When a Patient's Prior Decision to Forgo Treatment Conflicts with a Family's Current Insistence that Treatment Be Provided

By Robert N. Swidler

In hospitals and nursing homes, variations of this uncomfortable situation arise from time to time:

> *Patient is a 79-year-old man who was brought to the hospital by ambulance after a massive, second heart attack. He was stabilized, placed on a ventilator and admitted. The patient, a smoker, had several co-morbidities, including emphysema, diabetes and, in a new development, partial kidney failure. It quickly became clear to his attending physician and staff that he was dying. Still, as of Day 2 he was lucid and had decisional capacity.*
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> *On Day 2, the attending physician discussed with the patient his condition and his prognosis, including the prospect of his heart stopping again, and the likelihood that resuscitation efforts would not be successful. With a nurse present, the patient requested a do-not-resuscitate order (DNR), which the physician wrote and placed in the chart. The patient also stated to the attending physician and the nurse that he did not want to be on the ventilator indefinitely, and that he would want it shut off, "if I lose capacity and it's clear I'm never going to get off this machine." That night the patient lost consciousness; he would remain unconscious or semiconscious from that point on.*
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> *The patient's wife and two adult children (a son and daughter) were at the hospital much of the time since his admission. On the afternoon of Day 3, when all three were present, the attending physician explained to them the patient's poor prognosis—that he was in fact dying—and he told them about the DNR order. Moreover, he said, "we're also going to need to decide soon whether it's time to stop the ventilator."*
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> *The patient's son was visibly upset, and demanded the DNR order be removed and the ventilator continued. He said, "Dad's been through this before and you have to give him every chance to get through it this time." He accused the physician and the hospital of "giving up" on his father. He made comments that if the order was not removed, he would demand to see the CEO of the hospital, and that he would contact a lawyer, his state senator (who he knows) and "Channel 6 News." The patient's wife and daughter were less adamant but deferred to the son.*
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> *The physician, shaken by the son's strong opposition, directed staff to remove the DNR order. The nursing staff was distressed at the prospect of performing resuscitation efforts that, in their view, were both futile and contrary to the patient's express instructions. The director of nursing phoned the hospital counsel for advice. She pointed out, "you know, he could code any minute."*

Assuming there are no other relevant facts, this case is not especially difficult to analyze from a strictly legal standpoint. As explained below, the legal obligation of the hospital and the physician is to give effect to the patient's decision. That is, legal principles support keeping the DNR order in place, and discontinuing the ventilator once there is reasonable certainty that the patient will not recover decisional capacity or respiratory function.

Nor does this case present a vexing ethical dilemma. Under broadly accepted principles of medical ethics, the ethical value of patient autonomy would prevail in this case, compelling the provider to comply with the patient's directive.[1]

Nonetheless, the case is enormously challenging in many respects. A hospital that recognizes its legal and ethical obligation to honor the patient's wishes must still struggle to enlist a liability-adverse attending physician to its point of view; decide upon procedural and ethical issues regarding when to implement the

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patient's decision; defuse a potentially wrenching battle with the family; avoid a public relations disaster; and—these days—avoid becoming a new battleground in the culture wars.

This article reviews the relevant law, identifies exceptional circumstances that might affect the hospitals' obligation, and provides some suggestions for hospitals for meeting the challenges presented by this case.

"What many family members—even health care professionals—do not realize is that in New York, there is no statute that generally empowers family members to consent to treatment on behalf of patients who lack capacity."

Decisions by Patients

In New York, adult patients have a very broad right to make decisions about their own medical treatment. The Court of Appeals has repeatedly affirmed "the basic right of a competent adult to refuse treatment, even when the treatment may be necessary to preserve the person's life."[2] Accordingly, doctors and hospital staff have a legal, ethical and professional obligation to honor that right, and not to treat a patient who has expressly decided to forgo treatment, even life-sustaining treatment, absent some compelling countervailing interest.[3]

A patient does not lose the right to forgo treatment when he or she loses capacity. Rather, the Court of Appeals has upheld a rule "requiring the doctors and hospitals to respect the right even when the patient becomes incompetent if, while competent, the patient had clearly stated a desire to decline life-sustaining treatment under specified circumstances."[4]

There are no specific legal requirements about how a patient must express his or her wish to forgo treatment before that expression becomes binding upon a provider (except with respect to decisions about resuscitation).[5] Courts have required only that the evidence of the patient's decision must be "clear and convincing,"[6] which means it must reflect the patient's "firm and settled commitment to the termination of life supports" under the circumstances like those presented.[7]

Some patients may create a document, such as a "living will" to express their treatment wishes. Others may discuss their wishes with a friend or relative, who relays that information to the provider. But it would seem that the most reliable evidence would be the type of statement made under the circumstances described in the hypothetical: where the capable patient sat up in the hospital bed and, after a full explanation of the specific circumstances, personally informed the provider and a witness what he did not want done.[8] In such instance, the provider's obligation would be to carry out the patient's clear instructions.

