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Advance Directives, Consents and Medical Decisions Management Plan, MV-19-006

POLICY/PROCEDURE TITLE	SECTION
DD Forms, Checklists & Guidance	Appendix
FHCDA Forms	Appendix
MOLST Form and Legal Checklists	Appendix

PART A – CONSENTS

Mohawk Valley Health System affiliates Faxton St. Luke's Healthcare and St. Elizabeth Medical Center shall establish, document and maintain a process or processes to assure that patients receiving healthcare services are fully informed of the purpose, risks, benefits and alternatives to the healthcare services that are being provided and that the patient and/or the responsible party representing the patient, understand and agree with the planned treatment(s) and consent to having them administered/performed.

I. PURPOSE

The purpose of this procedure is to define and document the Consent Management Plan utilized at Mohawk Valley Health System affiliates Faxton St. Luke's Healthcare and St. Elizabeth Medical Center.

II. SCOPE

Faxton St. Luke's Healthcare and St. Elizabeth Medical Center

III. REFERENCES

NYS Public Health Law:

Article 25, Maternal and Child Health, § 2504 *Enabling certain persons to consent for certain medical, dental, health and hospital services;*
Article 28 Hospitals, §2803-c *Rights of patients in certain medical facilities,* §2805-d *Limitation of medical, dental or podiatric malpractice action based on lack of informed consent;*
Article 29-B, *Orders not to Resuscitate for Residents of Mental Hygiene Facilities*;
Article 29-C, *Health Care Proxies*;
Article 29-CC, *Family Health Care Decisions Act;* and
Article 29-CCC *Non hospital orders not to resuscitate.*

NYS Surrogate's Court Procedure Act (SCPA), Article 17-A, 1750-b *Health care decisions for mentally retarded persons.*

NYS Education Law, Section § 6530 *Definitions of professional misconduct.*

NYS Mental Hygiene Law, §33.21 *Consent for mental health treatment of minors.*

NYS Codes, Rules and Regulations:

Title 10, Department of Health, Part 400 All Facilities, § 400.21 *Advance Directives,* and Part 405, Hospital Minimum Standards, §405.7 *Patient Rights*;
Title 14. Department of Mental Hygiene, Part 633 *Protection of Individuals Receiving Services in Facilities Operated and/or Certified by OMRDD*, §§ 633.10 *Care and treatment* and 633.11 *Medical treatment*; Part 27 *Quality of Care and Treatment, §§ 27.5 Medical care and treatment, 27.8 Care and treatment; right to object and appeal, 27.9 Surgery and other treatments;* and Part 527 *Rights of Patients*, §527.8 *Care and Treatment; right to object.*

CMS Conditions of Participation 42 CFR §482.13(b)(2); §482.24(c)(2)(v) and §482.51(b)(2).
Department of Health publication 1449 "Your Rights as a Hospital Patient in New York State"

NYS Surgical and Invasive Procedure Protocol, September 2006 (accessed 12/2015 on www.health.ny.gov).

NIAHO Accreditation Requirements Interpretative Guidelines Surveyor Guidance, Revision 11 (6/17/2014).

Ethical and Religious Directives for Catholic Health Care Services, Fifth Edition 2009.

MV-19-008 Medical Orders For Life- Sustaining Treatment (MOLST) And Orders To Withhold/Withdraw Life-Sustaining Treatment (Including —"Do Not Resuscitate" (DNR) Orders)

MV-19-006 Appendix A - Procedures Requiring Informed Consent

RECORDS

- Patients' Medical Records
- MV-19-006 Form 1 Consent for Treatment and Release From Responsibility - FSLH
- MV-19-006 Form 2 Consent for Treatment and Release from Responsibility - SEMC
- MV-19-006 Form 3 Advance Directives Caregiver Information - FSLH
- MV-19-006 Form 4 Advance Directives Caregiver Information - SEMC

- MV-19-006 Form 5 Consent for Operative and/or Diagnostic Procedures and/or Treatment - FSLH
- MV-19-006 Form 6 Consent for Operative and/or Diagnostic Procedures and/or Treatment - SEMC
- MV-19-006 Form 7 Refusal of Consent for Examination or Treatment (AMA) - FSLH
- MV-19-006 Form 8 Refusal of Consent for Examination or Treatment (AMA) - SEMC
- MV-19-006 Form 9 Patient Leaving Hospital Against Medical Advice - FSLH
- MV-19-006 Form 10 Patient Leaving Hospital Against Medical Advice - SEMC
- MV-19-006 Form 19 ED Consent for Treatment and Release From Responsibility #1 - FSLH
- MV-19-006 Form 20 ED Consent for Treatment and Release From Responsibility #1 - SEMC
- MV-19-006 Form 21 ED Consent for Treatment and Release From Responsibility #2 - FSLH
- MV-19-006 Form 22 ED Consent For Treatment and Release From Responsibility #2 - SEMC
- MV-19-006 Form 23 UC Consent for Treatment and Release From Responsibility #1 - FSLH
- MV-19-006 Form 24 UC Consent for Treatment and Release From Responsibility #2 - FSLH

IV. DEFINITIONS / ABBREVIATIONS

ABBREVIATIONS

AMA	Against Medical Advice
CPR	Cardiopulmonary Resuscitation
CMS	Centers for Medicaid and Medicare Services
DD	Developmentally Disabled
DDSO	Developmental Disabilities Service Office
DNR	Do Not Resuscitate order
FHCDA	Family Health Care Decisions Act
FDA	Food & Drug Administration
FSLH	Faxton St. Luke's Healthcare
LST	Life-Sustaining Treatment
MOLST	Medical Orders for Life Sustaining Treatment
MHLS	Mental Hygiene Legal Service
MVHS	Mohawk Valley Health System
OMH	Office of Mental Health
OPWDD	Office for People with Developmental Disabilities (formerly OMRDD)
OMRDD	Office of Mental Retardation and Development Disabilities
SCPA	NYS Surrogate's Court Procedure Act
SEMC	St. Elizabeth Medical Center

DEFINITIONS

Adult, for the purposes of the FHCDA, means a person who is eighteen years of age or older or has married.

Advance Directive means prior written or oral instructions regarding treatment. Advance Directives include but are not limited to: Health care proxy, Living Will, DNR order, MOLST.

Attending Physician means a physician, selected by, or assigned to, a patient in accordance with hospital policy, who has primary responsibility for the care and treatment of the patient. Where more than one physician shares this responsibility, or where a physician is acting on the attending physician's behalf, any such physician can act as the attending physician to carry out responsibilities under this Management Plan.

Capacity – see definition for Decision-Making Capacity.

Cardiopulmonary Resuscitation (CPR) means measures, as specified in regulations issued by the NYS Department of Health, to restore cardiac function or to support ventilation in the event of a cardiac or respiratory arrest. CPR shall not include measures to improve ventilation and cardiac function in the absence of an arrest.

Close Friend means any person 18 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 or brother or sister) who has maintained such regular contact with the patient so as to be familiar with the patient's activities, health and religious or moral beliefs, and who signs a written statement to that effect for the Attending Physician (see **Part C.** for a documentation form).

Consent: Mutual understanding between the patient and the provider, who provides care, treatment, and services and authorization for care, treatment, and services, is given. Note: For the purposes of this Policy, the term "modified informed consent" that is used in the Medical Staff List

of Procedures Requiring Informed Consent has the means Consent as defined here.

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. Adult patients are presumed, by law, to have Decision-Making Capacity, unless determined otherwise by the procedures set forth in this Management Plan, by court order, or because a Guardian has been appointed under Mental Hygiene Law Article 81 and is authorized to make health care decisions. Minors are presumed not to have Decision-Making Capacity.

Developmental disability (DD) means a disability that originates before the patient is 22 years of age, has continued or can be expected to continue indefinitely, and is a substantial handicap to the person's ability to function normally in society, and the condition falls into one of the following categories: (i) is attributable to mental retardation, cerebral palsy, epilepsy, neurological impairment, familial dysautonomia or autism; or (ii) is attributable to any condition closely related to mental retardation that causes a similar impairment of intellectual functioning, or requires treatment and services similar to those with mental retardation; or (iii) is attributable to dyslexia resulting from a disability listed in category (i) or (ii) above.

Domestic Partner means a person who, with respect to the patient: (a) is formally in a domestic partnership or other relationship with the patient that is legally recognized in any state or local jurisdiction in the United States, or is registered as the patient's domestic partner in any registry maintained by the patient's or partner's employer, or any state, municipal or foreign jurisdiction; (b) is formally recognized as a beneficiary or covered person under the patient's employment benefits or health insurance, or the patient is a beneficiary under such benefits of the potential surrogate; or (c) the patient and the potential surrogate are mutually interdependent for support, as shown by all the circumstances demonstrating a mutual intention to be domestic partners, including but not limited to factors such as common ownership or leasing of a home or personal property, common householding, shared income or expenses, children in common, signs of intention to marry or to become domestic partners as defined in (a) and (b) above, or the length of the personal relationship. Domestic Partner does not include anyone younger than 18 years of age, or the adopted child of the patient, or someone related to the patient by blood in a way that would preclude marriage. See **Part C.** for a documentation form.

Do Not Resuscitate (DNR) Order means an order not to attempt CPR in the event a patient suffers cardiac or respiratory arrest. For the purposes of this Management Plan, a DNR Order is a withholding or withdrawal of Life-Sustaining Treatment (LST). See definition of Life-Sustaining Treatment.

Emergency: When, in the physician's judgment, an emergency exists requiring immediate medical attention and the delay caused by attempting to obtain consent would increase the risk to the patient's life or health, consent may be waived. The physician must clearly document the facts and circumstances of the emergency in the medical record, as well as any prior attempts to reach the next of kin.

Emancipated Minor means a Minor who is the parent of a child, or is 16 years of age or older and living independently from his or her parents or guardian.

Guardian of a minor patient or Guardian means a health care guardian or a legal guardian of the person of a Minor appointed by a court.

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 considered health care for the purposes of this Management Plan.

Health Care Agent is defined as an adult 18 years or older to whom authority to make health care decisions is delegated by a patient with a Health Care Proxy.

Health Care Decision means any decision to consent or refuse to consent to health care.

Health Care Provider means an individual or facility licensed, certified, or otherwise authorized or permitted by law to provide health care in the ordinary course of business or professional practice.

Health Care Proxy is a document which delegates the authority to another adult known as the Health Care Agent to make health care decisions when the patient loses capacity to make health care decisions. A Health Care Proxy is one type of Advance Directive.

Informed Consent: The discussion between the physician and the patient of information relative to a proposed procedure, treatment or surgery. The active participants, nature, purpose, risks, (including potential problems that might occur during recuperation) including benefits and alternatives to the proposed treatment, including no treatment, must be discussed, so the patient can decide whether to undergo treatment. This information must be presented in plain language that the patient can understand. Valid Informed Consent must be given voluntarily by patients with capacity, or their Health Care Agent, Guardian or legally empowered surrogate. See **Part A** of this Management Plan. Note: For the purposes of this Policy, the term "modified informed consent" that is used in the Medical Staff List of Procedures Requiring Informed Consent means "Consent" defined above.

Legally Separated in New York State means that the spouses have entered into a separation agreement or have obtained a judgment of separation or a judicial separation.

Life-Sustaining Treatment (LST) means any medical treatment or procedure without which the patient would die within a relatively short time, as determined by the Attending Physician, to a reasonable degree of medical certainty. A DNR Order is a withholding or withdrawal of LST.

Living Will is a type of Advance Directive. It is a document which contains specific instructions concerning a person's wishes about the type of health care choices and treatments that they do or do not want to receive.

Major Medical Treatment means any treatment, service or procedure to diagnose or treat the patient's physical or mental condition where: (i) general anesthetic is used; or (ii) which involves any significant risk; or (iii) which involves any significant invasion of bodily integrity requiring an incision, producing substantial pain, discomfort, debilitation or having a significant recovery period; or (iv) which involves the use of physical restraints as defined in Department of Health regulations, except in an emergency; or (v) which involves the use of psychoactive medications, except when provided as part of post-operative care or in response to an acute illness and treatment is reasonably expected to be administered over a period of 48 hours or less, or when provided in an emergency. Major Medical Treatment does not include Routine Medical Treatment or Life-Sustaining Treatment (LST).

