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New York Supreme Court

APPELLATE DIVISION FIRST DEPARTMENT



ELAINE GREENBERG, as Executor of the
Estate of GERALD GREENBERG, Deceased,

Plaintiff-Appellant,

against

MONTEFIORE NEW ROCHELLE HOSPITAL,
DIEGO ESCOBAR, M.D. and
MONTEFIORE HEALTH SYSTEM, INC.,

Defendants-Respondents.

Case Nos.
2021-01438
2021-01446

BRIEF FOR *AMICI CURIAE*
COMPASSION & CHOICES, JENNIFER FRIEDLIN
AND STACEY GIBSON IN SUPPORT OF
PLAINTIFF-APPELLANT

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PRELIMINARY STATEMENT

For over a century, the New York Court of Appeals has recognized that people in this State have a common law right to refuse unwanted medical treatment. This right stems from the fundamental principle that people can choose what happens to their own bodies. In case after case, the Court of Appeals has upheld and expanded this right, grounded in autonomy and bodily integrity, based in both the New York State Constitution and the common law. Such rights protect the wishes of people who have become permanently incapacitated and have decided to refuse life-sustaining care.

As the law and public consciousness grew, New York pioneered legislation to protect these rights by memorializing healthcare decisions through advance care directives. As technology allowed people to be kept alive long after they would have died naturally, even when they would never recover, many people wanted to opt out. They did not want their bodies kept alive in these circumstances or subjected to invasive medical procedures that would only prolong their pain and suffering. Through healthcare proxies, living wills, and other advance care planning documents, people in this State can create detailed healthcare plans, describing what they want to happen to their bodies if they are no longer able to communicate their wishes directly to their medical providers. In doing so, they are exercising their right to refuse medical treatment.

The problem posed in this case is that sometimes doctors do not respect this right. They perform unwanted medical procedures, without consent, on incapacitated individuals who have made the decision to die naturally after it is clear that they will not recover, and have made the effort to memorialize their decisions through the statutory framework outlined by the legislature and the courts. This is a battery. And tort law creates an economic disincentive to stop the tortious behavior. Put simply, if people can sue for damages when healthcare providers and hospitals ignore do-not-resuscitate orders and living wills, those providers will be far more likely to follow them—and not violate the patients’ right to decide what happens to their own bodies.

Unfortunately, in *Cronin v. Jamaica Hosp. Med. Ctr.*, the Second Department, following a line of clearly distinguishable “wrongful life” cases, found that claims for violating the patient’s right to refuse medical care must be dismissed, because the law does not recognize wrongfully allowing someone to remain alive as a cognizable injury. 60 A.D.3d 803 (2d Dept. 2009). This Court should not follow this flawed precedent. This is a claim for ordinary pain and suffering damages, like any other tort case. The law, courts, and jury are entirely capable of deciding how to calculate damages for the pain Plaintiff-Appellant, Dr. Gerald Greenberg, experienced over the month that he starved to death. The

“wrongful life” cases, where children sued for damages claiming they never should have been born in the first place, are inapplicable to these facts.

Overturning the lower court’s ruling will protect people’s right to refuse medical treatment. Upholding it makes it more likely that people, including Amici Curiae, will have their carefully-prepared advance care directives ignored, and their fundamental right to decide what happens to their bodies violated.

INTERESTS OF AMICI CURIAE¹

Were this Court to uphold the lower court’s decision, individuals in New York would have a lessened ability to direct their own medical care at the end of life. Amici Curiae have a pressing interest in ensuring that end-of-life documents, such as living wills and health care proxy designations, are respected by health care institutions and, in the case those documents are ignored or violated, that a remedy exists to ensure such documents will be complied with in the future. Compassion & Choices, and its supporters, have an interest in protecting the ability to enforce advance care planning documents, to ensure that individuals, and not their treatment providers, are directing the treatment they receive at the end of life. Individuals living in New York, including Jennifer Friedlin and Stacey Gibson,

¹ No party or party’s counsel has authored this brief in whole or in part, or contributed money that was intended to fund preparing or submitting the brief. No person has contributed money that was intended to fund preparing or submitting the brief, except that Compassion & Choices and Rickner PLLC paid to have this brief printed.

