

# 2026 HEALTH CARE DECISION MAKING GUIDE

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*Trusted Counsel*

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**[www.pierrolaw.com](http://www.pierrolaw.com) | [info@pierrolaw.com](mailto:info@pierrolaw.com) | 866 951-PLAN**

# A Personal Guide for Making Health Care Decision and How to Have Your Wishes Honored

## Introduction

Making decisions about one's life and medical care is a basic right of an autonomous human being. In health care, as in many areas involving experts and professionals, individuals are only recently getting accustomed to making their own decisions and, perhaps more importantly, questioning the decisions of others, including their physicians, in areas that have a direct bearing on their lives.

This Guide is designed to provide you with a path to keep control of your health, your body and your life to the maximum extent possible, even if you become ill and are unable to communicate your decisions and wishes for yourself. As Pierro, Connor & Strauss's founding partner Lou Pierro says, "Life Happens," and we will work with you to be prepared and ensure it happens your way, even when your treating physicians or members of your family may disagree.

Each day medical science offers new technologies; new technologies offer new options; and new options create new dilemmas. With advanced technologies capable of keeping more and more people alive longer and longer, life-and-death decision-making issues have become both more complex, and more common.

At the same time, patients have fought for and won the right to make decisions about their own health care, which were formerly the exclusive province of medical practitioners. Compounding the difficulty for patients or their surrogates, they must make these decisions at times of crisis, often under extreme stress. Under optimal circumstances it would be hard to absorb all the information thrown at you—options, therapeutic benefits, risk factors, possible side effects—all in scientific terms guaranteed to alarm even the most stout-hearted. Medical crises are rarely optimal circumstances. The more life-threatening the situation the more difficult the decision; the more difficult the decision, the more stressful the situation. It is a vicious cycle.



While you're trying to determine what's best to do, others may be undermining your efforts, trying to take the choice away from you. When it comes to confronting life-and-death issues, there are no easy answers. But there are laws and techniques that will empower you to assert your rights.

Our guide is designed to prepare you for making critical future decisions, even when your wishes are expressed by your representative. We believe our clients

must utilize the tools available today, so that each of you will be protected and your wishes about the kinds of medical treatment you want or don't want are carried out, especially at a time when you are not able to communicate your choices because of incapacity. Part One will explain the legal documents available to accomplish this goal, including what factors you should consider in choosing the persons who you wish to speak for you and how you communicate your wishes and values to them and your physicians.

Part Two is designed to provide you with a history of the law and background about the relationship between patients and their rights with respect to health care providers regarding health care decisions, particularly decisions regarding treatment at the end of life. This Part will also discuss practical steps a patient can take when dealing with physicians and the health care system with respect to honoring their treatment decisions.

Finally, Part Three will discuss the rights of persons who are terminally ill, and their options to hasten death to avoid prolonged suffering in the various states.

## **The Tools: Advance Directives for Health Care**

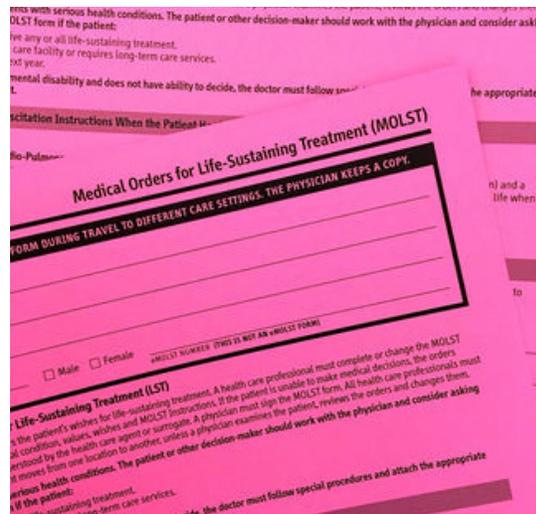
Unfortunately, medical decisions are not usually made at leisure. Nor are they always made when the patient can understand, make, and communicate decisions about his or her health. Your right to have your wishes respected continues even if you are incapacitated. If you are no longer in a position to state them, others are allowed by law to assert them on your behalf as your surrogate. If a person's wishes are expressed when he or she has capacity, either through a written document such as a living will - which we prefer to call a Health Care Declaration (HCD) - or orally to another person, those wishes must be respected. There are tools to make this happen: health care advance directives.