Medical Orders for Life-Sustaining Treatment (MOLST) means medical orders to provide, withhold or withdraw Life-Sustaining Treatment (LST). The MOST form is authorized for use by the Public Health Law. MOLST is a document designed to help health care providers honor the treatment wishes of their patients. The MOLST document is a short summary of a patient's current treatment preferences. Depending on those preferences, a physician order for Do Not Resuscitate (DNR), Do Not Intubate (DNI), and/or other LST that is easy to read in an emergency situation can be designated on the MOLST forms. The MOLST form and guidance and checklists for using MOLST are posted on the Department of Health's website and **Part C**. of this Management Plan.

Mental Hygiene Facility means a facility operated or licensed by OMH or OPWDD, including psychiatric centers and developmental centers, institutions, institutes, clinics and wards, wings or units at hospitals operated to provide services for the mentally disabled.

Medical Futility is a concept from the prior law for hospital DNR orders. The medical futility concept previously allowed entry of a DNR order for an incapable patient who did not have a surrogate if the physician and a concurring physician determined that CPR would be medically futile (i.e. CPR would be unsuccessful in restoring cardiac and respiratory function or that the patient would experience repeated arrest in a short time period before death occurs). The standard has been changed; please refer to the FHCDA standard, Section 5.3.2, of **Part B.** of this Management Plan, for the current standard for decisions to forgo LST.

Mental Illness means a mental disease or condition manifested by a disorder or disturbance in behavior, feeling, thinking, or judgment to such an extent that the person requires care, treatment, and rehabilitation. The term does not include dementia, or other disorders related to dementia such as Alzheimer's disease.

Mental Retardation means sub average intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior. **See** Developmental Disability.

Minor, for the purposes of the FHCDA, means any person who is less than 18 years of age and is not married.

For purposes of this Policy, **modified informed consent**, a term used in the Medical Staff List of Procedures Requiring Informed Consent, has the same meaning as "Consent" as defined above.

Parent means a parent who has custody of, or has maintained substantial and continuous contact with, a Minor patient.

Procedures Requiring Consent: New York State law requires physicians to obtain informed consent from their patients prior to initiation of any non-emergency therapeutic or diagnostic procedure, treatment or surgery which is invasive, disrupts the integrity of the body and/or has substantial risk to life or health. Patients with physical or cognitive barriers to hearing or to understanding the surgical/procedural process must have whatever aids or supports necessary to facilitate understanding. This may include an interpreter and/or guardian in attendance with them at the time consent is obtained and the surgical site is marked.

Reasonable Efforts is a term that is not capable of a precise definition and must be determined on a case-by-case basis. The term is based upon a standard of reasonableness, which is a subjective test of what a reasonable person – or provider or hospital – would do in the individual circumstances, taking all factors into account, to achieve the goal.

Reasonably Available means that the person can be contacted with diligent efforts by an Attending Physician or by someone acting on behalf of the Attending Physician or the hospital.

Routine Medical Treatment means any treatment, service or procedure to diagnose or treat a patient's physical or mental condition, such as the administration of medication other than chemotherapy for non-psychiatric conditions, the extraction of bodily fluids for analysis, or dental care performed with a local anesthetic, for which health care providers ordinarily do not seek specific consent from an adult patient. Routine medical treatment does not include the long-term provision of treatment such as ventilator support or a nasogastric tube, but shall include such treatment when provided as part of post-operative care or in response to an acute illness and recovery is reasonably expected within one month or less. Routine Medical Treatment does not include Major Medical Treatment or Life-Sustaining Treatment (LST).

Surrogate means the person selected to make a health care decision on behalf of a patient under this Management Plan, the FHCDA, Surrogate Court Procedure Act and/or Mental Hygiene Law or regulations, as appropriate. See Part B. for Surrogate procedures.

Surrogate List means the prioritized list of decision makers authorized by law to serve as Surrogate for patients without Decision-Making Capacity.

Therapeutic Exception is an obsolete concept from the prior DNR law, which permitted issuance of a DNR order based on a surrogate's consent rather than the patient's consent when physicians agreed that the discussion about DNR would be harmful to the patient. The therapeutic exception was eliminated with enactment of the FHCDA on June 1, 2010. A surrogate is no longer allowed to make a DNR decision for a patient who has capacity.

Written Consent Document: Document that verifies that the physician had the discussion with the patient and consent was obtained.

- PROCEDURE / DIRECTIVE

1. General Consent
   A. A general consent for treatment shall be signed by all patients who seek care at Faxton St. Luke's Healthcare or St. Elizabeth Medical Center. Each patient shall be required to sign the general consent form during the admission process. Care must not be initiated without a signed general consent form unless an Emergency exists, as defined in Part A. Definitions above. Refer to MV-19-006 Forms 1 - 4 & Forms 19 - 24.
2. Informed Consent
   A. Procedures Requiring Informed Consent.
      - **Informed Consent** is required for any non-emergency therapeutic or diagnostic procedure, treatment or surgery which is invasive, disrupts the integrity of the body and/or has substantial risk to life or health. Informed consent is required for all patients receiving either inpatient or outpatient care for all procedures and treatments specified by the hospital's medical staff on a list established and maintained by the Medical Staff as a supporting document and as required by state or federal laws or regulations and MVHS policies and procedures. Refer to MV-19-006 Forms 5 & 6.
      - For list of Procedures Requiring Informed Consent refer to MV-19-006 Appendix A.

   B. Special Consents
      - Refusal of Consent/leave AMA (refer to MV-19-006 Forms 7 & 8)
      - Administration of blood and blood products
      - Procedures, medications, treatments or use of equipment that are: Not approved by the FDA, or not approved by the FDA for the intended use or under clinical investigation.
      - Consent for taking and publishing of photographs, tape recordings, videotapes and movies.
      - Anatomical gifts/organ donation
      - HIV-related information

   C. Elements of Informed Consent
      1. The informed consent discussion is the sole responsibility of the physician. The physician may delegate the responsibility for obtaining informed consent to a Nurse Practitioner or Physician Assistant but must co-sign the consent. Such delegation of this responsibility does not relieve the physician (who is performing the procedure) from the ultimate responsibility of completing the informed consent process. The discussion must include the nature and purpose of the proposed treatment/procedure and its risks, benefits and alternatives (including the alternative of no treatment).
      2. Documentation of Informed Consent: When a physician discusses a proposed treatment, test or procedure with a patient in order to obtain the patient's informed consent, the following (or similar) should be included in the history & physical and/ or progress notes:
         - I have explained the nature, purpose, risk and benefits of, and alternatives to (including no treatment) the proposed procedure/treatment with the patient.
         - Risks discussed include but are not limited to: (include a few of the most severe and most frequent including potential problems that might occur during recuperation).
         - The patient understood and had an opportunity to ask questions.
         - All of his/her questions were answered to his/her satisfaction.
      3. The informed consent discussion must be completed prior to the proposed treatment, allowing sufficient opportunity for the patient to ask and receive answers to all questions and make an informed choice.
      4. Valid informed consent requires the discussion between the physician and the patient must be in a language the patient can understand. If requested or deemed necessary by the physician or other providers, an interpreter must be obtained to convey all relevant information to the patient and relay questions from the patient to the physician.
      5. Written Consent Document Form must contain at least the following:
         - First and Last Name of Patient (Legal Name).
         - Date of Birth of Patient.
         - Medical Record Number of Patient.
         - Name of Hospital.
         - Date the Consent is Obtained.
         - Name and description of surgery or procedure in terms that are understandable to the patient (correct site/side, level, and digit with the side spelled out as "left, "right" or "bilateral").

- Specific Implant/Implant System to be placed or Device/Implant to be removed.
- Identities of all Physicians (more than one physician can be listed), Dentists, Podiatrists(s) who are reasonably expected to perform or to be actively involved with the procedure(s) or important aspects of the procedures.
- Signature of Patient/Family/Surrogate/Legal Guardian/Health Care Agent.
  - A patient who has capacity but is unable to sign their full signature may write "X" after which should be noted "his/her mark". Two witnesses are required in such an event. The physician shall document in the medical record the nature and extent of the impairment that has prevented the patient from signing the consent form.
- Signature and Date of the Provider(s) performing the Procedure.
- Signature and Date of one person witnessing the consent. The witness must be age 18 or older, who is not related to the patient. The role of the witness is to acknowledge the patient's signature, not to consent. There is no requirement that the witness be impartial (not involved in the procedure to be performed) **unless** required by an IRB or research study.
- No abbreviations or acronyms.
- Every blank should be filled in **before** the patient or responsible person signs and it is witnessed.
- Documentation of Close Friend or Domestic Partner, when appropriate.

3. **Alteration in Consent Form**
   A. If the consent form is altered or illegible it must be re-done and re-signed by all parties prior to the administration of any preoperative medications and commencement of the procedure/operation/treatment.
4. **Who May Give Consent**
   A. See **Part B**.
5. **Consent is Not Needed**
   A. **Emergency**: When, in the physician's judgment, an Emergency exists, requiring immediate medical attention and the delay caused by attempting to obtain consent would increase the risk to the patient's life or health, consent may be waived. The physician must clearly document the facts and circumstances of the emergency in the medical record, as well as any prior attempts to obtain consent.
6. **Duration of Consent**
   A. The consent for hospital admission remains valid for the patient's entire hospitalization unless revoked by the patient or Health Care Agent.
   B. When a consent for a specific operation or procedure (Informed Consent) has been signed by the patient, the consent form is valid for the duration of the present hospitalization as long as there is no significant change in the patient's condition or the procedure contemplated or revocation of the original consent by the patient or Health Care Agent. Consent obtained outside the hospital for an in-hospital procedure is valid for 90 days from the date the physician obtained written consent, provided there is no significant change in the patient's condition or procedure contemplated or revocation of the consent by the patient or Health Care Agent.
   C. The patient has the right to revoke any previously granted consent at any time.
7. **Refusal of Consent**
   A. A patient with Decision-Making Capacity may refuse to consent, even if such refusal jeopardizes the patient's life and health. The physician must provide all of the information required for an Informed Consent, particularly the consequences resulting from the patient's refusal to consent and availability of alternative treatments. The facts and reasons for the patient's refusal must be documented by the physicians and nursing staff in the chart preferably by using the facility's Refusal of Consent Form (refer to MV-19-006 Forms 7 - 10).
   B. Generally speaking, a Parent/Guardian may refuse to consent to a course of treatment for a Minor. There are certain exceptions, and also mandatory reporting requirements if there is a suspicion of child abuse or maltreatment. Please see Section H of Part B.
8. **Verbal/Telephone/Faxed Consents**
   A. In cases when a patient has Decision-Making Capacity and is able to give consent verbally (orally) but is unable to sign, his/her consent must be documented in the space for signature of patient. The Verbal Consent must be witnessed by two employees. The physician shall document in the medical record the nature and extent of the impairment that has prevented the patient from signing the consent form.
   B. Telephone Consents may be used in place of written consent only when a telephone consent is the most reasonable alternative available for securing consent. This will be accomplished by a "conference call" which must include the physician, the witness and the party legally authorized to give consent for the incapable patient (Health Care Agent, Guardian, Parent or Surrogate). The physician must provide the same informed consent discussion that would have been provided during a face-to-face encounter. At the time of the conference call, the physician shall request that a written consent form be forwarded or faxed to the hospital to confirm that consent was in fact given for the treatment/procedure to be performed. Two witnesses must document the telephone consent.

PART B – MEDICAL DECISIONS

Faxton St. Luke's Healthcare and St. Elizabeth Medical Center, affiliates of Mohawk Valley Health System, shall establish, document and maintain policies and procedures for obtaining and documenting health care decisions for patients, consistent with the requirements of New York State law, rules and regulations, including the New York Family Health Care Decisions Act, the Surrogate Court Procedure Act, and Mental Hygiene Law and Regulations.