Moreover, with respect to decisions about resuscitation, the obligation to carry out the patient's decision to forgo that procedure is expressly set forth in New York's DNR statute. That law provides that when a decisionally capable hospitalized patient consents to a DNR order, either orally or in writing, the attending physician must either (i) issue the DNR order—either promptly, or at such time as the conditions, if any, specified in the patient's consent are met; (ii) or transfer the care of the patient to someone who will issue the order; or (iii) commence a dispute mediation process.[9] He or she may not simply veto or refuse to enter the order. Thus, in our hypothetical, once the hospitalized patient consented to a DNR order, the provider became bound by law to write the order, transfer the patient to another provider who would write the order, or commence dispute resolution.

Decisions by Family Members

When a patient lacks capacity and did not leave clear prior instructions, the doctor and hospital staff generally turn to family members for guidance regarding treatment decisions.[10] Indeed, it is common and customary for hospitals to accept consent for treatment from family members on behalf of patients who lack capacity and who did not previously provide such consent.

What many family members—even health care professionals—do not realize is that in New York, there is no statute that generally empowers family members to consent to treatment on behalf of patients who lack capacity.[11] To be sure, even absent such statute, it is generally safe for a provider to render medically necessary, noncontroversial treatment based on the consent of the incapable patient's closest available relative. But the principal legal support for such practice is New York's informed consent law.[12] That law generally requires that the provider secure the patient's informed consent before commencing a significant treatment, but then identifies exceptions, among them: when obtaining the patient's consent was not reasonably possible because of incapacity, and emergency treatment.[13] The law then does not empower family members to give consent;

rather it excuses providers from getting consent directly from the patient.

The point here is that the closest relative does not, by virtue of being the closest relative, possess authority to make health care decisions for an incapable patient, much less the authority to override the patient's clear prior decision.

Indeed, where the patient has made a clear prior decision, the provider has no legal obligation even to seek a second, redundant decision from a family member since the decision had already been made by a higher authority, the patient.[14] But in those situations where, for whatever reason, the provider asks a family member to decide the same question, or where the family member on his or her own initiates purports to decide the question, it must be noted that the family member has no general power to override the patient's prior decision.

There are, indeed, instances where a family member may have or secure specific statutory or regulatory authority to make decisions for an incapable adult patient. The three principal statutes authorizing surrogate decisions for incapable patients are the Health Care Proxy Law, the DNR Law and MHL Article 81 Guardians.[15] But all of those statutes obligate the surrogate to make health care decisions in accordance with the patient's wishes, if such wishes are known, and, therefore, make it clear that the surrogate decision-maker does not have the authority to override a clear prior decision by the patient:

- ***Health Care Agents.*** A health care agent, appointed by the patient pursuant to the Health Care Proxy Law, can make health care decisions for the decisionally-incapable patient, including life-sustaining treatment decisions.[16] However, the agent is obligated to make health care decisions "in accordance with the principal's wishes, including the principal's religious and moral beliefs. . . ."[17] Accordingly, a health care agent cannot override the clearly stated prior wishes of the patient.[18]

- ***DNR Law Surrogates.*** A surrogate decision-maker, identified pursuant to New York's DNR Law, may consent to the entry of a DNR order on behalf of a decisionally-incapable patient.[19] However, the surrogate is required to make such decision "on the basis of the adult patient's wishes, including a consideration of the patient's religious and moral beliefs. . . . "[20] Accordingly, the DNR Law surrogate cannot override the unequivocally stated prior wishes of the patient.[21]

- ***Article 81 Guardians for Personal Needs.*** A guardian of the person appointed pursuant to Mental Hygiene Law Article 81 can make health care decisions for the decisionally-incapable patient, other than life-sustaining treatment decisions.[22] However, the guardian is obligated to make such decisions "in accordance with the patient's wishes, including the patient's wishes and moral beliefs. . . . "[23] Accordingly, an Article 81 guardian cannot override the unequivocally stated prior wishes of the patient.