### **The Basic Advance Directives**

- **Health Care Proxy.** Also called in some states a Durable Power of Attorney for Health Care, the Health Care Proxy (HCP) allows you to designate an agent in advance to make decisions on your behalf if you later become incapacitated. The proxy form designates someone else to ensure that the wishes you have expressed in your Health Care Declaration (HCD) are carried out, and to make health care determinations on your behalf, if you're not capable or don't have a HCD, or for things not anticipated in your HCD. The health care proxy is sometimes a separate document, but it is our practice at Pierro, Connor & Strauss to merge the two tools in one "combined" instrument which also included a HIPAA release section.



- **Health Care Declaration (“Living will”).** The health Care Declaration, often referred to as a “living will,” states your desires concerning future medical care, specifying what treatment you want or don’t want. These are sometimes called a Living Will Directive, or Instructional Directives. We use the term Health Care Directive because that’s a more descriptive term for what it is.
- **MOLST (Medical Order for Life Sustaining Treatment).** The MOLST is a form authorized by state law in several states prepared by a physician working with the patient, usually in a hospital setting for a patient who is undergoing an invasive or serious procedure or is terminally ill. It is a detailed form – almost a chart – of the patient’s wishes about very specific treatments and procedures. Because it is a physician’s order and is in the patient’s chart, it is more likely to be followed in the hospital setting and may in some cases minimize the issue of compliance with the patient’s wishes; a serious issue that we will discuss later. In some states, the term used is Physician Order for Life Sustaining Treatment (POLST).



The MOLST document, kept in the patient’s chart, does not replace the Health Care Declaration or Health Care Proxy but rather supplements them. It can also guide the health care agent’s decision if she or he is not sure of the maker’s wishes, just as the Health Care Declaration does.

- **DNR Order.** There is a physician’s written instruction stating ‘do not resuscitate’ if the patient’s heart or breathing stops. It is a form signed by a physician and a patient who has capacity or can be signed by the health care agent when the patient lacks capacity to give informed consent. A DNR order need not be executed in advance and can be signed in the hospital at admission or just before a procedure.

## The Health Care Declaration

The Health Care Declaration (“Living Will”) has become common since the U.S. Supreme Court decided the case of Nancy Cruzan in 1990 which established the legal principle recognizing patients’ wishes expressed through advance directives. The famous actress Helen Hayes had one. Her story is vividly told in a video prepared by the American Bar Association’s Commission on Law and Aging. The video has an epilogue by her son, James MacArthur, movingly demonstrating the important role the document had at the time of Ms. Hayes’ death.

How does it work? If you’re well enough and have the capacity, you tell your doctors what you want and don’t want. If you’re not able, your Health Care Directive does it for you; it speaks for you when you can’t. It ensures that your

family, your health care agent and your doctor - and any other doctor or medical facility treating you - knows your wishes in the event you aren't able to make your own medical decisions.

## What else do you need to know about a Health Care Directive?

- When and under what conditions it becomes effective
- What medical care is authorized and what medical care is not authorized
- How the directive itself is sanctioned in your state, what form must be used and what necessary signatures and witnesses

Health Care Directives are governed by state law. Most states and the District of Columbia have specific laws authorizing and regulating their use. The other states recognize them and rely on interpretation of court decisions. New York does not have an authorizing statute, but they are recognized by court decisions.