V. PURPOSE

The purpose of this procedure is to set forth MVHS's procedure for obtaining and documenting health care decisions for patients, consistent with the requirements of New York State law, rules and regulations, including the New York Family Health Care Decisions Act, the Surrogate Court Procedure Act, and Mental Hygiene Law and Regulations.

VI. SCOPE

Faxton St. Luke's Healthcare and St. Elizabeth Medical Center.

VII. REFERENCES

See Part A.

VIII. DEFINITIONS / ABBREVIATIONS

See **Part A**.

- PROCEDURE / DIRECTIVE

A. **Procedures Requiring Informed Consent**

1. Informed Consent is required for any non-emergency therapeutic or diagnostic procedure, treatment or surgery which is invasive, disrupts the integrity of the body and/or has substantial risk to life or health. Informed consent is required for all patients receiving either inpatient or outpatient care for all procedures and treatments specified by the hospital's medical staff on a list established and maintained by the Medical Staff as a supporting document and as required by state or federal laws or regulations.
2. Please see **Part A.** of this Management Plan for the procedures requiring informed consent, the elements of informed consent and documentation requirements.

B. **The following actions are to be taken on admission or in a reasonable time thereafter**:

1. **Statement on FHCDA.** Offer the patient, Health Care Agent, Parent, Guardian and/or Surrogate a copy of a statement summarizing the rights, duties, and requirements of FHCDA, Department of Health publication 1449 "Your Rights as a Hospital Patient in New York State".
2. **Determine if Health Care Agent or Surrogate Available.** Make Reasonable Efforts to determine if the patient has appointed a Health Care Agent or has a Guardian, or if at least one person is available to act as Surrogate. The Reasonable Efforts will be documented.
3. **Identify Prior Orders.** Determine if there is an order to withdraw or withhold LST from the transferring facility or physician, including a non-hospital DNR order, a DNR order, a MOLST form, or other written orders. If there is such an order, include the order in the medical record and follow the hospital policy for honoring decisions from other facilities.
4. **Identify Advance Directives.** Determine if the patient has signed a Health Care Proxy or Living Will or other prior instructions regarding treatment, and include copies of any such documents or instructions in the patient's medical record. The DOH publication provided to the patient/family, "Your Rights as a Hospital Patient in New York State", includes a HCP form and instructions.

C. **Decision-Making Capacity**

1. **Purpose and Scope**
   a. **Presumption of Capacity.** By law, Adult patients are presumed to have Decision-Making Capacity, unless determined otherwise by the procedures set forth in this Management Plan, by court order, or because a Guardian has been appointed under Mental Hygiene Law Article 81 and authorized to make health care decisions. Minors are presumed *not* to have Decision-Making Capacity, unless the Attending Physician, in consultation with the Minor's Parent(s) or Guardian, determines that the Minor has Decision-Making Capacity (see Section 8 Minors).
   b. **Commencement and termination of Surrogate Authority.** Until there is a determination that an Adult patient lacks Decision-Making Capacity, a Surrogate is not authorized to make treatment decisions for the patient, and an Attending Physician is not authorized to decide about treatment for the patient who lacks a Surrogate. If a patient regains Decision-Making Capacity, the authority of a Surrogate or the Attending Physician to make decisions for the patient ends.
   c. **Patients with Mental Illness or a Developmental Disability**. If the Attending Physician has reason to believe that a patient has a history of receiving services for, or has Mental Retardation or a Developmental Disability, or that the patient has been transferred

from an OPWDD or mental hygiene facility, please refer to **Section 2** (2.a) and (2.b.) for the process for determining incapacity and **Section K** and **Section L** for decisions for such patients.

2. **Process for Determining Incapacity**
   a. **Initial Determination.** The Attending Physician will make an initial determination that the patient lacks Decision-Making Capacity, to a reasonable degree of medical certainty. The determination will include an assessment of the cause and extent of the patient's incapacity and the likelihood that the patient will regain Decision-Making Capacity. The determination shall be included in the patient's medical record. A concurring opinion of incapacity in accordance with this Management Plan is required if the Surrogate will make a decision to withdraw or withhold LST.
   b. **Process for Determining a Patient Lacks Decision-Making Capacity Due to Mental Illness.** If the Attending Physician determines that the patient lacks capacity due to Mental Illness, the physician must have the following qualifications, or another physician with such qualifications must make an independent determination, to a reasonable degree of medical certainty, whether the patient lacks Decision-Making Capacity: the physician must be NYS licensed and a diplomate or eligible to be certified by the American Board of Psychiatry and Neurology, or certified by the American Osteopathic Board of Neurology and Psychiatry, or eligible to be certified by that Board. A record of the determination shall be included in the medical record. See Section 12 for decisions for patients lacking capacity due to Mental Illness.
   c. **Process for Determining a Patient Lacks Decision-Making Capacity Due to a Developmental Disability.** If the Attending Physician determines that the patient lacks capacity due to a Developmental Disability, then either the Attending Physician must have the following qualifications or another professional with such qualifications must make an independent determination, to a reasonable degree of medical certainty, whether the patient lacks Decision-Making Capacity: a physician or clinical psychologist employed by a developmental disabilities services office (a list of these offices is posted at http://www.opwdd.ny.gov/opwdd_contacts/ddro), or employed for a minimum of two years to provide care and services in a facility operated by OPWDD, or who has been appr**oved by OPWDD regulations. The Central New York DDSO (315-336-2300) may a resource for professionals** qualified to make this determination. The determination shall be included in the medical record. See Section 11 for decisions for DD patients.
   d. **Concurring Determination for Decisions to Forgo LST. If the Surrogate's decision involves the withdr**awal or withholding of LST, a second physician employed by or otherwise formally affiliated with the hospital must independently determine that the patient lacks Decision-Making Capacity, to a reasonable degree of medical certainty. The concurring determination shall include an assessment of the cause and extent of the patient's incapacity and the likelihood that the patient will regain Decision-Making Capacity. The determination shall be included in the medical record.
   e. **Limited Purpose of the Determination.** A determination that the patient lacks Decision-Making Capacity at the time of the initial determination of incapacity in accordance with this Management Plan does not mean that the patient lacks capacity for health care decisions other than those pending at the time of the determination, or for other types of decisions or purposes.
   f. **Subsequent Decisions –** Confirmation of Incapacity. For health care decisions that arise after the time of the initial determination of incapacity, the Attending Physician shall confirm that the Adult patient continues to lack Decision-Making Capacity. The Attending Physician shall include this determination in the medical record. Health care providers are not required to inform the patient or Surrogate of the confirmation.
   g. **Disagreement about the Determination.** If the Attending Physician has determined that the patient lacks Decision-Making Capacity, and the provider consulted for a concurring opinion disagrees with the Attending Physician's determination, the matter shall be referred to the Medical Ethics Review Committee, if it cannot otherwise be resolved.
3. **Notifications**
   a. **Patients with Surrogates.** Notice of a determination that a Surrogate will make health care decisions because the patient has been determined to lack Decision-Making Capacity shall be given promptly to the patient, if there is any indication of the patient's ability to understand the information, and to at least one person on the Surrogate List highest in order of priority listed of the surrogates who are available, willing, and competent to serve.
   b. **Patients without Surrogates.** Notice of a determination that the patient has been determined to lack Decision-Making Capacity and that the Attending Physician will be authorized to decide about Routine and Major medical Treatment, with the concurrence of a second physician for Major Medical Treatment decisions, shall be given promptly to the patient, if there is any indication of the patient's ability to understand the information.
   c. **Patients Transferred From a Mental Hygiene Facility.** If the patient was transferred from a mental hygiene facility, the patient, the director of the mental hygiene facility and the Mental Hygiene Legal Service must be notified in the event the patient has been determined to lack Decision-Making Capacity and a Surrogate will make health care decisions, or in the case where the patient has no Surrogate that physicians are authorized to decide about medical treatment. Please refer to **Section L** for decisions for patients lacking capacity due to Mental Illness.
   d. **Patients with Developmental Disabilities.** Prior to the implementation of decisions to withdraw or withhold LST, notification must be made to the patient (unless the Attending Physician determines in writing after consulting with another physician or licensed psychologist determines that the person would suffer immediate and severe injury from such notification) and the Mental Hygiene Legal Service (MHLS). Additionally, if the person was transferred from an OPWDD operated or certified residential facility, the

Executive Director of the facility must be notified. If the person is not transferred from such a facility, the director of the local DDSO must be notified. Refer to **Section K.11.f.** for details on the required notices for patients with DD.

e. **Patients Transferred from a corrections facility. If** the patient is an inmate in, or is transferred from, a correctional facility, the director of the correctional facility must also be notified that the patient has been determined to lack Decision-Making Capacity and that a Surrogate will make health care decisions, or if the patient has no Surrogate, that physicians are authorized to decide about medical treatment.

4. **Patient Objection. If the patient objects to the determination of** incapacity or to the choice of a Surrogate or to a health care decision made by a Surrogate, the patient's decision shall prevail *unless*: (a) a court has determined that the patient lacks capacity to make the pending treatment decisions or all decisions; (b) a court has authorized the treatment decision; or (c) another legal basis exists to override the patient's treatment decision.

D. **Decisions by Adults with Decision-Making Capacity**

1. Adult patients are *presumed* by law to have Decision-Making Capacity *unless* determined otherwise by the proc*edures* set forth in this Management Plan, or by court order, or because a Guardian has been appointed under Mental Hygiene Law Article 81 and authorized to make health care decisions. Adults with Decision-Making Capacity have a right to consent to or decl**i**ne health care and LST. They also have the right to execute Advance Directives (see **Prior Treatment Decisions Section E**).

E. **Prior Treatment Decision**

1. **Purpose and Scope**
   In general, a prior consent or decision by an Adult patient who has lost Decision-Making Capacity should be honored if the decision applies to the current treatment and circumstances. If there is credible information that the patient lacked capacity at the time of the prior decision, or uncertainty about whether the decision applies to the current treatment, then patient's prior instructions should be treated as evidence of the patient's wishes, and should be used by a Surrogate to guide a decision for the patient.
2. **Determination of Decision-Making Capacity.** Except for any decision made by the patient at or about the time the treatment decision will be implemented, the Attending Physician will determine that the patient lacks Decision-Making Capacity, to a reasonable degree of medical certainty, before relying on prior decisions by the patient.
   a. **Informing the Patient.** Notice of a determination that the Attending Physician will rely on a prior decision(s) by the patient because the patient has been determined to lack Decision-Making Capacity shall be given promptly to the patient, if there is any indication of the patient's ability to understand the information.
   b. **Patient Objection.** If the patient objects to the determination of incapacity or to the reliance on a prior decision, the patient's objection shall prevail unless: (a) a court has determined that the patient lacks capacity to make the pending treatment decisions or all decisions; (b) a court has authorized the treatment decision; or (c) another legal basis exists to override the patient's treatment decision**.**
   c. **If the Patient Regains Decision-Making Capacity.** If the patient regains capacity at any time, the Attending Physician shall immediately discuss with the patient any orders entered based on the patient's prior decision(s), and cancel any orders if the patient no longer consents to such orders.
3. **Prior Decision by the Patient**
   a. **Consent to Treatment**
      - **Prior Decision.** If the patient previously provided consent to treatment orally to the Attending Physician or provided clear written evidence of a decision to consent to treatment, for a decision that arises after the patient has lost Decision-Making Capacity, the Attending Physician may honor the patient's prior decision. The physician shall record the prior decision in the medical record. The patient's prior decision should be honored, especially if the decision was provided as part of an Informed Consent discussion between the patient and the Attending Physician during hospitalization, or in written instructions that clearly apply to the current circumstances. However, if there is credible information that the patient lacked capacity at the time of the decision, or there is uncertainty about whether the decision applies to the current treatment, the patient's prior instructions should be treated as evidence of the patient's wishes, and should be considered as such by a Surrogate in making a decision for the patient. If the prior decision involves withdrawal or withholding of LST, see **E.3.b.** below**.**
      - **Living Will.** A Living Will is only an indication of a patient's wishes; it is not considered a decision by the patient about a specific treatment issue. So, if a patient loses Decision-Making Capacity and does not have a Health Care Proxy, the Surrogate provisions will come into play (**see Section F**). The Surrogate is required to act in the patient's best interests, guided by the Living Will.
      - **Notice to the Surrogate**. If a Surrogate has already been identified for the patient, the Attending Physician, or someone acting on his or her behalf shall make reasonable efforts to notify the Surrogate before implementing the decision.
   b. **Decisions to Withdraw or Withhold LST**
      - **Decision to Forgo LST.** If the patient's prior decision involves the withdrawal or withholding of LST, to provide prior consent or authorization, the patient must have expressed the decision when capable: (i) orally during hospitalization in the presence of two witnesses 18 years of age or older, at least one of whom is a health or social service practitioner affiliated with the hospital, or (ii) in writing. Any such prior oral or written decision by the patient shall be included in the medical record.