need the security of knowing that their deeply personal end-of-life wishes will be respected by healthcare professionals. Therefore, Compassion & Choices, Ms. Friedlin, and Ms. Gibson respectfully submit this brief in support of Plaintiff-Appellant, and along with him, respectfully request that this Court reverse the judgment of the lower court and allow the Plaintiff to proceed in litigation.

a. Interests of Compassion & Choices

Compassion & Choices is a non-profit organization whose mission is to improve end-of-life care, expand end-of-life options, and empower everyone to chart their end-of-life journey. Its services include educating the public about the importance of end-of-life planning and about the range of end-of-life services available, advocating for policies that empower people to make their own healthcare decisions and medical practices that prioritize patients, and defending against efforts to restrict access to existing end-of-life options.

Given its mission and services, Compassion & Choices has a profound interest in and is uniquely positioned to comment on the issues at stake in this litigation: ensuring that advance care planning documents are respected at the end of life.

b. Interests of Jennifer Friedlin

Jennifer Friedlin is a 52-year-old Communications Director who lives in Brooklyn, New York. Ms. Friedlin has executed her own advance care planning

documents, including a health care proxy designation form, and expects that those documents will be strictly adhered to if or when they are needed. Ms. Friedlin also acted as the designated secondary health care proxy for her father, Howard Friedlin, whose end-of-life decisions were ultimately ignored by his treatment facility. Ms. Friedlin has an interest in this matter both to ensure (1) that her own advance care planning documents will be respected at the end of life; and (2) that a remedy exists for individuals, like her father, whose advance care planning documents were ignored or disrespected, and who received, or continued to receive, treatment against their explicit wishes.

Mr. Friedlin passed away in January 2020 after suffering from advanced dementia and a severe stroke. Many years before Mr. Friedlin's Alzheimer's diagnosis, he executed a health care proxy form, designating his wife as his primary proxy, and his daughter, Ms. Friedlin, as his secondary proxy. Mr. Friedlin's health care proxy form indicated that, upon his incapacity, his designated proxies were to make all health care decisions on his behalf. Mr. Friedlin's form also laid out his end-of-life wishes, including his desire not to be kept alive by life-sustaining measures, or receive any treatment that would serve only to artificially prolong the dying process. Mr. Friedlin went to great lengths to ensure his end-of-life wishes would be respected, and as his designated proxies, Ms. Friedlin and her mother were prepared to act on his behalf.

After Mr. Friedlin's condition worsened—he could not communicate, did not recognize his family, and could not interact with those around him—Ms. Friedlin and her mother attempted to exercise their proxy rights to deactivate Mr. Friedlin's pacemaker, which was working to artificially prolong his life. If Mr. Friedlin still had capacity, he would have had every right to have his pacemaker deactivated. As his designated proxies, Ms. Friedlin and her mother had the same authority to make that decision. Despite this, the facility refused to comply with the proxy requests and never deactivated Mr. Friedlin's pacemaker.

Ms. Friedlin was in a constant state of mourning witnessing her father's dementia progression, with every visit bringing another change that signified he had lost a little bit more of himself. At the end of her father's life, Ms. Friedlin wanted to spend whatever time she had left with her father reflecting on the love they had for one another. Instead, Ms. Friedlin spent the final months of her father's life fighting with his treatment providers to effectuate his documented wishes and proxy's requests. In the midst of her own grief, Ms. Friedlin was forced to witness the violation of her father's deeply-held desire to not have his life artificially prolonged, resulting in further pain, stress, and heartbreak for Ms. Friedlin and her family, as well as the extended and unnecessary suffering of her father, against his explicit wishes.