You should talk with those closest to you and your health care agent about your wishes ahead of time—that's why your written expression of your wishes (your Health Care Declaration) is called an "advance directive." Take the time now to talk to family, physicians, and clergy. A Health Care Directive is your protection when and if you become incapable of making or communicating decisions about your health care. While it may not seem like an appropriate discussion for the Thanksgiving table, if that is the only time the family gathers, it should be done.

## When does a Health Care Directive become effective?

**Answer:** When you're incapable of making or communicating your own necessary health care decision; in other words, when you have lost the capacity to give informed consent. If you could speak for yourself, your advance directive would not be effective or necessary.

## What is the definition of capacity?

**Answer:** For health care purposes, a person with capacity is able to understand the illness, the nature and benefits of the proposed treatment, and the risk in accepting or refusing it. That's "informed consent."

Several states impose restrictions on the use of living wills. In many states, the statutes say a living will may be used only if the patient has a "terminal condition;" in some states, death must be "imminent." The wording of these statutes can make the effectiveness of a Health Care Declaration less meaningful. For example, a person with advanced Alzheimer's disease or totally incapacitated from a stroke might not be deemed "terminal" so that the Health Care Declaration may not be deemed to be in effect. And the patient's death may not be deemed "imminent."



Statutory language such as this is unfortunate and probably not binding. Under the Cruzan decision, you have the right to refuse treatment by orally stating your wishes or through your Health Care Declaration, whether you are in a terminal condition and your death is “imminent” or not. Since New York does not have a living will law there is no such legal limitation. But many New York living wills are badly drawn and include such wording – don’t sign such a form! And because you may at some time move to a state that imposes such restrictions you should state in your living will that your wishes are to be binding “even if I am not in a terminal condition and even if my death is not imminent.” And do not include wording that you don’t want “heroic measures.” Be precise in the language you use. Is a heart transplant “heroic” or routine medical procedure today?

A HCD becomes effective only when and if you are incapable of making or communicating decisions about your health care. If you are capable, you can speak up – after all, you may have changed your mind.

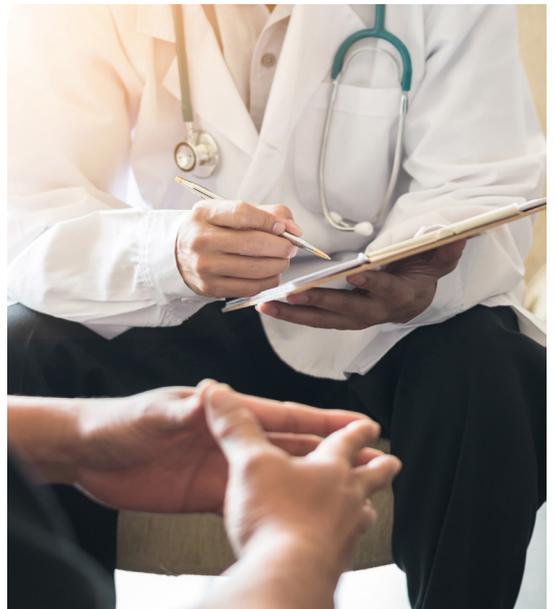
### **Must my wishes be honored? If not, what do I do?**

How serious is the problem of hospitals and physicians refusing to honor a patient’s wishes? Very serious (we discuss this issue here and again in Part Two of this Guide).

Patient wishes, even if there is a Health Care Declaration, are not always honored. Having an agent acting under a proxy to advocate for your stated wishes may make a difference, but there will be situations where you receive unwanted treatment. The courts have not been comfortable in disciplining hospitals and physicians who provide unwanted treatment – “erring” on the side of life is usually not viewed as a wrong, notwithstanding Justice Cardoza’s words.

You (or a family member acting as your surrogate) may need a lawyer to enforce your rights. In Florida, Estelle Browning left specific written instructions not to intubate her. Because she was in a vegetative condition, but death was not imminent, as she specified in her living will, her instructions were ignored, and she was kept alive against her wishes. Subsequent legal action, unfortunately too late for Mrs. Browning, upheld her right to refuse the tube feeding.