To rely upon a prior decision to withdraw or withhold LST, the writing or oral statement must clearly apply to both the LST under consideration and the medical circumstances, e.g., terminal illness. Examples are DNR Orders and MOLST. A Living Will is only an indication of a patient's wishes; it is not considered a decision by the patient about a specific treatment issue. The Surrogate must act in the best interests of the patient, a Living Will is only used to guide a Surrogate decision.

- **Notice to the Surrogate for Decisions to Withdraw or Withhold LST.** If a Surrogate has already been identified for the patient, the Attending Physician or someone acting on his or her behalf shall make diligent efforts to notify the Surrogate before carrying out the treatment decision. If unable to notify the Surrogate, the Attending Physician shall document the efforts to contact the Surrogate in the medical record.

c. **Objection by the Surrogate.** If the Surrogate objects to reliance on the patient's prior decision, the Attending Physician may refer the matter to the Medical Ethics Review Committee if it cannot otherwise be resolved.

F. **Decisions by Surrogates for Adult Patients without Decision-Making Capacity Who Do Not Have A Health Care Agent or Guardian**

1. **Purpose and Scope.** This section covers treatment decisions for Adult patients who lack Decision-Making Capacity by policy (see Section C) or by court order, and did not make a valid prior decision for the treatment (see Section E) when capable, have appointed no Health Care Agent and have no Guardian.

   Patients with Developmental Disability or Mental Illness. If the Attending Physician has reason to believe that a patient has a history of receiving services for, or has mental retardation or a Developmental Disability, or that the patient has been transferred from a mental hygiene facility, this Section 6 does not apply. See Section K and Section L for decisions for such patients.

2. **Identifying the Surrogate**

   a. **The Surrogate List.** Identify one person from the following list who is in the highest priority class who is Reasonably Available, willing, and competent to serve as Surrogate for a patient without Decision-Making Capacity:

   - a Guardian authorized to decide about health care pursuant to Mental Hygiene Law Article 81;
   - the Spouse (if not Legally Separated from the patient) or the Domestic Partner;
   - a son or daughter 18 years of age or older;
   - a Parent;
   - a brother or sister 18 years of age or older; or
   - a Close Friend.

   One person from the highest class of the list above who is Reasonably Available, willing, and competent to serve shall be the Surrogate. Any person who is highest on the list may designate someone else on the list to be Surrogate, as long as no one who is higher on the list than the person designated objects.

   b. **Restrictions on Who May Serve as Surrogate.** An operator, administrator, or employee of the hospital or a mental hygiene facility that transferred the patient, a physician who has privileges at the hospital, or a health care provider under contract with the hospital cannot serve as surrogate for a patient unless the person is related to the patient by blood, marriage, Domestic Partnership or adoption, or is a Close Friend of the patient whose friendship preceded the patient's admission to the hospital. If a physician serves as Surrogate, the physician may not act as the patient's attending physician once the patient loses Decision-Making Capacity and the Surrogate's authority begins.

3. **Before relying on a decision by a Surrogate,** the Attending Physician shall determine that the patient lacks capacity to make pending health care decisions, in accordance with Section C of this Management Plan, determine whether there are prior treatment decisions or Advance Directives (see Section E), and make Reasonable Efforts (see definition in Part A.) to determine if the person has appointed a Health Care Agent or has a Guardian.

4. **Scope of Surrogate's Authority.** The Surrogate has the authority to make all health care decisions on the Adult patient's behalf that the patient could make if the patient was capable, subject to the standards and limitations in this Management Plan. The decisions that the Surrogate has the authority to make are decisions regarding health care in the hospital. A Surrogate does not have the authority to withhold/withdraw nutrition and/or hydration from patients who are able to eat and drink orally. When nutrition/hydration is deemed to be a medical condition (NG tubes, hyper-alimentation, PEG tubes, etc.), the Surrogate, if appropriate, has the authority to decide and consent to withhold or withdraw that nutrition/hydration under the procedures in this Management Plan, including Section F.6 below and Section I Managing Decisions about LST.

5. **Right and Duty to Be Informed.** The Surrogate has the right to receive medical information and records necessary to make informed decisions about the patient's health care. For HIPAA purposes, the Surrogate is considered the patient's "personal representative" as that term is defined by HIPAA. Health care providers shall provide, and the Surrogate is obligated to seek, all information needed to make informed decisions for the patient, including information about the patient's diagnosis and prognosis, the nature and consequences of proposed health care, and the benefits and risks of and alternatives to, proposed health care decisions.

6. **Decision-Making Standards**

   a. **General Standards for All Health Care Decisions.** The Surrogate shall make health care decisions that are consistent with:

- the patient's wishes, including the patient's religious and moral beliefs, if reasonably known, 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. In assessing the patient's best interests, the Surrogate shall consider: 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 other values that a reasonable person in the patient's circumstances would wish to consider.

  In assessing the patient's wishes and best interests, the Surrogate shall make a decision that is patient-centered and made on an individualized basis to be consistent with the patient's values, including the patient's religious and moral beliefs, to the extent reasonably possible.

b. **Standards and Medical Criteria for Decisions to Forgo LST.** In addition to meeting the standards above in **Section F.6.a** of this subsection F., Surrogate decisions to withdraw or withhold LST must also meet **one** of the standards set forth in (1) or (2) below. Note that these standards apply to entry of DNR orders and replace the clinical criteria that were in the prior DNR law. All determinations made under these standards shall be included in the medical record.

   1. **Patients who are Terminally Ill or Permanently Unconscious**
      i. the Surrogate decides that treatment would be an extraordinary burden to the patient; **and**
      ii. the Attending Physician determines, to a reasonable degree of medical certainty, that the patient has an illness or injury that can be expected to cause death within six months whether or not treatment is provided, or that the patient is permanently unconscious; **and**
      iii. a second physician makes an independent determination, to a reasonable degree of medical certainty, that the patient has an illness or injury that can be expected to cause death in six months whether or not treatment is provided, or that the patient is permanently unconscious.
   2. **Patients with an Incurable or Irreversible Condition**
      i. the Surrogate decides that 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**
      ii. the Attending Physician determines, to a reasonable degree of medical certainty, that the patient has an irreversible or incurable condition; **and**
      iii. another physician makes an independent determination, to a reasonable degree of medical certainty, that the patient has an irreversible or incurable condition.
   3. **Objection by Attending Physician to Decision to Forgo Artificial Nutrition and Hydration for Patients who are not Terminally Ill or Permanently Unconscious.** If the Attending Physician objects to a Surrogate's decision to withdraw or withhold artificial nutrition and hydration for a patient who has an irreversible or incurable condition, but is not terminally ill or permanently unconscious, the decision shall not be implemented until the Medical Ethics Review Committee, including at least one physician not directly involved in the patient's care, or a court, reviews the decision and determines that it meets the standards for such decisions. Such decision is further subject to the Facilities Conscience Policy and the Ethical and Religious Directives for Catholic Health Care Services. See **Section I.7**.

7. **Patient Regains Decision-Making Capacity.** If the patient regains Decision-Making Capacity at any time, and the Surrogate has consented to the withdrawal or withholding of LST, the Attending Physician shall immediately: (i) note in the medical record that the patient has regained Decision-Making Capacity; (ii) promptly cancel the orders or plans of care to forgo LST; and (iii) inform the hospital staff responsible for the patient's care, unless the patient consents to such orders or plans of care.
8. **Expression of Decisions by Surrogates**. A Surrogate can consent to withdraw or withhold LST either orally to an Attending Physician or in writing.
9. **Obligation to Pay for Treatment.** No person shall be liable for the cost of health care for an adult patient solely by virtue of making decisions as a Surrogate under this Management Plan. Liability for the cost of health care shall be the same as if the patient made the decision.
10. **DNR Decisions.** Consent to a DNR order does not constitute consent to withdraw or withhold any other treatment.
11. **Addressing Objections and Disagreements.**
    a. If the Attending Physician has knowledge of the following objections or disagreements, the matter *must* be referred to the Medical Ethics Review Committee, if it cannot otherwise be resolved:
       - a physician consulted for a concurring determination of capacity disagrees with the Attending Physician;
       - any person on the Surrogate List objects to the designation of Surrogate by the person highest in priority on the Surrogate List; and
       - any person on the Surrogate List objects to the Surrogate's decision.
    b. The following matters *may* be referred to the Medical Ethics Review Committee if not otherwise resolved:

- the Surrogate objects to reliance on a prior decision by an Adult patient; and
- disagreement exists among potential surrogates about who will act as Surrogate.
  See **Section 10** Medical Ethics Review Committee.

G. **Treatment Decisions for Adult Patients without Capacity Who Have No One Available to Decide for Them**

1. **Scope and Purpose of Section.** This section covers treatment decisions for Adult patients who lack Decision-Making Capacity by policy (**see Section C**) or by court order, and did not, when capable, make a valid prior decision for the treatment (**see Section E**) , have not appointed a Health Care Agent, have no Guardian, and have no Surrogate (**see Section F**).

   Patients with Developmental Disability or Mental Illness. If the Attending Physician has reason to believe that a patient has a history of receiving services for, or has mental retardation or a Developmental Disability, or that the patient has been transferred from a mental hygiene facility, this Section does not apply. See **Section K** and **Section L** for decisions for such patients.

   a. **Presumption of Capacity.** All Adults are presumed capable of deciding about treatment for themselves, unless they are determined to lack capacity in accordance with hospital policy (see **Section C.2** Process for Determining Incapacity) or by court order.

   b. **Authorization for Physician Decisions.** Physicians are authorized to decide about treatment for Adult patients who lack capacity and have no one to decide for them, in accordance with the standards and procedures in this **Section G**.

   c. **Preconditions to Physician Authority.** Physicians are not authorized to decide about treatment for an Adult patient unless a determination has been made that the patient lacks Decision-Making Capacity in accordance with the hospital's policy for such determinations (**see Section C**), or by a court. If the patient regains Decision-Making Capacity, physicians' authority to make decisions under this Management Plan ends.

      Additionally, before relying on physician authority to decide about treatment, the Attending Physician or designee shall determine whether there are prior orders or Advance Directives (**see Section 5**), shall make Reasonable Efforts to determine if the person has appointed a Health Care Agent or has a Guardian; and shall make Reasonable Efforts to identify a Surrogate (**see Section 6**).

   d. **Decisions Covered.** This Section G covers decisions to provide treatment. It also covers decisions to withdraw or withhold LST provided: (i) the treatment offers the patient no medical benefit because the patient will die imminently, even if treatment is provided; and (ii) the provision of the treatment would violate accepted standards of medical practice.