Ms. Friedlin has executed her own health care proxy form and is fearful that her proxy's requests could be ignored at the end of her life. After Ms. Friedlin's experience with her father's end-of-life care, she questioned whether executing advance care planning documents made any difference in the care she would receive if treatment providers could ignore those documents without consequence. Ms. Friedlin has a strong interest in ensuring her documented end-of-life wishes will be respected, and if ignored or violated, that she or her loved ones will have a remedy for the harm caused by such a violation.

c. Interests of Stacey Gibson

Ms. Stacey Gibson is a 70-year-old retired human resources manager from Garrison, New York. Ms. Gibson is a two-time cancer survivor: she had breast cancer in 1997 and lung cancer in 2019. Ms. Gibson has executed her own advance care planning documents and expects that, if or when these documents are needed, they will be respected and followed. Ms. Gibson has an interest in this matter to ensure that her own end-of-life decisions will be respected, and if not, that the treatment providers who violated her documented decisions will be held accountable.

Ms. Gibson has executed a health care proxy designation form, living will with a dementia provision, power of attorney, and universal digital advance directive. Ms. Gibson was motivated to create these advance care planning

documents after her mother had a cerebral hemorrhage in 1980, at the age of 52. Ms. Gibson's mother had not planned for her end-of-life care and was put on life support, despite being brain dead.² There was nothing Ms. Gibson or her family could do. Ms. Gibson executed her own advance care planning documents so her family would never be put in a similar position.

The importance of planning for her end-of-life care was further underscored by Ms. Gibson's husband's terminal illness. Ms. Gibson's husband developed a progressive neurological disease at the age of 60. He had executed advance care planning documents and refused treatment at the end of life. He died in hospice care on May 5, 2014.

Ms. Gibson designated her stepdaughter as her primary health care proxy, and her grandson as her secondary proxy. Ms. Gibson has had extensive conversations with her family about her end-of-life wishes. Her designated proxies love her and know her wishes, and she knows they will carry out her end-of-life decisions if or when it is necessary. It is very important to Ms. Gibson that, if she could not make medical decisions for herself, her proxies' informed decisions would be respected by her health care providers.

² Four years later, the Court of Appeals of New York held that brain death constituted legal death. *People v. Eulo*, 63 N.Y.2d 341, 346 (N.Y. 1984). As such, individuals who are found brain dead today would not receive life-support.

Ms. Gibson executed her advance care documents out of love for her family. She planned for her end-of-life care to prepare her family and to take as much fear and uncertainty out of her death as possible. When she dies, Ms. Gibson knows her family will be dealing with the stress and heartbreak of the grieving process. Her advance care planning documents help ensure, that at the very least, they will not have to second guess what she would have wanted. Instead, Ms. Gibson's family can take comfort in knowing her final wishes are being honored.

Ms. Gibson greatly respects doctors. They have twice saved her life from cancer. Yet doctors know Ms. Gibson only from a medical perspective, they do not know the totality of her wishes as a human being. Ms. Gibson believes that a doctor cannot make a fully-informed end-of-life decision about what is right for her based solely on her medical condition or prognosis. Ms. Gibson has taken the time, based on the totality of her experiences and values, to put together her advance care planning documents. She believes her treatment providers have an obligation to respect those documents and the decisions she has made and legally memorialized. Ms. Gibson has a strong interest in ensuring her advance care planning documents are respected by her treatment providers, and if not, that they be held liable for the harm they cause.

ARGUMENT

I. PEOPLE HAVE A BROAD COMMON LAW AND CONSTITUTIONAL RIGHT TO REFUSE MEDICAL TREATMENT UNDER NEW YORK LAW—EVEN IF IT MEANS THEY WILL DIE WITHOUT IT.

Over the last one-hundred years, the Court of Appeals has developed a broad right under the common law and the State constitution to refuse medical treatment, even if it means you will die without it. The doctrine first developed as a common law right to decide what doctors can, and cannot, do to your body:

Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages.

Schloendorff v. Soc’y of New York Hosp., 211 N.Y. 125, 129–30 (N.Y. 1914). New York no longer views negligent medical malpractice as an assault, *see Bing v. Thunig*, 2 N.Y.2d 656 (N.Y. 1957), but the right to refuse medical care—rooted in the right to determine what happens to one’s own body—has been reaffirmed and expanded by the Court of Appeals in the century since Justice Cardozo’s decision in *Schloendorff*.