"Indeed, where the patient has made a clear prior decision, the provider has no legal obligation even to seek a second, redundant decision from a family member since the decision had already been made by a higher authority, the patient."

In our hypothetical, the patient stated his wishes clearly and unequivocally. As a result, the decision-maker, whether he or she is a health care agent, a surrogate under the DNR Law, or an Article 81 guardian, would be legally obligated to make his or her decision consistent with those instructions.

In sum, providers are obligated to give effect to a clear, unequivocal decision by a patient to forgo life-sustaining treatment (except in the unusual case where there is a contrary compelling state interest). Providers who have such a clear decision from the patient have no obligation, if the patient later loses capacity, to seek another decision from a relative. Indeed, close relatives have no general authority to make decisions for incapable patients, much less authority to override the patient's clear prior decision. Indeed, even family members who are health care agents, DNR surrogates and Article 81 guardians are obligated to make decisions that reflect the patient's wishes.

Exceptional Circumstances

Notwithstanding the principles stated so far, there are a number of exceptional circumstances that, if substantiated, would support overriding the patient's decision to forgo treatment. For example, there might be evidence that:

- the patient never actually made the statement that he was alleged to have made, or the patient

never wrote the document he was alleged to have written;

- the patient lacked capacity at the time he or she gave the prior instructions;
- the attending physician or another person exerted undue pressure upon the patient to agree to the decision;
- the patient's instructions were vague or ambiguous;
- the patient's instructions were made so long ago, or under such different circumstances, as to call into question their currency or applicability;
- the patient issued subsequent instructions that superseded the earlier instructions; or
- the patient subsequently revoked his or her prior instructions.

Any of these allegations, if true, would call into question the basic premise that the patient would want treatment withdrawn or withheld under the current circumstances. Accordingly, if such allegation is made, it is incumbent upon the provider to look into the matter and determine if the allegation is credible or specious. If the allegation appears at all credible, it would be prudent for the provider to defer the withdrawal or withholding of treatment and refer the matter to an ethics committee for guidance, or to court for a legal determination.

On the other hand, the provider should not allow clearly unbelievable allegations of exceptional circumstances by a relative, or purely personal opposition by a relative, to lead it to disregard the patient's prior instructions. Accordingly, when a relative demands that the provider provide life-sustaining treatment despite the patient's prior instructions, the provider must listen carefully to the relative's rationale: "Because I said so" is not a basis to provide treatment; "Because dad said so," may be.

Practice Tips for Providers

As noted at the outset, cases like the hypothetical at the outset of this article may be easy to resolve as a matter of legal and ethical analysis, but are still quite problematic for providers. Indeed, an assessment of the case from a pure risk management standpoint would lead a provider to conclude that he or she should follow the demands of a healthy, litigious relative rather than the prior instructions of an incapable dying patient. But that course would violate the provider's legal and ethical obligations.

Accordingly, the provider's goal should be to meet his or her obligation to the patient while trying to defuse the dispute with the insistent relative. While there is no sure way to accomplish both of those conflicting goals, these approaches merit consideration:

- ***Explain that it's the patient's decision that counts.*** A staff member who has the best rapport with the relative, or whom the relative respects, should remind the relative, in a non-adversarial manner, that the core question is "What would the patient want?" It is not, "What do you family members want?" or "What do we the providers think is best?"
- ***Buy time.*** If possible, the provider should give the family member some time to adjust to the situation. It is very difficult for a family member to make a well-considered decision, or accept advice, when they are absorbing tragic news. Thus, the decision about discontinuing a ventilator might be deferred a few days to allow the relative time to think, to grieve, and to understand that it's the patient's decision that counts. Unfortunately, the DNR decision might have to be made more promptly. But even that can often be put off, at least for a few hours or overnight.[24]
- ***Offer the ethics committee's guidance.*** If the hospital has a clinical ethics committee, the relative should be offered the opportunity to discuss the matter with that committee and get the benefit of its guidance. However, the relative must be assured that the committee is not controlled by the institution and obligated to affirm the institution's decision. If that is done, perhaps the committee can make the relative accept the appropriateness of complying with the patient's decision.
- ***Use an educational brochure.*** At Northeast Health, we are in the process of introducing a brochure that specifically addresses the issue of family members attempting to override patient decisions. It was our view that the use of such brochure would:
  - — provide a clear, consistent explanation to family members of their limited authority, and of the provider's legal obligation to comply with the patient's wishes;

— help family members realize that the provider did not single them out for an ad hoc decision rejecting their instructions. Rather the provider is implementing a consistent policy of honoring patient wishes;

— help take pressure off of staff to justify the decision, and deflect anger from them;

— inform family members about the facts that would constitute legitimate grounds for overriding a patient's prior decision, and the arguments that would not do so; and

— also serve as an educational tool for hospital staff, including the medical staff.