2. **Identify the Patient's Treatment Values and Wishes**

   a. **Prior to the Loss of Decision-Making Capacity.** If an Adult patient has Decision-Making Capacity but is at risk of losing capacity, and no Health Care Agent or person from the Surrogate List has been identified to make health care decisions in the event the patient loses Decision-Making Capacity, the hospital staff should attempt to identify the patient's wishes and preferences, including the patient's religious and moral beliefs, about treatment decisions that may arise in light of the patient's medical condition. Information from such discussions with the patient shall be included in the medical record.

   b. **After the Loss of Decision-Making Capacity.** If the patient has lost Decision-Making Capacity, and no Health Care Agent or person from the Surrogate List has been identified to make decisions for the patient, the hospital shall identify, to the extent reasonably possible, the patient's wishes and preferences, including the patient's religious and moral beliefs, about pending health care decisions and shall record the information in the medical record.

3. **Determine that the Patient Lacks Decision-Making Capacity.** Prior to authorizing decisions under this Management Plan, the Attending Physician shall determine that the patient lacks the capacity to make pending health care decisions, in accordance with hospital policy for such determinations (**see Section C.2** Process for Determining Incapacity).

4. **Standards for Treatment Decisions**

   a. **Decision-Making Standard for Decisions to Provide Routine and Major Medical Treatment.** Physicians may authorize Routine and Major Medical Treatment for a patient who lacks Decision-Making Capacity and has no Surrogate or Health Care Agent provided that the procedures set forth below are followed. All decisions shall be based on the following standards:

      - The patient's wishes, including the patient's religious and moral beliefs.
      - If the patient's wishes are not reasonably known and cannot with reasonable diligence be ascertained, in accordance with the patient's best interests. In assessing the patient's best interests, physicians shall consider 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 other values that a reasonable person in the patient's circumstances would wish to consider.
      - In assessing the patient's wishes and best interests, physicians shall make a decision that is patient-centered and made on an individualized basis to be consistent with the patient's values, including religious and moral beliefs, to the extent reasonably possible.
      - Under no circumstances shall any decision be based on the financial interests of the hospital or any health care professional.

   b. **Standard for Decisions to Forgo LST.** Physicians may authorize the withdrawal or withholding of LST for a patient who lacks

Decision-Making Capacity and has no Surrogate or Health Care Agent to decide for them, in accordance with the procedures in Section G.5.c below if: (i) the treatment offers the patient no medical benefit because the patient will die imminently even if treatment is provided; and (ii) the provision of LST would violate accepted medical standards. Physicians may authorize a DNR order if the patient would meet this standard in the event of cardiac arrest. The Medical Ethics Review Committee must review the LST decision prior to implementation, see Section J.

5. **Procedures for Medical Treatment Decisions**

   a. **Routine Medical Treatment.** The Attending Physician is authorized to decide about Routine Medical Treatment for a patient who lacks Decision-Making Capacity and has no Health Care Agent or Surrogate to decide in accordance with the standards in Section G.4.a above.

   b. **Major Medical Treatment.** An Attending Physician may authorize a decision to provide Major Medical Treatment for a patient who lacks Decision-Making Capacity and has no Health Care Agent or Surrogate if the Attending Physician makes a recommendation regarding the treatment, in consultation with hospital staff directly responsible for the patient's care, and a second physician, designated by the hospital, makes an independent determination and concurs with the Attending Physician's recommendation. The recommendation by the Attending Physician and the determination of the second physician shall be consistent with the standards in Section G.4.a above, and shall be included in the medical record.

   c. **Decisions to Withdraw or Withhold LST.**

      - **Treatment that Provides no Medical Benefit; Violates Accepted Medical Standards.** A decision to withdraw or withhold LST for an Adult patient who lacks Decision-Making Capacity and has no Health Care Agent or surrogate to decide about treatment will be authorized if: (i) the Attending Physician determines, to a reasonable degree of medical certainty, that the standard set forth in III-B above has been met, and (ii) a second physician, designated by the hospital, makes an independent determination, to a reasonable degree of medical certainty, that the standard has been met. Both the Attending Physician's determination and the determination by the second physician shall be included in the medical record. Prior to implementing decision, there must be an Medical Ethics consult, see Section J.
      - **Judicial Proceeding; Other Decisions to Withdraw or Withhold LST.** A proceeding may be initiated in a court of competent jurisdiction to seek judicial approval for decisions to withdraw or withhold LSTs for decisions that that do not meet the standard set forth in Section G.4.b of this Management Plan. This decision would be taken by Administration in consultation with the Legal Department.

   d. **Disagreement about Determinations and Decisions.** If a physician consulted for a concurring opinion disagrees with the Attending Physician's clinical determination or treatment recommendation, or a member of the hospital staff directly responsible for the patient's care objects to an Attending Physician's recommendation about major medical or LST, the matter shall be referred to the Medical Ethics Review Committee, if it cannot otherwise be resolved. See Section J.

H. Minors

1. **Scope and Purpose**. This Section covers decisions for Minors and Emancipated Minors.

   a. **Presumption of Incapacity.** Minor patients are presumed to lack capacity to make treatment decisions, unless the Attending Physician, in consultation with the Minor's Parent(s) or Guardian, determines that the Minor does have Decision-Making Capacity.

   b. **Standard for Decisions.** Decisions for a Minor must be based on a judgment about the Minor's best interests, taking into account the Minor's wishes, as appropriate under the circumstances.

   c. **Scope of Policy; Mentally Ill and Developmentally Disabled Patients.** If the Attending Physician has reason to believe that a patient has a history of receiving services for, or has mental retardation or a Developmental Disability, or that the patient has been transferred from a mental hygiene facility, this section H does not apply to these patients. See Section K and Section L for decisions for them.

2. **Treatment Decisions for Minors**

   a. **The Parent or legal Guardian** of a Minor may give effective to the Minor's care and treatment, **except** in the following situations:

      - Medical, dental, health and hospital services may be rendered without seeking consent when, an Emergency (as defined in the Definitions in Part A. of this Consents and Medical Decisions Management Plan) exists in the physician's judgment.
      - A pregnant woman, regardless of her age, may consent to prenatal care and for labor and delivery.
      - Minors who have married or had a child may give consent to treatment for themselves and their children.
      - Minors may also give consent for sex-related treatment and the release of information regarding such treatment. Parents may neither be notified about such treatment, nor obtain copies of records containing information about such treatment without the minor's written consent.
      - Minors may also consent to treatment for chemical dependency if the Parent/Guardian refuses to consent to treatment or if, in the judgment of a physician, parental involvement and consent would have a detrimental effect upon a minor voluntarily seeking treatment. If the physician believes that the treatment is in the best interest of the minor, he/she may provide treatment. The physician must document the reasons for dispensing with parental consent for treatment.
      - Minors who voluntarily seeks mental health treatment may consent to such treatment if it is clinically indicated and necessary

to the minor's well-being and

i. A Parent or Guardian is not reasonably available *or*

ii. Parental consent and/or involvement would have a detrimental effect on the course of treatment *or*

iii. A Parent or Guardian has refused to consent to treatment and the physician believes that the treatment is necessary and in the minor's best interests. The physician must document the reasons for his/her determinations in the minor's medical record.

b. **Parental/Guardian Refusal**. With the exception of the situations in **Section H.2.a** above, a Parent/Guardian has the right to refuse to consent to a Minor's care and treatment.

- However, if the refusal of the Parent/Guardian creates a suspicion of child abuse or maltreatment in the judgment of the physician (or any state mandated reporter (including Social Workers, Residents, Interns, PAs, NPs, RNs and hospital personnel) a report must be made immediately. Every mandated reporter **is required** to report suspected child abuse or maltreatment immediately -- at any time of the day and on any day of the week – by calling the New York Statewide Central Register of Child Abuse and Maltreatment (the State Central Register or SCR) at 800-342-3720. If a Minor is in immediate danger, call the local police or 911.
- Consider consulting with Case Management regarding questions about child abuse/maltreatment or CPS reporting.

c. **Legal Custody of Minors**.

- In no case shall the need for consent delay or preclude life-saving treatment in the event that an Emergency exists (as defined in **Part A. Definitions**).
- Primary legal custody of a Minor is usually provided to one Parent by a court order or separation agreement. In such case, the custodial Parent is the only parent authorized to consent to treatment unless the separation agreement or divorce decree provides for the other, non-custodial Parent, to access the child's medical records and consent for medical treatment. If no provision is made for the non-custodial Parent to consent for medical treatment, then either the consent of the custodial Parent is required or a court order must be obtained.
- The Parent who can consent for treatment must provide a copy of the relevant separation agreement or divorce decree that permits him/her to consent for the child's medical treatment except in a true emergency. When this occurs, the physician may accept in good faith the Parent's representation. These documents should be reviewed by Case Management or as necessary by legal counsel.
- If Parents have joint legal custody by agreement or decree, both have equal access to the Minor's medical record and each is entitled to consent for the child's medical treatment.

d. **Foster Children**

- In no case shall the need for consent delay or preclude life saving treatment in the event that an Emergency exists (as defined in **Part A. Definitions**).
- Medical care will be delivered to Minors in foster care if:

i. The foster parents present a copy of a New York State Family Court order authorizing such treatment or permitting the foster parent to consent.

ii. The foster care caseworker is contacted to obtain authorization from the Commissioner of Social Services or designee.

iii. After hours, the Oneida County Sheriff is contacted. The Sheriff then contacts the emergency caseworker to obtain the appropriate authorization.

iv. If the natural parent retains custody rights, the Parent may give consent.

3. **LST Decisions for Minors**

a. **Upon admission** of a Minor patient or in a reasonable time thereafter, the hospital staff shall provide the Minor's Parent(s) or Guardian with a copy of a statement summarizing the rights, duties, and requirements of FHCDA, Department of Health publication 1449 "Your Rights as a Hospital Patient in New York State".

b. **Determination of Minor's Capacity to Decide about Treatment.** Minor patients are presumed to lack the capacity to decide about LST, unless the Attending Physician, in consultation with the Minor's Parent(s) or Guardian, determines that the Minor has the capacity to decide about LST.

c. **Minor's Consent.** If the Minor has Decision-Making Capacity, the Minor's consent, in addition to consent by the Parent(s) or Guardian, is required to withdraw or withhold LST.

d. **Authority of Parent(s) or Guardian to Withdraw or Withhold LST.** A Parent or Guardian of a Minor patient shall have the authority to consent to withdraw or withhold LST from the Minor, subject to the standards and limitations in this Subsection H.3.

e. **Decision-Making Standard.** A decision by a Parent or Guardian to withdraw or withhold LST from a Minor patient must meet the following standards:

- **Best Interests Standard.** The decision must be in accordance with the Minor's best interests. In assessing best interests, the

Parent or Guardian shall consider: the dignity and uniqueness of every person; the possibility and extent of preserving the Minor's life; the preservation, improvement or restoration of the Minor's health or functioning; the relief of the Minor's suffering; and other values that a reasonable person in the Minor's circumstances would wish to consider. The Parent or Guardian shall make a decision that is patient-centered and made on an individualized basis, taking into account the Minor's wishes as appropriate under the circumstances.

- **Standards to Withdraw or Withhold LST.** In addition to the best interests' standard above, one of the two following standards must be met. Decisions and clinical determinations for the standards shall be included in the medical record.

  i. **The Minor is Terminally ill or Permanently Unconscious**

     a. the Parent or Guardian decides that treatment would be an extraordinary burden to the Minor; **and**

     b. the Attending Physician determines, to a reasonable degree of medical certainty, that the Minor has an illness or injury that can be expected to cause death within six months whether or not treatment is provided, or that the Minor is permanently unconscious; **and**

     c. a second physician makes an independent determination, to a reasonable degree of medical certainty, that the Minor has an illness or injury that can be expected to cause death within six months whether or not treatment is provided, or that the Minor is permanently unconscious; or

  ii. **The Minor Has an Incurable or Irreversible Condition**

     a. the Parent(s) or Guardian decides that 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**

     b. the Attending Physician determines, to a reasonable degree of medical certainty, that the Minor has an irreversible or incurable condition; **and**

     c. another physician makes an independent determination, to a reasonable degree of medical certainty, that the Minor has an irreversible or incurable condition.