In *Matter of Storar*, the Court of Appeals considered the advance directives of Brother Joseph Fox, a member of the Society of Mary Catholic religious order, who worked at a religious school called Chaminade. 52 N.Y.2d 363, 371 (N.Y. 1981) (consolidated on appeal with the John Storar matter). A few years before in 1976, the Supreme Court of New Jersey decided the seminal *Matter of Quinlan*

case. 70 N.J. 10 (N.J. 1976). There, the court ruled that Joseph Quinlan, the father of Karen Quinlan, who was in a persistent vegetative state, could be appointed as Ms. Quinlan's guardian, and if the hospital agreed that Ms. Quinlan would never recover, Mr. Quinlan could have her taken off of a respirator, allowing her to die naturally. *Id.* at 55. This case sparked a national debate, and while discussing the *Quinlan* case, Brother Fox clarified to the other members of his church that, if he was in a vegetative state, he would not want his life artificially extended with a respirator. *Storar*, 52 N.Y.2d at 371.

Unfortunately, Brother Fox had a complication during hernia surgery and ended up in a "vegetative state," supported by a respirator. *Id.* Father Philip Eichner, the president of Chaminade, applied to be Brother Fox's guardian so he could have Brother Fox removed from the respirator, in accordance with Brother Fox's wishes. *Id.* The application was granted, and that order was upheld by the Court of Appeals, who found that Brother Fox had "carefully reflected on the subject, expressed his views and concluded not to have his life prolonged by medical means if there were no hope of recovery," and found that New York law, "identifies the patient's right to determine the course of his own medical treatment as paramount to what might otherwise be the doctor's obligation to provide needed medical care." *Id.* at 377-79.

A few years later, in *Rivers v. Katz*, the Court of Appeals, relying on *Schloendorff* and *Storer*, further enlarged this right, finding that people with mental illness have a constitutional right to refuse medication. 67 N.Y.2d 485, 492–98 (N.Y. 1986). “[N]either mental illness nor institutionalization per se can stand as a justification for overriding an individual’s fundamental right to refuse antipsychotic medication,” even when this medication may treat the person’s symptoms and improve their quality of life. *Id.* at 498.

In *Fosmire v. Nicoleau*, the Court of Appeals clarified that the right to refuse lifesaving treatment was not limited to people on respirators or the elderly; even healthy, young people may refuse medical treatment. 75 N.Y.2d 218, 221 (N.Y. 1990). The patient, Denise Nicoleau, was a nurse in her 30s and a Jehovah’s Witness, whose religious beliefs prohibited blood transfusions. *Id.* at 222. After giving birth by Cesarean section, she developed a hemorrhage and lost a lot of blood. *Id.* The doctor wrote that, “unless her medical condition improves (which I consider unlikely), she must have a blood transfusion in order to preserve her life.” *Id.* at 223.

On appeal, the hospital argued that “a patient’s right to decline lifesaving treatment should be limited to cases where the patient has a terminal or degenerative disease,” and that the State has a strong interest in preserving life, “when the patient is a parent.” *Id.* at 224. The Court of Appeals disagreed, and

reaffirmed “the basic right of a competent adult to refuse treatment even when the treatment may be necessary to preserve the person's life,” relying on both the common law right in *Schloendorff* and *Storer*, and the constitutional right in *Rivers*. *Id.* at 226. Interestingly, even though the Ms. Nicoleau was refusing the blood transfusion for religious reasons, the Court of Appeals did not factor her right to religious freedom into its analysis; the ruling rested entirely on the common law and constitutional right to refuse treatment. *Id.* at 225–26.

Finally, in *Myers v. Schneiderman*, the Court of Appeals clarified that refusing life-saving treatment “is not considered a suicidal act.” 30 N.Y.3d 1, 14–15 (N.Y. 2017) (quoting *Fosmire*, 75 N.Y.2d at 227). Refusing treatment, even at the risk of dying, is protected, and distinct from taking affirmative steps to end one’s life—even if both result in death. *Id.*

II. ADVANCE CARE PLANNING DOCUMENTS ALLOW PEOPLE TO EXERCISE THEIR RIGHT TO REFUSE MEDICAL TREATMENT.

As the right to refuse medical treatment developed, the legislature and Governor crafted laws that would allow people to exercise this right using advance care planning documents. These documents allow patients to express their wishes in advance, and then appoint someone to act in their stead should they become incapacitated and unable to advocate for themselves.

a. The Legislature Has Enacted a Substantial Set of Laws to Protect the Right to Refuse Medical Treatment.