This has been a national problem, particularly in New York, where court decisions made it almost impossible to successfully sue health care providers when they failed to respect the expressed wishes of patients near the end of life and the patients suffer as a result. In a 2009 New York case, Cronin v. Jamaica Hospital Medical Center, 60 AD. 2nd 803 (2009), a lawsuit for medical malpractice and negligence, the Appellate Division, Second Department, of



the NYS Supreme Court, upheld a lower court decision dismissing the case of a 72 year old man admitted to Jamaica Hospital Medical Center suffering from various illnesses who was resuscitated on two occasions, in violation of two do-not-resuscitate orders which had been signed by members of the decedent's family and approved by hospital physicians. On June 9, 2004, following the second resuscitation, two weeks after the decedent would have died if the DNR order had been respected, he was removed from life support systems and died. The suit charged that he survived for about a month in the unresponsive state that he had sought to avoid. "They made the end of his life horrible and painful and humiliating," his widow said. "What's the sense of having a living will if it's not honored?" In dismissing the case, the trial court judge wrote that the plaintiff was asserting a claim for "wrongful living" and that no such claim existed under the law. The appeals court, as noted above, agreed.

And in February of 2021, Lanzetta v. Montefiore Med. Center, another suit to recover damages for the pain and suffering experienced by a man who lived 20 days after being administered life-sustaining medical treatment, including multiple doses of antibiotics and intravenous fluids, in contravention of both the terms of his living will and the instructions of his health care agent was dismissed. The judge wrote that "Plaintiff's claim is, in effect, one for wrongful prolongation of life. Such a claim is neither cognizable under New York's common law nor recognized by statute."



But the law is changing, as evidenced by 2017 New Jersey case, Koerner v. Bhatt, where the trial court judge held that a woman could sue her deceased mother's (Stica) health care providers for resuscitating her against her clearly stated instructions after she went into cardiac arrest. Ms. Stica lived for several months in a "terrible state." The case was settled for a nondisclosed amount, so there was no subsequent appeals court decision.

However, in a more recent New York decision of greater significance is the 2022 appeals court decision in Greenberg v. Montefiore, 205 A.D.3d 47) where the court held the hospital liable for damages for causing pain and suffering. The patient was a medical doctor. He had signed a health care proxy, a living will and working with his treating physician had completed a MOLST form. These documents were in his hospital chart, as were clear notations that he was "DNR, DNI, no feeding tubes, no antibiotics, no IV fluids, and see MOLST in chart." These documents were ignored.

Justice Gesmer writing for the appeals court said:

"... I find that the holdings in ... (citing other prior decisions) ... do not bar plaintiff from proceeding with the medical malpractice claim set forth in the complaint on the theory that the failure to follow decedent's directives was a departure from the standard of care." (205 A.D.3d 52]

While this case shows favorable progress, because the decision is not established law in all districts in New York or other states, there is a need to clarify New York law to require health care providers to comply with clearly expressed patient wishes and permit such lawsuits. A bill was introduced in the New York 2021 legislative session by Assemblyperson Richard Gottfried<sup>†</sup> to require such compliance (A.250 2021) that did not pass. A similar bill was introduced in 2022 and again re-introduced in the New York legislature in the 2023 session for consideration but did not pass.

<sup>†</sup> Now retired Assemblymember Gottfried was chair of the Health Committee for many years.