- **Informing Non-Custodial Parent.** If a Parent or Guardian has made a decision to withdraw or withhold LST and the Attending Physician has reason to believe that the Minor has a Parent or Guardian who has not been informed of the decision, including a non-custodial Parent or Guardian, the Attending Physician or someone acting on the physician's behalf, shall make Reasonable Efforts to determine if the uninformed Parent or Guardian has maintained substantial and continuous contact with the Minor, and, if so, shall make diligent efforts to notify the Parent or Guardian prior to implementing the decision.

f. **Conflicts About a Treatment Decision or Determination of Incapacity.** Conflicts about a treatment decision or determination of incapacity shall be promptly referred to the Medical Ethics Review Committee, if they cannot be resolved.

4. **LST Decisions for Minor Without a Parent or Guardian**

   a. **Appointment of health care Guardian.** If a determination has been made that a Minor patient has no Parent or legal Guardian available, willing, and competent to decide about treatment, the following persons may begin a proceeding in a court of competent jurisdiction to seek appointment as the health care Guardian of a Minor patient for the purpose of deciding about LST:

      - the hospital administrator;
      - the Attending Physician;
      - the local commissioner of social services or the local commissioner of health, authorized to make medical decisions for the Minor under Social Services Law Section 383-b; or
      - an individual, 18 years of age or older, who has assumed care of the Minor for a substantial and continuous period of time.

   b. **Notice of the Proceeding.** Notice of the proceeding shall be provided (i) to the Parent(s) of the Minor, and if the Minor is married, to the Minor's spouse, if such individuals live in the state and their residences are known or, if the Parent(s) or spouse cannot be identified and contacted, to grandparents who live within the county; (iii) to the person who has care and custody of the Minor or with whom the Minor resides; and (iii) to the Minor if the Minor is over the age of 14. No notice is required to any Parent or spouse who is incompetent, has abandoned the Minor, or has been deprived of civil rights, or in the case of a Parent, if the Parent is divorced from the Parent who has custody of the Minor or has been judicially deprived of custody of the Minor.

   c. **Standard for the Decision. A heal**th care Guardian shall make decisions for the Minor consistent with the standards stated above for decisions by Parents and legal Guardians and in accordance with any additional direction provided by the court order appointing the health care Guardian.

   d. **Effect of Appointment.** Seeking appointment or being appointed as a health care Guardian shall not otherwise affect the legal status or rights of the individual who seeks or obtains appointment. No person shall become liable for the cost of health care solely by virtue of making a decision as a Guardian of a Minor in accordance with this Management Plan or seeking judicial appointment as a health care Guardian.

5. **LST Decisions about Emancipated Minors**

   a. **Determine if Patient is Emancipated.** The Attending Physician or someone acting on his or her behalf shall determine if the

Minor is Emancipated (see **Definition in Part A.**).

b. **Determine Decision-Making Capacity.** If the Minor is Emancipated, the Attending Physician shall determine, to a reasonable degree of medical certainty, whether the Minor has the capacity to decide about LST and record the determination in the medical record. If the Minor may lack Decision-Making Capacity due to a Developmental Disability or Mental Illness, the Attending Physician shall consider whether special expertise is required to make the determination, and if so, shall have or shall arrange for a physician or health care professional with such expertise to determine the Minor's capacity.

c. **Standards and Approval of the Decision.** If a Minor is Emancipated and has the capacity to decide about LST, the Minor shall have the authority to consent to withdraw withhold LST under the following circumstances:

- The Attending Physician and the Medical Ethics Review Committee determine that the decision meets the standards for Surrogate decisions by Adult patients to withdraw or withhold LST (see standards for Surrogate decisions for Adult patients, **Section G.4** above); and
- The Medical Ethics Review Committee approves the decision.

d. **Notice to Parent(s) or Guardian.** If the hospital can, with Reasonable Effort, ascertain the identity of the Parent(s) or Guardian of an Emancipated Minor, the hospital shall notify the Parent(s) or Guardian prior to withdrawing or withholding LST.

I. **Managing Decisions About LST – including DNR:**

For procedures please refer to MV-19-008 Medical Orders For Life- Sustaining Treatment (MOLST) And Orders To Withhold/Withdraw Life-Sustaining Treatment (Including —"Do Not Resuscitate" (DNR) Orders)

1. **Scope and Purpose.** This Section I sets forth the policies for managing decisions by Surrogates to consent to treatment or decisions by a Health Care Agent, Surrogate or the Parent or Guardian of a Minor patient to withdraw or withhold LST, including:
   a. review and implementation of such decisions;
   b. revocation of consent;
   c. duties of the Attending Physician;
   d. review of decisions;
   e. transfer of orders between facilities;
   f. conscience objections of health care professionals; and
   g. Facility conscience policy.
2. **Procedure for Recording, Implementing, and Reviewing Decisions to Withdraw or Withhold LST**
   a. Decisions by Health Care Agent, Surrogates or the Parent(s) or Guardian for a Minor patient to withdraw or withhold LST shall be recorded in the patient's medical record in accordance with hospital policy.
   b. Decisions to withdraw or withhold LST shall be implemented in accordance with hospital policies and procedures.
   c. The hospital shall regularly review of decisions to withdraw or withhold LST in accordance with accepted medical standards.
3. **Duties of Attending Physician Regarding Decisions to Withdraw or Withhold LST**
   a. **Duty to Enter Order or Object.** When an Attending Physician is informed of a decision for a patient who lacks Decision-Making Capacity to withdraw or withhold LST by a Health Care Agent, Surrogate or by the Parent or Guardian of a Minor patient, the Attending Physician shall:
      - record the decision in the medical record;
      - review the medical basis for the decision;
      - either promptly implement the decision or, if the Attending Physician objects to the decision, he or she shall promptly inform the decision-maker of the objection and the reason for the objection; and
      - either make all reasonable efforts to arrange to transfer the patient to another physician, if necessary, or promptly refer the matter to the Medical Ethics Review Committee.
   b. **Review of Decisions to Forgo LST.** The Attending Physician shall review decisions to withdraw or withhold LST in accordance with hospital policies established for such review.
   c. **Duties if Patient Regains Capacity or Condition Improves.** If the patient regains Decision-Making Capacity or if the patient's condition improves, and the Attending Physician determines that the decision to withdraw or withhold LST by a Surrogate is no longer appropriate or authorized in light of the improvement in the patient's condition, he or she shall immediately:
      - include such determination in the medical record;
      - cancel any orders or plans of care implementing the decision;
      - inform the person who made the decision to withdraw or withhold treatment, or, if that person is not Reasonably Available, inform at least one person on the Surrogate List highest in the order of priority listed; and
      - inform the hospital staff directly responsible for the patient's care.

4. **Revocation of Consent**
    a. An Adult patient with Decision-Making Capacity or authorized Health Care Agent may at any time revoke their consent to withdraw/withhold LST by making an oral or written declaration to an Attending Physician or any member of the medical or nursing staff, or by any other act that evidences a specific intent to revoke their consent.
    b. A Surrogate or Parent or Guardian of a Minor patient may revoke their consent by notifying by notifying a physician or member of the nursing staff, in writing that is dated and signed, or by orally notifying the Attending Physician in the presence of a witness eighteen years of age or older.
    c. Any member of the medical or nursing staff informed by the patient, Health Care Agent, Surrogate, or Parent or Guardian of a Minor of a revocation of the decision to withdraw/withhold LST shall immediately inform the Attending Physician.
    d. An Attending Physician informed of a revocation shall immediately: (i) record the revocation in the patient's medical record, with the date and time; (ii) record the name of the Surrogate, Parent or Guardian who provided oral notification of revocation (if applicable); (iii) cancel any orders implementing the decision; and (iiii) notify the hospital staff directly responsible for the patient's care of the revocation and cancellation of orders.
5. **Transfer of Orders to Withdraw or Withhold LST Between Institutions.**
    a. If a patient with an order to: (i) withdraw or withhold LST, including a DNR order, is transferred from a mental hygiene facility, a nursing home or another hospital to the hospital; or (ii) a patient with a non-hospital DNR order is transferred from another facility or from an outpatient setting to the hospital, such order shall remain effective, until an Attending Physician first examines the transferred patient. The Attending Physician must then:
        - Issue an appropriate order to continue the order or appropriate plan of treatment. Such orders may be issued without obtaining another consent to withhold or withdraw LST or
        - Cancel such order, if the Attending Physician determines that the order is no longer appropriate or authorized. Before canceling the order, the Attending Physician shall make reasonable efforts to notify the person who made the decision to withdraw or withhold treatment and the hospital staff directly responsible for the patient's care of any such cancellation. If such notice cannot reasonably be made prior to canceling the order or plan, the Attending Physician shall provide such notice to the Health Care Agent or Surrogate as soon as reasonably practicable after cancellation.
6. **Conscience Objections by Health Care Professionals**
   Individual health care providers shall not be required to honor an advance decision by an Adult patient, a decision by a Surrogate, or by a Parent or Guardian of a Minor to provide or to refuse treatment if: (i) the decision is contrary to the individual's sincerely held religious beliefs or sincerely held moral convictions; and (ii) the individual health care provider promptly informs the person who made the decision and the hospital of his or her refusal to honor the decision. In such event, the hospital shall promptly transfer responsibility for the care of the patient to another individual health care provider willing to honor the decision. The individual health care provider shall cooperate in facilitating the transfer.
7. **Facility Conscience Policy**
   SEMC is subject to the Ethical and Religious Directives for Catholic Health Care Services. Additionally, SEMC and FLSH have the right to refuse, on grounds of moral or religious conscience, to implement a decision of a Surrogate, Parent or Guardian of a Minor patient. In order to do so, the hospital will undertake the following steps.
    a. **Notice to the Patient, Surrogate, Parent, or Guardian for a Minor.** The hospital shall inform the patient, Health Care Agent, family, or Surrogate of the hospital's conscience policy prior to or upon admission, if reasonably possible.
    b. **Transfer of the Patient.** The hospital shall cooperate in allowing the prompt transfer of the patient to another facility that is reasonably accessible under the circumstances and willing to honor the decision. If the patient's Health Care Agent, family or Surrogate is unable or unwilling to arrange such a transfer, the hospital may intervene to facilitate such a transfer. While such arrangements are being made, the hospital shall continue to provide LST.
    c. **Judicial Review.** If a transfer does not occur as specified in **Section I.7.b** above, the hospital may seek judicial relief or honor the decision.

J. **Medical Ethics Review Committee**

1. **Purpose and Scope.** This Section J sets forth the requirements for Medical Ethics Review Committee review of healthcare decisions, consistent with the provisions of FHCDA and MVHS policy.
2. **Additional definition for Section J. "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 patient transferred from a correctional facility.
3. **Function and Authority**
    a. **Required Medical Ethics Review Committee Functions.** The Medical Ethics Review Committee shall carry out the following responsibilities:

- **Resolve Disputes.** Consider and respond to any health care matter or request for assistance in resolving a dispute presented by a Person Connected with the Case, including, but not limited to: the determination of incapacity for a patient, the choice of Surrogate, a decision by a Surrogate, a recommendation or concurring opinion for treatment for a patient who lacks a Surrogate, or a clinical determination required for decisions to withdraw or withhold LST.
- **Review LST decisions for patients lacking capacity who have no Surrogate or Health Care Agent.**
- **Physician Objection to Surrogate Decision.** In cases where the Attending Physician objects to a Surrogate's decision to withdraw or withhold artificial nutrition and hydration for a patient who is not terminally ill or permanently unconscious, the Medical Ethics Review Committee shall review the Surrogate's decision and determine whether it meets the standards set forth in this Management Plan for such decisions. At MVHS, such decision is also subject to the Facilities Conscience Policy and the Ethical and Religious Directives for Catholic Health Care Services for SEMC patients (Section 9.8 above).
- **Decisions for Emancipated Minors.** Determine if a decision to withdraw or withhold LST by an Emancipated Minor meets the standard for such decisions, and determine whether or not to approve the decision.

b. **Authority of the Committee**

- **Binding Decisions.** When the Medical Ethics Review Committee carries out the functions in Section 10.3 paragraph (A) subparagraphs (3) and (4) above, it has the authority to decide whether a Surrogate's or an Emancipated Minor's decision meets the standards of the applicable policies for such decisions.
- **Advisory Role.** The Medical Ethics Review Committee response to any other matter or dispute shall be advisory and nonbinding, and may include:
  i. providing advice about the ethical aspects of proposed health care;
  ii. making a recommendation about proposed health care; or
  iii. providing assistance in resolving disputes about proposed health care or other matters, such as the determination of incapacity or the choice of Surrogate.