Brother Fox's wishes were ultimately respected because he, by happenstance, had clearly expressed his desires in somber conversations with Father Eichner. *Storar*, 52 N.Y.2d at 371. In fact, the Court of Appeals only sided with Father Eichner because he proved, by clear and convincing evidence, that Brother Fox did not want to remain on a respirator. *Id.* at 379. The Court found this standard, the highest civil standard of proof, is required, "where it is claimed that a person, now incompetent, left instructions to terminate life sustaining procedures when there is no hope of recovery." *Id.*

In *Matter of O'Connor*, the Court of Appeals explained that, to meet this burden, a written document outlining the patient's wishes is the best method:

The ideal situation is one in which the patient's wishes were expressed in some form of a writing, perhaps a 'living will,' while he or she was still competent. The existence of a writing suggests the author's seriousness of purpose and ensures that the court is not being asked to make a life-or-death decision based upon casual remarks. Further, a person who has troubled to set forth his or her wishes in a writing is more likely than one who has not to make sure that any subsequent changes of heart are adequately expressed, either in a new writing or through clear statements to relatives and friends. In contrast, a person whose expressions of intention were limited to oral statements may not as fully appreciate the need to "rescind" those statements after a change of heart.

72 N.Y.2d 517, 531–32 (N.Y. 1988) (also finding that "a requirement of a written expression in every case would be unrealistic"). But, absent legislative action, the

courts had no authority to enforce these written expressions, known as living wills. *See Saunders v. State*, 129 Misc. 2d 45, 53 (Sup. Ct., Nassau Co.1985) (“only the legislature has the authority to enact a statute recognizing the validity of living wills”).

Thus, after *Saunders* and *Storar*, while *Matter of O’Connor* was moving through the courts, in 1985, then Governor Mario Cuomo, “recognizing the need to develop public policy regarding the ethical, moral and legal considerations arising from decisions to save and/or prolong life due to advancements in medical technology, convened the New York State Task Force on Life and Law (Task Force).” *See In re Doe*, 53 Misc. 3d 829, 851 (Sup. Ct., Kings Co. 2016). In 1986, the Task Force published *Do Not Resuscitate Orders*, with proposed legislation.³ These recommendations became Article 29-B of the Public Health Law §§ 2960–2989. Under this law, “an adult with capacity may express a decision consenting to an order not to resuscitate in writing.” *Id.* at § 2964(a). The healthcare providers are then allowed, although not required, to issue an order not to resuscitate. *Id.* at § 2962(a).

In 1987, the Task Force published a longer analysis of end-of-life decision making and advance care directives, along with proposed legislation, entitled

³ *See* Susan M. Golden, *Do Not Resuscitate Orders: A Matter of Life and Death in New York*, 4 J. Contemp. Health L. & Pol’y 449, 450 (1988).

“Life-Sustaining Treatment Making Decisions and Appointing a Health Care Agent.”⁴ The Task Force recognized the broad right to refuse medical treatment developed by the Court of Appeals, and the practical difficulties of determining what the patient wants, after they are incapacitated. *Id.* at iv-vii.

The Task Force’s recommendations became Article 29-C of the Public Health Law §§ 2980-2994. This statute created a procedure for patients to appoint health care proxies to make medical decisions for them once they become incapacitated. *Id.* at § 2980(a) (“A competent adult may appoint a health care agent in accordance with the terms of this article.”). And subject to “any express limitations in the health care proxy,” this agent can make “any and all health care decisions on the principal’s behalf that the principal could make.” *Id.* at § 2982(1). Had Father Eichner had a health care proxy, he would not have had to apply to make decisions for Brother Fox. *See In re M.B.*, 6 N.Y.3d 437, 439 at n.1 (N.Y. 2006) (“a competent adult can, of course, relieve family and friends of the burden of seeking such a court order by executing a health care proxy”).