The brochure we developed is set forth as an Appendix to this article.

- ***Document, document, document.*** This is, of course, the health lawyer's mantra. Obviously, the provider that clearly documents the patient's expression of his or her wishes will be better able to prevail in a lawsuit, if it comes to that. But beyond that advantage, solid documentation of the patient's wishes will help the provider convince the family to defer to the patient's wishes. It will also help the provider avoid regulatory liability and respond to political and media inquiries.
- ***Reassure physicians and staff.*** The attending physician and hospital clinical staff understandably will be concerned about civil liability and threats to their licenses for withdrawing or withholding treatment from a patient over the objection of a family member. It would be helpful to reassure them that, notwithstanding family member threats, applicable law supports honoring the patient's wishes. This article, and the attached brochure, may be useful tools in that effort.

Finally, even when it is clear that the provider must honor the patient's wish to forgo treatment, and not the family's insistence upon the provision of treatment, the provider must consider, as an independent question, whether to seek court approval of its impending withdrawal or withholding of treatment, or act without such approval. Attorneys who are focused strictly on minimizing provider liability exposure would likely advise seeking court approval before withdrawing or withholding treatment whenever the matter is disputed. However, that approach could result in subjecting dying patients to treatments and procedures they may have pleaded to avoid.

Another article in this edition, in the course of discussing decisions by health care agents that are contrary to the prior decision of principal, describes factors that provider's counsel should consider in determining whether to seek the protection of a court order before following the principal's decision:

> On one end of the spectrum is the case where the patient's decision was recent, absolutely clear and unequivocal, and reasonable under the circumstances; where the agent's rationale for overriding the patient's decision is basically "because I say so"; and where the agent will have sufficient time to seek a court order to restrain the provider's action if he or she decides to do so (for example, where a feeding tube is withdrawn). In such case, the provider should feel secure in notifying the agent that it intends to disregard his or her decision and carry out the patient's decision.
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> However, as those elements weaken—e.g., in a case where the patient's decision is less recent or clear; where the agent's rationale is more plausible ("he told me he changed his mind"); and where the provider's action might become irrevocable before the agent could contest it (for example, where mechanical ventilation is discontinued), it becomes more advisable and prudent for the provider to commence the court proceeding.

That advice seems equally applicable here.[25]

Endnotes

1. *See generally*, T. Beauchamp, J. Childress, *Principles of Biomedical Ethics, 5th ed*. (Oxford 2001); A. Jonsen, M. Siegler, W. Winslade, *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine* (McGraw-Hill (2002)). Indeed, the decision would be consistent with the core ethical values of beneficence and fairness as well. *Id.* Note—This article will use the generic term "provider" when referring to the attending physician and hospital collectively.
2. *Fosmire v. Nicoleau*, 75 NY.2d 218 at 226, citing *In re Storar*, 52 N.Y.2d 363, *Rivers v. Katz*, 67 N.Y.2d 485 and *In re Westchester County Medical Center [O'Connor]*, 72 N.Y.2d 517.
3. *Fosmire v. Nicoleau*, 75 N.Y.2d 218. One of the few examples of a state interest that overrides a capable patient's right to refuse treatment is the state's interest in preventing suicide. *See Vacco v. Quill*, 521 U.S. 793 (1997).
4. *Fosmire*, *supra* at 228, citing *In re Eichner v. Dillon*, 52 N.Y.2d 363.