K. **Decisions for Patients with Developmental Disability (DD)**

1. **Scope and Purpose.** This section covers decisions for patients that have a history of receiving services for, or have a diagnosis of MR or a developmental disability (DD), or have been transferred from an OPWDD facility. The purpose of this Management Plan is to provide a procedure for obtaining and documenting health care decisions for DD patients, which is ethically sound, medically appropriate and consistent with the requirements of law. Such laws include New York State Surrogate's Court Procedure Act (SCPA), Mental Hygiene Law Article 80, and OPWDD regulations.
2. **Definitions.** The following definitions apply to this Section K:
   Adult means anyone who is 18 years of age or older, or is the parent of a child, or has married.

   Guardian means a person appointed by a court under the SCPA Article 17-A to be the guardian of a patient with DD.

   Family Member means a person in the category highest in priority on the following list, who is Reasonably Available (as defined in **Part A.**), willing and decisionally capable of making a decision on behalf of the DD patient, **and** who has significant and ongoing involvement in the patient's life so as to know the patient's needs and, when reasonably known or ascertainable, the patient's wishes, including moral and religious beliefs:
   a. spouse;
   b. parent;
   c. adult child;
   d. adult sibling; or
   e. adult person related to patient by blood, marriage or legal adoption.

   Note: Domestic Partners and Close Friends, as defined by the FHCDA, are *not* included in the prioritized list of Family Members for DD patients (14 NYCRR §§ 633.11 and 633.10).

   Surrogate Decision-Making Committee (SDMC) is a decision-maker of last resort for hospital or nursing home patients with DD who do not have a family member to make such decisions. The SDMC is authorized by New York State Law to make decisions to consent or treatment and to withdraw or withhold LST.
3. **Procedures requiring consent – Patients with DD.** Informed consent for proposed treatment will be obtained from the patient, Health Care Agent, Guardian, Family Member or SDMC unless such consent is not required by law. **See Part A. – Consent Management Policy** for the procedures requiring Informed Consent, as well as the elements of Informed Consent and documentation requirements.
4. **Presumption of Decision-Making Capacity.** Persons aged 18 years or older are presumed by law to have Decision-Making Capacity unless determined to lack capacity by (i) the procedures set forth in this Section 11, (ii) by a court order, or (iii) because a court has appointed a Guardian to make health care decisions for the patient.

An Adult patient with capacity to understand the appropriate disclosures regarding proposed treatment must provide Informed Consent to proposed treatment. This means having the ability to understand and appreciate the nature and consequences of Health Care decisions, including risks, benefits and alternatives to proposed health care, and to reach an informed decision. Until there is a determination that a patient lacks Decision-Making Capacity, another person is not authorized to make decisions for an Adult patient; when a patient regains Decision-Making Capacity, a Surrogate's authority ends.

5. **Priority of Prior Decisions made by Adult patient with DD.** If an Adult patient, when capable, personally consented to the treatment, the patient's oral or written directions should be honored without need to rely on a Health Care Agent, Guardian or other decision-maker. If there is credible information that the patient lacked capacity at the time of the decision, or there is uncertainty about whether the decision applies to the current treatment, then the patient's prior directions should be used as evidence of the patient's wishes to guide the patient's surrogate.

   If the patient's prior decision involves the withdrawal or withholding of LST, to provide prior consent or authorization, the patient must have expressed the decision, when capable: (i) orally during hospitalization in the presence of two witnesses 18 years of age or older, at least one of whom is a health or social service practitioner affiliated with the hospital, or (ii) in writing. To rely upon a prior decision to forgo LST, the writing or oral statement must clearly apply to both the LST under consideration and the medical circumstances, e.g., terminal illness.

6. **Priority of Health Care Agent appointed by Adult patient with DD.** If an Adult patient, when capable, signed a Health Care Proxy appointing a Health Care Agent, that Agent is authorized to make any and all health care decisions on the patient's behalf that the patient could make if he/she had capacity, including decisions to withdraw or withhold LST. (Note, however, that the Agent does not have authority to consent or refuse nutrition and hydration on the patient's behalf if the patient does not make known to his/her Agent their wishes about artificial hydration and nutrition.) The authority of the Agent begins when a determination has been made that a patient lacks capacity to make a health care decision and ends when the patient regains capacity.

7. **Prioritized List of decision makers for incapable DD patients who have no valid Prior Decision or Health Care Agent:**
   a. Unless specifically prohibited by the court, a Guardian has the authority to make health care decisions on behalf of an DD patient who lacks capacity.
   b. If no Guardian has been appointed, a qualified Family Member will have the authority to make health care decisions on behalf of an DD patient who lacks capacity. See Definition of Family Member in **Section K.2** for prioritized list.
   c. If no Guardian or Family Member is Reasonably Available, health care decisions may be made by, *where applicable* a local commissioner of social services who has custody over the person pursuant to law.
   d. Where 1-3 do not apply, the Consumer Advisory Board for the Willowbrook Class (CAB) (only for members it fully represents).
   e. Where 1-4 do not apply, a court may decide or an application may be made for a Surrogate Decision-Making Committee to make a decision about Major Medical Treatment or LST/DNR.

   Note, once a person is eligible for decisions by a Surrogate Decision-Making Committee, the person remains eligible regardless of change in residential status (Mental Hygiene Law, Article 80, Surrogate Decision-Making for Medical Care and Treatment, Section 80.3 [b]).

   SDMC Forms are available at http://www.justicecenter.ny.gov/services-supports/sdmc/form

8. **Decision-making standards for decisions for DD patients**
   a. The Health Care Agent, Guardian or Family Member must base all advocacy and health care decision-making solely and exclusively on the best interests of the DD patient and, when reasonably known or ascertainable with reasonable diligence, on the DD patient's wishes, including moral and religious beliefs.
   b. An assessment of the best interests of the DD patient must include consideration of five factors:
      - the dignity and uniqueness of every person;
      - the preservation, improvement or restoration of the health of the person;
      - the relief of the suffering of the person by means of palliative care (care to reduce the person's suffering) and pain management;
      - the unique nature of artificially provided nutrition or hydration, and the effect it may have on the person; and
      - the entire medical condition of the person.
   c. A Health Care Agent's, Guardian's or Family Member's health care decisions may not be influenced by a presumption that persons with DD are not entitled to the full and equal rights, equal protection, respect, medical care and dignity afforded to other persons, nor by financial considerations of the surrogate.

9. **Additional standard for decisions for DD patients regarding LST/DNR Orders**
   For decisions regarding LST/DNR, a Health Care Agent, Guardian or Family Member has an obligation to advocate for the full and

efficacious provision of health care, including LST. CPR is presumed to be LST without needing a medical judgment by an attending physician. There is no longer a separate process for obtaining a DNR Order; all decisions involving the withholding or withdrawal of LST must comply with the process set forth in **Section K.11**, below.

10. **PROCEDURE – CONSENT TO TREATMENT for DD Patients**
    a. **Determination of Capacity.**
        - An Adult patient with capacity to understand the appropriate disclosures regarding proposed treatment must provide informed consent to proposed treatment.
        - To accept consent to treatment from a Health Care Agent, a Guardian or Family Member on behalf of a DD patient, rather than obtaining the consent of the patient, there must be an initial determination of incapacity by the Attending Physician. The determination must be made to a reasonable degree of medical certainty, and include an assessment of the cause and extent of the patient's incapacity and the likelihood that the patient will regain capacity. The determination will be documented in the patient's medical record.
            i. If the Attending Physician determines that the patient lacks capacity due a Developmental Disability (see **Definition in Part A.** of this Plan, then either the Attending Physician must have the following qualifications or another professional with such qualifications must make an independent determination, to a reasonable degree of medical certainty, whether the patient lacks Decision-Making Capacity: a physician or clinical psychologist employed by a developmental disabilities services office (a list of these offices is posted at http://www.opwdd.ny.gov/opwdd_contacts/ddro), or employed for a minimum of two years to provide care and services in a facility operated by OPWDD, or who has been approved by OPWDD regulations. The Central New York DDSO (315-336-2300) is a resource for professionals qualified to make this determination.
            ii. If the Attending Physician determines that the patient lacks capacity due to Mental Illness (see **Definition in Part A.** of this Plan), then the physician must have the following qualifications, or another physician with such qualifications must make an independent determination, to a reasonable degree of medical certainty, whether the patient lacks Decision-Making Capacity: the physician must be NYS licensed and a diplomate or eligible to be certified by the American Board of Psychiatry and Neurology, or certified by the American Osteopathic Board of Neurology and Psychiatry, or eligible to be certified by that Board.
            iii. If the patient lacks capacity for reasons unrelated to Mental Illness or DD, these special qualifications are not required.
    b. **Authorized Decision-maker.** If an incapable patient with DD does not have a Health Care Agent or a valid Prior Decision, identify decision maker in the Prioritized List set forth in **Section K.7** above.
    c. **Documenting Consent.** The consent of the Health Care Agent, Guardian, Family Member or other authorized decision maker on behalf of the incapable patient shall be documented on the consent form that would be used for other patients. See **Part A.** of this Management Plan for the procedures requiring informed consent, the elements of informed consent and documentation requirements.
    d. **Emergency Treatment; Routine Treatment**.
        - **Emergency Treatment.** Medical, dental, health and hospital services may be rendered without seeking informed consent when, in the physician's judgment, an Emergency (as defined in the **Definitions in Part A.** of this Management Plan) exists.
        - **Routine Medical Treatment.** Routine Medical Treatment, as **defined in Part A.** Definitions an, may be provided without specific consent.

11. **PROCEDURE – LST/DNR Decisions for patients with DD.**
    a. **Determination of incapacity.**
        - **Attending Physician:** Prior to implementing a decision by a Guardian or a Family Member to withhold or withdraw LST on behalf of a patient with DD, the Attending Physician must determine that the patient lacks capacity to make health care decisions. The determination will be made to a reasonable degree of medical certainty, and include an assessment of the cause and extent of the patient's incapacity and the likelihood that the patient will regain capacity. The determination will be documented in the patient's medical record.
        - **Confirmation by physician or psychologist:** Another physician or a licensed psychologist must further confirm the person's lack of capacity.
        - **Special qualifications.** Either Attending Physician or the concurring physician or psychologist must have the following qualifications: a physician or clinical psychologist employed by a DD services office (a list of these offices is posted at http://www.opwdd.ny.gov/opwdd_contacts/ddro), or employed for a minimum of two years to provide care and services in a facility operated by OPWDD, or who has been approved by OPWDD regulations. The Central New York DDSO (315-336-2300) may a resource for professionals qualified to make this determination.
        - **Documentation.** A record of the determination and concurring consultation must be included in the medical record.
    b. **Determination of Medical Criteria.** In addition, the Attending Physician, with the concurrence of another physician, must also determine to a reasonable degree of medical certainty that both of the following conditions are met. The determination must be

documented in the chart.