Article 29-B addressed do not resuscitate orders, and Article 29-C addressed removing artificial nutrition sustaining life, but the law did not cover the other

⁴ THE NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, LIFE SUSTAINING TREATMENT: MAKING DECISIONS AND APPOINTING A HEALTH CARE PROXY (JUL. 1987), available at https://www.health.ny.gov/regulations/task_force/reports_publications/docs/life-sustaining_treatment.pdf (last accessed Dec. 8, 2021).

potential medical interventions at the end of life. *See Borenstein v. Simonson*, 8 Misc. 3d 481, 494 (Sup. Ct., Queens Co. 2005) (explaining the statutory scheme in Article 29-C for discontinuing artificial nutrition). In 2010, to fill this gap in the statutory scheme, the legislature passed Article 29-CC of the Public Health Law §§ 2994-a-2994-u, the Family Health Care Decisions Act, “in order to allow competent adults who lose decision-making capacity due to catastrophic illnesses to control their medical treatment.” *Sloane v. M.G.*, 164 A.D.3d 158, 169 (1st Dept. 2018).

Under this law, a surrogate, such as a health care proxy, can refuse life-sustaining treatment on behalf of a patient, in accordance with that patient’s wishes, if the treatment would be “an extraordinary burden to the patient” and the patient is expected to die “within six months,” or is “permanently unconscious,” or the treatment would “involve such pain, suffering or other burden that it would reasonably be deemed inhumane or extraordinarily burdensome” and “the patient has an irreversible or incurable condition.” Pub. Health Law § 2994-d(5). Further, if the patient’s wishes are not clearly established, the law provides a mechanism for determining what is in the patient’s best interests, which could mean refusing life-sustaining treatment. *See In re Norsen*, 939 N.Y.S.2d 740 (Sup. Ct., Erie Co. 2011) (explaining how the Family Health Care Decisions Act expanded the law).

The New York State Department of Health has also taken steps to protect the right to refuse treatment. They have created a standard form for “Medical Orders for Life-Sustaining Treatment” (“MOLST”), and found that “[h]onoring patient preferences is a critical element in providing quality end-of-life care.”⁵ This additional action by the executive branch has made advance care planning more accessible and easier to implement.

New York has thus developed into a flexible, practical way for people to exercise their right to refuse medical treatment at the end of life. Patients can express their wishes in advance care planning documents, including a MOLST, and then rely on healthcare proxies to carry out their wishes if they become incapacitated. It is impossible to predict what happens at the end of life, so the healthcare proxies have some flexibility to address unexpected situations, while still honoring the patient’s express wishes.⁶

⁵ NEW YORK DEPT. OF HEATH: MEDICAL ORDERS FOR LIFE-SUSTAINING TREATMENT, available at https://www.health.ny.gov/professionals/patients/patient_rights/molst/ (last accessed Dec. 8, 2021).

⁶ In fact, this flexibility in part motivated the passage of New York’s health proxy law. *Supra*, n.4 at 78 (“Appointment of a health care agent avoids the difficulty, inherent in the use of living wills, of trying to anticipate future medical circumstances and make treatment choices at a time which may be far removed from the actual events.”).

b. Many People in this State, and Amici Curiae, Rely on Advance Care Planning to Protect Their Rights.

These advance care planning documents are very popular with New Yorkers. Before COVID-19, 1 in 3 adults had executed an advance care directive,⁷ with data showing even higher rates in the State of New York.⁸ Since the beginning of the pandemic, these numbers have risen significantly, increasing almost five-fold.⁹ The reasons for executing these directives are often very personal. Amicus Curiae Stacey Gibson's mother did not execute advance care directives. After a cerebral hemorrhage, she ended up in a vegetative state on life-support without a chance of recovery. But Ms. Gibson had not discussed her end-of-life wishes with her family, and had not executed any advance care planning documents. Thus, her family could do nothing to remove the life-support. Ms. Gibson's husband, however, did execute a plan for his end-of-life care. After he developed a progressive

⁷ Kuldeep N. Yadav et al, *Approximately One In Three US Adults Completes Any Type Of Advance Directive For End-Of-Life Care*, 36 *Health Affairs* 7 (Jul 2017), available at <https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0175> (last accessed Dec. 8, 2021).