5. New York's DNR law specifies the manner in which a capable patient may express a decision about resuscitation. N.Y. Public Health Law § 2964.2 (PHL).
6. *In re Storar*, 52 N.Y.2d 363.
7. *O'Connor*, *supra* at 531.
8. To be sure, even in the case described there could be extraneous factors that might undermine reliance upon the patient decision. See discussion *infra*, at pp 77-78.
9. PHL § 2964(2)(c). If the physician opts for dispute mediation but the dispute cannot be resolved within 72 hours, the physician must either enter the order or transfer the patient to another physician or hospital. PHL § 2972.4.
10. See NYS Task Force on Life and the Law, *When Others Must Choose: Deciding for Patients Who Lack Capacity* (1992) at 37.
11. The proposed Family Health Care Decisions Act would accomplish this. *Id. See* S.5807/A.5405-A (2005).
12. PHL § 2805-d.
13. PHL § 2805-d(4).
14. See R.N. Swidler and N.M. Daratsos, "Informed Consent and Decisions for Patients Who Lack Capacity, " in R. Abrams and D. Moy, eds., *Legal Manuel for New York Physicians* (NYSBA and Medical Society of the State of New York 2003) § 20.7 at 323.
15. Other statutes or regulations authorize family members or others to make health care decisions for persons with mental illness or developmental disabilities. E.g., N.Y. Mental Hygiene Law art. 80 (Surrogate Decision-making Committees and Panels); Surrogate's Court Procedure Act § 1750-B (Health Care Decisions for Mentally Retarded Persons). 10 N.Y.C.R.R. § 27.9(b) (Family consent to treatment for patients of mental health facilities). Those provisions are less deferential to the prior expressed wishes of patients, given the greater likelihood that the patients had diminished capacity at the time they expressed such wishes.
16. PHL art. 29-C.
17. PHL § 2982.2. This issue is discussed in greater detail elsewhere in this edition. See K. Burke, A. Herb and R. Swidler, *Three Stubborn Misconceptions About the Authority of Health Care Agents*, NYSBA Health Law Journal, vol. 10, No. 3, at 63 (Summer/Fall 2005).
18. This issue is discussed in greater detail elsewhere in this edition of the *NYSBA Health Law Journal*. See K. Burke, A. Herb and R. Swidler, *Three Stubborn Misconceptions About the Authority of Health Care Agents*, NYSBA Health Law Journal, vol. 10, no. 3, at 63 (Summer/Fall 2005).
19. PHL art. 29-B.
20. PHL § 2965.3(a).
21. Moreover, the DNR expressly directs the attending physician to honor the decision a patient made when capable, and authorizes the surrogate to revoke only a DNR order that the surrogate consented to, not a DNR order that the patient consented to. PHL § 2969.
22. N.Y. Mental Hygiene Law art. 81. (MHL).
23. MHL § 81.22(a)(8).
24. A particularly difficult problem arises when, as in the hypothetical, the DNR order must be addressed immediately because the patient "could code any minute." In that circumstance every option is bad: keeping the DNR order in place will appall and enrage the family, and induce them to take the most drastic adversarial steps. Suspending the order could result in staff performing futile and burdensome CPR on a patient who expressly sought to avoid it. Other options like instituting a "slow code," "show code," or covert DNR order are deceitful and unacceptable both legally and ethically. In this author's view, the least-worst option is to keep the DNR order in place provisionally (because the provider has a legal and ethical duty to honor the patient's decision), but promptly inform the family of their right to submit the matter to the hospital's dispute mediation system. See PHL § 2972. If they opt to do so, the order will be suspended until (a) the dispute is resolved or (b) 72 hours elapse, whichever occurs first. *Id.*, § 2972.3. After that time if the issue has not been resolved, and if it is still clear that patient unequivocally wanted to avoid resuscitation, in this author's view the provider should reissue the order unless a court enjoins it from doing so.
25. K. Burke, A. Herb and R. Swidler, *Three Stubborn Misconceptions About the Authority of Health Care Agents*, NYSBA Health Law Journal, vol. 10, no. 3, at 63 (Summer/Fall 2005).

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APPENDIX

When a Patient's Prior Decision To Forgo Treatment Conflicts With a Family's Current Decision To Provide Treatment

Guidance for Family Members

Northeast Health

Introduction

Usually, when an important treatment decision must be made, such as whether or not to perform a medical procedure, the doctor will discuss the decision with the patient, and the patient will make the decision personally. But sometimes, patients who are very seriously ill lack the ability to make treatment decisions personally at the time the need for the decision arises.

In those situations, sometimes a patient will have given prior written or verbal instructions about his or her wishes. Often family members are available and provide their direction as well. Sometimes those instructions conflict.

This pamphlet addresses the role of prior decisions by the patient and current decisions by family members -- and the obligations of medical staff when those directives conflict.

As explained below, in general the legal, ethical and professional obligation of the doctor and the hospital, is to follow the decision the patient previously made - if the patient had capacity at the time he or she made the decision, and if the decision clearly applies to the circumstances.

Decisions by Patients

In New York, adult patients have a very broad right to make decisions about their own medical treatment - that is, whether to consent to medical treatment, or choose to forgo treatment - even life-sustaining treatment. And in general, doctors and hospital staff have a legal, ethical and professional obligation to follow the treatment decisions of their patients.