- The Person with DD has a medical condition as follows:
  i. a terminal condition, which means an illness or injury from which there is no recovery and which reasonably can be expected to cause death within one year[1]; or
  ii. permanent unconsciousness; or
  iii. a medical condition other than such person's mental retardation or DD which requires life-sustaining treatment, is irreversible and which will continue indefinitely;
  and
- The life-sustaining treatment would impose an extraordinary burden on the person, in light of:
  i. the person's medical condition, other than the person's mental retardation or DD; and
  ii. the expected outcome of the life-sustaining treatment, notwithstanding the person's mental retardation or DD; **and**
- In the case of a decision to withdraw or withhold artificially provided nutrition or hydration, one of the following additional factors must also be met:
  i. there is no reasonable hope of maintaining life; or
  ii. the artificially provided nutrition or hydration poses an extraordinary burden.

c. **Authorized Decision-maker.** If an incapable patient with DD does not have a Health Care Agent or a valid Prior Decision, decisions can be made by the decision maker identified in the Prioritized List set forth in **Section K.7** above.

d. **Obligation of Guardian or Family Member:** The Guardian or Family Member has an affirmative obligation to advocate for the full and efficacious provision of health care, including LST. In the event that a Guardian or Family Member makes a decision to withdraw or withhold LST from a patient with DD:

e. **Expression of Guardian or Family Member's Decision.** The Guardian or Family Member shall express a decision to withdraw or withhold LST either: (i) orally, to two persons 18 years of age or older, at least one of whom is the person's Attending Physician; or (ii) in writing, dated and signed in the presence of one witness 18 years of age or older who must also sign the decision, and presented to the Attending Physician.

The decision must clearly specify the LST that is requested withdrawn or withheld. The decision shall be included in the patient's medical chart.

f. **Required Notices.**

- At least 48 hours prior to the implementation of a decision to **withdraw** LST, the Attending Physician/designee shall notify:
  i. the patient, except if the Attending Physician determines in writing after consulting with another physician or licensed psychologist that, to a reasonable degree of medical certainty, the person would suffer immediate and severe injury from such notification; and
  ii. if the person is in or was transferred from an OPWDD operated or certified residential facility, the Executive Director of the agency operating the facility and the Mental Hygiene Legal Service (MHLS); and
  iii. if the person is not in and was not transferred from such a facility, the director of the local DDSO.
- For decisions to implement a decision to **withhold** LST/DNR, the notifications shall be made at the earliest possible time prior to the implementation of the decision. Note there is no 48 hour requirement for decisions to withhold LST.

g. **Objections to Guardian or Family Member's decision to withdraw or withhold LST.** If after notice is made, no objection is received, or all notified parties have responded that they do not object, the Surrogate's decision shall be imple**mented. If there is an objection, the Surrogate's decision shall be suspended a**nd notice of the suspension shall be provided to the Guardian or Family Member and the other parties identified in paragraph F above. Disputes shall be referred to the Medical Ethics Review Committee.

h. **Provider's obligations**.

- A health care provider shall comply with the health care decisions made by a Health Care Agent, Guardian or qualified Family Member in good faith pursuant to this section, to the same extent as if such decisions had been made by the DD patient, if such patient had capacity.
- Notwithstanding paragraph (i) above, nothing in this Management Plan requires an individual health care provider honor a decision-maker's health care decision that the individual would not honor if the decision had been made by the DD patient, if such patient had capacity, because the decision is contrary to the individual's religious beliefs or sincerely held moral convictions, provided the individual health care provider promptly informs the Guardian or Family Member and the facility, of his or her refusal to honor the Guardian or family member's decision. In such event, the facility shall promptly transfer responsibility for the DD patient to another individual health care provider willing to honor the Guardian or Family Member's decision. The individual health care provider shall cooperate in facilitating such transfer of the patient.

- Notwithstanding the provisions of any other paragraph of this subdivision I, if a Guardian, Health Care Agent or Family Member directs the provision of LST, the denial of which in reasonable medical judgment would be likely to result in the death of the DD patient, and the hospital or any individual health care provider does not wish to provide such treatment, the hospital or individual provider, as the case may be, shall nonetheless comply with the decision pending either transfer of the DD patient to a willing hospital or individual health care provider, or judicial review.

L. **Decisions for Patients With Mental Illness**

1. Decisions for patients who are inpatients on FSLH or SEMC inpatient Psychiatric Unit or who are transferred from a mental hygiene facility operated or licensed by the office of Mental Health are governed by laws other than the FHCDA. These laws include Mental Hygiene Law Article 80, Public Health Law Article 29-B, and Department of Mental Hygiene regulations. Application of these laws and regulations often results in different requirements for decisions for persons with Mental Illness than for other patients.

   For decisions for incapable patients who are inpatients on an inpatient Psychiatric Unit or have been transferred from an OPWDD or mental hygiene facility, consult case management or the legal affairs department.
2. For decisions for inpatients with Mental Illness that whose incapacity is unrelated to their Mental Illness, the Medical Decisions Management Plan applies.

M. **Immunity**

1. Public Health Law § 2994-o states in part:
   a. No health care provider or employee thereof shall be subject to criminal or civil liability, or deemed to have engaged in unprofessional conduct, for honoring reasonably and in good faith a health care decision made pursuant to provisions of the Family Health Care Decisions Act or for other actions taken reasonably and in good faith pursuant to such Act.
   b. No person shall be subject to criminal or civil liability, or be deemed to have engaged in unprofessional conduct, for acts performed reasonably and in good faith in compliance with the Family Health Care Decisions Act as a member of or as a consultant to an ethics review committee or as a participant in an ethics review committee meeting.
2. Public Health Law § 2986 states in part:
   a. No health care provider or employee thereof shall be subject to criminal or civil liability, or deemed to have engaged in unprofessional conduct, for honoring in good faith a health care decision by a Health Care Agent, or for other actions taken in good faith pursuant to New York Public Health Law provisions regarding Health Care Agents and Proxies.

CONTENT EXPERT(S) / RESEARCHER(S) / CONTRIBUTOR(S):

Risk Management Committee

This Document Replaces: SPP0140, SPP077, RI-11.

APPENDIX

PART C – GUIDANCE, FORMS AND CHECKLISTS

Department of Health publication 1449 "Your Rights as a Hospital Patient in New York State" (includes Health Care Proxy forms and instructions)

DECISIONS FOR MEDICAL TREATMENT FOR PATIENTS (Note these forms are NOT for LST/DNR DECISIONS)

- FHCDA Form 1—Adult Patient Without Capacity – With a Prior Decision
- FHCDA Form 2—Adult Patient Without Capacity – Surrogate to Consent to Treatment
- FHCDA Form 5—Authorization for Major Medical Treatment for an Adult Patient Without Capacity Who Has No Surrogate

DOCUMENTATION for DOMESTIC PARTNER OR CLOSE FRIEND

- FHCDA Form 7—Documentation of Patient's Domestic Partner or Close Friend

DECISIONS FOR DEVELOPMENTALLY DISABLED PATIENTS—INFORMATION, FORMS and CHECKLISTS

- NYS Office for People With Developmental Disabilities (OPWDD)
  44 Holland Avenue
  Albany, New York 12229
  www.opwdd.ny.gov
- NYS Office For People with Developmental Disabilities, Putting People First, *Health Care Choices: Who Can Decide*?
- MOLST Forms and checklists for DD patients are available at: http://www.opwdd.ny.gov/opwdd_resources/information_for_clinicians/MOLST
  - MOLST Legal Requirements Checklist for Persons with DD
  - MOLST Form

- New York State Justice Center – Forms for Surrogate Decision-Making Committee: http://www.justicecenter.ny.gov/services-supports/sdmc/forms

MV-19-008 Medical Orders For Life- Sustaining Treatment (MOLST) And Orders To Withhold/Withdraw Life-Sustaining Treatment (Including —"Do Not Resuscitate" (DNR) Orders)

MOLST

http://www.compassionandsupport.org

Medical Orders for Life-Sustaining Treatment (MOLST)

MOLST Form (DOH 5003): http://www.health.ny.gov/forms/doh-5003.pdf

MOLST Legal Checklists for LST/DNR Decisions: http://www.health.ny.gov/professionals/patients/patient_rights/molst/MOLST Documentation Forms (align with MOLST Legal Checklists): http://www.compassionandsupport.org/index.php/for_professionals/molst/checklists_for_adult_patients

MOLST LEGAL CHECKLISTS	MOLST DOCUMENTATION FORM (Align with MOLST Legal Checklists)
MOLST Checklist #1 - Adult patients with medical decision-making Capacity (any setting)	MOLST Chart Documentation Form #1 – Adult patients with medical decision-making capacity (any setting)
MOLST Checklist #2 - Adult patients without medical decision-making capacity who have a health care proxy (any setting)	MOLST Chart Documentation Form #2 – Adult patients without medical decision-making capacity who have a health care proxy (any setting)
MOLST Checklist #3 - Adult hospital or nursing home patients without medical decision-making capacity who do not have a health care proxy, and decision-maker is a Surrogate	MOLST Chart Documentation Form #3 – Adult hospital or nursing home patients without medical decision-making capacity who do not have a health care proxy, and decision-maker is a Surrogate
MOLST Checklist #4 - Adult hospital or nursing home patients without medical decision-making capacity who do not have a health care proxy or a Surrogate	MOLST Chart Documentation Form #4 – Adult hospital or nursing home patients without medical decision-making capacity who do not have a health care proxy or a Surrogate
MOLST Checklist #5 – Adult without decision-making capacity, who do not have a health care proxy, and MOLST form is being completed in the community	MOLST Chart Documentation Form #5 – Adult without decision-making capacity, who do not have a health care proxy, and MOLST form is being completed in the community
MOLST Legal Requirements Checklist for Individuals with Developmental Disabilities Note: OPWDD Legal Checklist on pages 18-19 of OPWDD Health Care Choices: Who Can Decide? (See DD Forms and Checklists section of this Appendix.).	
MOLST Legal Requirements for Minor Patients	MOLST Chart Documentation Form for Minor Patients

[1] Note that the time period for the terminal illness medical criteria is different for patients with DD versus other patients. For patients with DD, the standard requires expectation of death within **one year**. For Adult and Minor patients, the time period is **6 months** (see Subsections 6.6 and 11.11).

Attachments:

Flowchart
MV-19-006 Appendix A - Procedures Requiring Informed Consent
MV-19-006 Form 01 Consent for Treatment and Release From Responsibility - FSLH
MV-19-006 Form 02 Consent for Treatment and Release from Responsibility - SEMC
MV-19-006 Form 03 Advance Directives Caregiver Information - FSLH
MV-19-006 Form 04 Advance Directives Caregiver Information - SEMC
MV-19-006 Form 05 Consent for Operative and/or Diagnostic Procedures and/or Treatment - FSLH
MV-19-006 Form 06 Consent for Operative and/or Diagnostic Procedures and/or Treatment - SEMC
MV-19-006 Form 07 Refusal of Consent for Examination or Treatment (AMA) - FSLH
MV-19-006 Form 08 Refusal of Consent for Examination or Treatment (AMA) - SEMC
MV-19-006 Form 09 Patient Leaving Hospital Against Medical Advice - FSLH
MV-19-006 Form 10 Patient Leaving Hospital Against Medical Advice - SEMC
MV-19-006 Form 19 ED Consent for Treatment and Release From Responsibility #1

- FSLH
MV-19-006 Form 20 ED Consent for Treatment and Release From Responsibility #1 - SEMC
MV-19-006 Form 21 ED Consent for Treatment and Release From Responsibility #2 - FSLH
MV-19-006 Form 22 ED Consent For Treatment and Release From Responsibility #2 - SEMC
MV-19-006 Form 23 Urgent Care Consent for Treatment and Release from Responsibility #1
MV-19-006 Form 24 Urgent Care Consent for Treatment and Release from Responsibility #2

Approval Signatures

Step Description	Approver	Date
President / Chief Executive Officer	Scott Perra: President/CEO	4/10/2018
Chief Operating Officer	Robert Scholefield: Chief Operating Officer	4/10/2018
Chief Medical Officer	Michael Trevisani: Chief Medical Officer	4/10/2018
Chief Nursing Officer	Linda McCormack-Miller: Chief Nursing Officer	4/3/2018
Approver	Traci Boris: VP, Legal Counsel and Compliance	3/28/2018
Owner	Heather Haglund: Assistant General Counsel	3/16/2018