⁸ See generally R. Sean Morrison, MD and Diane E. Meier, MD, *High Rates of Advance Care Planning in New York City's Elderly Population*, *JAMA Network*, (Dec. 13, 2004), available at <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/217760> (last accessed Dec. 8, 2021).

⁹ Catherine L. Auriemma, MD et al, *Completion of Advance Directives and Documented Care Preferences During the Coronavirus Disease 2019 (COVID-19) Pandemic*, *JAMA Network* (Jul. 20, 2020), available at <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2768372> (last accessed Dec. 8, 2021).

neurological disease, he refused treatment at the end of his life, dying in hospice in accordance with his wishes. Now, if Ms. Gibson becomes incapacitated, she wants her stepdaughter to carry out her end-of-life decisions, because she trusts her family to carry out her wishes—and protect her right to refuse medical treatment.

These advance care documents also take the burden away from families. Absent advance care planning, it may not be clear what the patient wants. Not only will the family often be powerless to act absent authority and clear directives, they may wonder what the patient would have wanted and who the patient would have wanted to decide. Worse, absent direction, the family could fight amongst themselves over who should be allowed to make these decisions. Ms. Gibson’s family will have no such burden if her advance care directives are followed. Her wishes are clear, as is her stepdaughter’s authority to act in her stead.

III. THE LOWER COURT’S RULING MAKES IT MORE LIKELY THAT PEOPLES’ RIGHT TO REFUSE MEDICAL TREATMENT WILL BE VIOLATED, AND THEIR ADVANCE CARE PLANNING DOCUMENTS IGNORED.

The lower court’s decision, if upheld on appeal, effectively leaves people in the First Department without a meaningful remedy if they are forced to undergo medical treatment at the end of their lives, against their express wishes. Amici Curiae are rightly concerned that, absent an effective enforcement mechanism in the courts, their rights, and the rights of their family members, could be violated.

For Amici Curiae Jennifer Friedlin, like Dr. Elaine Greenberg, this nightmare was real. Her father was diagnosed with Alzheimer’s and executed a health care proxy. He made it clear that once he lost capacity, he wanted to discontinue any measures that would artificially extend his life. After watching him deteriorate, she asked the treatment providers to honor his wishes, and deactivate his pacemaker. They refused, and she spent months fighting the facility who was violating her father’s rights, rather than spending time mourning him as he passed. She has executed her own advance planning documents, and after what happened to her father, she fears the same could happen to her.

One of the core purposes of tort law is to “provide a sufficient economic disincentive” to discourage future tortious behavior. *Greene v. Esplanade Venture P’ship*, 36 N.Y.3d 513, 527 (N.Y. 2021) (Rivera, J., concurring). Articles 29-C and 29-CC do not create a private right of action. *See Lanzetta v. Montefiore Med. Ctr.*, 71 Misc. 3d 508, 512–15 (Sup. Ct., Bronx Co. 2021). But no statutory cause of action is necessary here because the right to refuse medical treatment comes from the constitution and the common law. *See Brown v. State*, 89 N.Y.2d 172, 187 (N.Y. 1996) (“the courts have the obligation to enforce these rights by ensuring that each individual receives an adequate remedy for violation of a constitutional duty”); *Zimmerman by Zimmerman v. New York City Health & Hosps. Corp.*, 91

A.D.2d 290, 293 (1st Dept. 1983) (“Surgery performed without informed consent” is a battery).