When a patient lacks "capacity" - the mental ability to make a reasoned decision - then the next best guidance staff have is the prior decision the patient made, provided the patient had capacity when he or she made the decision.

Court decisions in New York establish that if a patient leaves clear instructions that he or she would not want treatment under specific circumstances, those wishes must be honored later, when the patient no longer has the capacity to state his or her wishes directly.

There are no specific legal requirements about how a patient must express his or her wishes - except that they must be clear. Some patients may create a document such as a "living will" to

express treatment wishes. Others may simply tell their doctor or the hospital staff what they would want under certain circumstances. In either case, if the patient, when capable, makes his or her decision about treatment clearly known, it generally must be honored, even after the patient loses capacity.

For example, if a patient tells her doctor, or writes in a living will, that she does not want resuscitation in the event her heart stops, in general staff will honor those instructions. More specifically, the physician will write a "do-not-resuscitate order (DNR)" on the patient's medical chart, to reflect that decision.

Decisions by Family Members

When a patient lacks capacity and did not leave clear prior instructions, the doctor and hospital staff will generally turn to family members for guidance regarding treatment decision. Indeed, it is common for hospitals to accept consent for treatment from family members on behalf of patients who lack capacity and who did not previously provide such consent.

But as a result of laws and court decisions, some special rules apply to decisions to forgo life-sustaining treatment:

- If there is a clear prior decision by the patient, that should be honored;
- If there is no clear prior decision by the patient, in general family members have no authority to authorize the withdrawal or withholding of life-sustaining treatment - but there are two exceptions noted below:
- New York's "DNR Law" law allows family members to authorize the entry of a DNR order in certain circumstances.
- New York's "Health Care Proxy Law" enables adults to appoint someone - a "health care agent," who could make health care decisions - including life-sustaining treatment decisions - on behalf of the adult, if the adult loses the capacity to make those decision personally.

Significantly, under both the DNR Law and the Health Care Proxy Law, the decisionmaker's obligation is to make the decision the patient would make, if known.

Conflicts

It is rare for there to be a situation in which a now-incapable patient's prior decision is in clear conflict with a family's current instructions about withdrawal of life-sustaining treatment. But it does occur.

When it occurs, it is important for the family and the patient's doctor to discuss the issue thoroughly, and make sure all involved understand the important facts, including: the patient's medical condition, the benefits and burdens of the proposed treatment, the evidence of patient's decision, the reason for the family's conflicting decision. Usually, conflicts can be resolved simply after a complete discussion of these matters.

But when the conflict persists, the family must try to understand that in each case, the core question is "What would the patient want?" It is not "What do family members want?"

Accordingly, when the patient's decision is clear, it is the legal, ethical and professional responsibility of the doctor and staff to give effect to that decision. Family members cannot

override, revoke or rescind a clear prior decision by the patient.

This principle applies both when the patient opts for treatment, and when the patient opts to forgo treatment.

DNR Decisions

NY's DNR Law reflects the principle that the patient's decision controls. Although family members, under certain circumstances, can consent to the entry of a DNR order and then revoke their own consent, they cannot override the prior consent to a DNR order by the patient.

Health Care Agents

New York's Health Care Proxy Law also reflects the principle that the patient's decision controls. The law gives health care agents broad authority to make decisions for incapable patients. But it specifies that the health care agent must make the decision that the patient would make, if known. Accordingly, when the patient previously made a clear decision, the agent is bound by that. In sum, the health care agent's role is to give effect to the patient's wishes, not to override them.

Valid Reasons for Overriding a Patient's Decision

Even though the general principle is that the patient's decision controls, there may be valid reasons for overriding a patient's decision, for example:

- If there is evidence that the patient lacked capacity at the time he or she made his or her decision
- If there is evidence that the patient changed his or her mind at some point after making his or her decision.
- If the decision previously expressed by the patient does not clearly apply to the current circumstances.

Because these reasons would call into question whether the patient made a clear prior decision, the doctor and hospital staff will have to evaluate them carefully.

On the other hand, a family's opposition to a patient's decision that is based on the family's personal beliefs or preferences is not a valid reason for overriding the patient's clear prior decision.

Northeast Health Ethics Consult Service

Northeast Health offers an Ethics Consult Service that is available to discuss and provide advice to family member in ethically difficult cases. For more information, ask staff for the pamphlet "Northeast Health Ethics Consult Service."