledge of the patient's wishes. PHL Art. 29-CCC.

Other sections of the new law govern DNR orders in non-hospital settings such a hospice (PHL Article 29-CCC), permitting FHCDA's surrogacy provisions also to apply in such cases, and in mental hygiene facilities (renamed PHL Article 29-B).

For More Information

The NYS Dept. of Health has posted this information about the new law:

- **Deciding About Health Care: A Guide for Patients and Families (NYS Dept. of Health, rev 2018)** (English & Spanish)

- Dear Hospital CEO Letter (NYS Dept. of Health, June 1, 2010)

- Dear Nursing Home Administrator Letter (NYS Dept. of Health, June 1, 2010)

The FHCDA Information Center is a project of the NYSBA Health Law Section. It is designed as a resource for all persons - including health care professionals, health care attorneys, advocacy groups, policymakers and members of the public - who are seeking information about the FHCDA. Information posted at the above link includes:

- Text of the FHCDA (PDF)(updated through Dec. 2020) and Summary of Amendments
- CHART of family members and other individuals who can make decisions about specific medical decisions, updated 2020
- The Family Health Care Decisions Act: A Summary of Key Provisions, Robert N. Swidler, NYSBA Health Law Journal (Spring 2010)
- *The following documents are available in the* FHCDA Information Center:

    - *Video - End of Life Decisions (30-minutes - 2019)*
    - List of NYSBA articles about the history of the New York's Family Health Care Decisions Act --
    - Frequently Asked Questions *(Including Q&A's added or revised in 2020)*
    - Related Laws and Regulations
    - *When Others Must Choose, NYS Task Force on Life and the Law (1992) and other reports*

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