Thus, courts agree there is a right and a cause of action. But one court wrongly found the cause of action still cannot succeed, because it is too difficult to calculate damages arising from the tort. This is illogical. In *Cronin v. Jamaica Hosp. Med. Ctr.*, the defendants violated “two do-not-resuscitate orders,” prolonging the plaintiff’s life against his express instructions. 60 A.D.3d at 803. But the Second Department dismissed the claim, finding that “the status of being alive does not constitute an injury in New York.” *Id.* at 804. This ruling was based on two Court of Appeals cases finding that wrongful life is not a “legally cognizable injury” because it “‘demands a calculation of damages dependent upon a comparison between the Hobson’s choice of life in an impaired state and nonexistence,’ which the law is not equipped to make.” *Alquijay by Alquijay v. St. Luke’s-Roosevelt Hosp. Ctr.*, 63 N.Y.2d 978, 979 (N.Y. 1984) (quoting *Becker v Schwartz*, 46 N.Y.2d 401, 412 (N.Y.1978)). The lower court here, following *Cronin*, framed Plaintiff-Appellant’s claim as one for wrongful life, and dismissed the action accordingly. R.140.

This Court, however, is not bound by *Cronin*, and should not follow its flawed logic and reliance on these two distinguishable decisions. In *Alquijay*, the plaintiff was a child, litigating through her parents, who demanded compensation

for the extraordinary cost of treating her Down's Syndrome, after "defendants negligently performed an amniocentesis test on her mother during pregnancy[,]"" causing the mother to carry her to term "instead of aborting the fetus." 63 N.Y.2d at 979. The child in *Becker* also had Down's Syndrome and brought essentially the same claim. 46 N.Y.2d at 406.

The Court of Appeals wrestled with the question of how to calculate damages for what it called "wrongful life." *Id.* To calculate damages in these negligence actions, the Court reasoned, the law would have to place the plaintiffs into the position they would have occupied "but for the negligence of the defendant." *Becker*, 46 N.Y.2d at 411. For the children in *Alquijay* and *Becker*, the position they would have occupied, but-for the negligence, is never having been born. The plaintiffs were effectively asking the finder of fact to award damages measured as though they never existed in the first place. This unsolvable logic puzzle required dismissal of their cases.

But the Greenberg family is not asking the trier of fact, or the law, to ponder Dr. Gerald Greenberg's non-existence. They are asking for ordinary tort damages for the pain and suffering he experienced as result of the artificial prolongation of his life against his direct wishes. Even in difficult cases, the law can manage this calculation. In *Zimmerman by Zimmerman*, a doctor performed spinal surgery on a child, without informed consent, to prevent future paralysis. 91 A.D.2d at 293–94.

This was a battery. The operation was a success and the child could still walk, and even run around the gym. *Id.* at 294. But the child became incontinent because of the surgery, although, absent surgery, the same may have resulted. *Id.* Despite this Hobson’s choice between the risks of not having surgery (paralysis and incontinence), and the child becoming incontinent after the otherwise successful surgery, the jury agreed on a substantial award for damages, which this Court upheld on appeal. *Id.* at 293 (“[W]e may properly consider how much, if at all, the patient is worse off than she would have been had the surgery not been performed.”).

Like the difficult choice the jury and court faced in *Zimmerman*, the jury and court here can readily weigh whether Dr. Greenberg was better off being subjected to unwanted medical treatment, in violation of his rights, leaving him to starve to death over the course of a month, or if he was better off being allowed to die naturally, in accordance with his wishes. *Alquijay* and *Becker*, and the “wrongful life” analysis on which they rely, is simply not applicable here. Thus, *Cronin* was wrong to extend it to cases where a patient’s right to refuse treatment is violated, and this Court should not follow it here.

This Court can, and should, allow the Greenberg family’s case to go forward, so they can recover for the unnecessary pain and suffering Dr. Greenberg

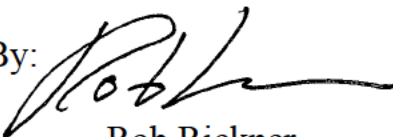
endured, and to protect people like Amici Curiae, who want to ensure hospitals and doctors honor their patients' advance care directives.

CONCLUSION

WHEREFORE, Amici Curiae respectively ask that this Court reverse the decision of the Supreme Court and allow the Greenburg case to proceed, in accordance with the relief sought by Petitioner-Appellant in this matter.

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