## **What Can Be Done to Enforce My Wishes?**

At Pierro, Connor & Strauss, we have developed a new approach to deal with this issue by including some strong language in our Health Care Declaration that states:



### **Enforcement of My Directives**

It is my intention that my wishes, as evidenced by this document and my agent's instructions, be honored by everyone, including my family, friends, courts, physicians and all others concerned with my care. I expect all such persons to be legally and morally bound to act in accord with my wishes, as expressed on my behalf by my agent. If any hospital or other institution or any physician, nurse or other health care personnel refuses to obey my wishes as set forth herein, I hereby direct my agent to take one or more of the following actions: (1) commence suit against such institution and/or personnel for all hospital costs, drugs, medical expenses and all other damages flowing from such refusal, including my pain and suffering, (2) not to pay bills for unwanted services from any such health care provider, (3) file objections with Medicare, Medicaid and any private insurance company for payment of such charges and (4) file complaints against such providers with appropriate state regulatory agencies and licensing and professional associations. Assault and battery charges should also be seriously considered. I request, but do not direct, my agent acting from time to time to consult with the persons I have nominated as successor agents to advise and support the acting agent in his or her responsibilities and decision making.

We also empower a client's agent appointed in a property Power of Attorney by including a provision that allows the agent to provide funds to the health care agent so that she or he can hire an attorney to enforce compliance with the patient's wishes. We believe that this strong language that we include in our Health Care Declaration and authority provided to the agent appointed in the Power of Attorney will make compliance with client wishes more likely.

## Specific Treatment Instructions

People do not generally clearly express their feeling about illness and dying either in their advance directives or in conversations with family. They generally phrase their thoughts in vague expressions like “I don’t want to be kept alive like that,” which may refer to anything from being mentally incapacitated to receiving artificial feeding or respiration. Drafting and executing a living will forces you to confront these issues.

Should you be specific about the kinds of treatment you want or wish to forego? Some documents spell out categories, and that may be sufficient. But being too specific can be misunderstood to mean that treatments you would not want that were not specifically mentioned would be acceptable.

## Artificial Nutrition and Hydration and Spoon Feeding

People have special feelings about eating and drinking. Although many people have no qualms about refusing medication or ending aggressive measures for themselves or family members who are very ill (such as kidney dialysis), they balk at ending basic support of nutrition and hydration, sometimes because of religious, moral or ethical reasons, or for fear of pain or discomfort. The courts have dealt with the issue of withholding or withdrawing artificial feeding and nutrition for many years and, more recently, with the question of whether spoon feeding can also be withheld.



The Supreme Court decision in the 1990 case of Nancy Cruzan made clear that there was no legal distinction between artificial nutrition and hydration (nasal-gastro tubes or PEGs) and other forms of life-sustaining treatment (such as antibiotics, ventilators, or kidney dialysis). In fact, studies indicate that even competent hospital patients eat and drink little at the end of their lives and do not experience additional discomfort by avoiding artificial nutrition and hydration.

According to some medical experts, there is no evidence that individuals dependent on artificial nutrition and hydration would experience any discomfort if these treatments were foregone or removed if started; in fact, the imposition of artificial nutrition and hydration may actually contribute to an uncomfortable death. Modern medicine acknowledges that artificial feeding may sometimes be harmful for a patient and constitute inappropriate and harmful treatment.

Nevertheless, problems arise with artificial or tube feeding. In some states, you must expressly indicate in your health care proxy that you don’t want mechanical nutrition and hydration. This is the case in New York. You must make it clear in your Health Care Proxy document that artificial nutrition and hydration is not

wanted. Thus, in New York, your health care agent cannot withhold or withdraw this unless she or he has specific knowledge of your wishes, so the health care proxy must state that you do not want this or that your agent is aware of your wishes regarding artificial feeding.

## **New in 2026: Medical Aid in Dying Act**

New York Governor Kathy Hochul intends to sign New York's Medical Aid in Dying Act into law, taking effect six months after signing to allow time for thoughtful implementation, regulation, and provider training.



For some individuals facing the final stages of a terminal illness, the Act offers an additional, highly regulated option within end-of-life care. It allows mentally competent adults (age 18 or older) with a medically confirmed terminal condition and a prognosis of six months or less to live to request and self-administer prescribed medication to hasten death. Eligibility is based strictly on medical criteria, not age or disability, and there is no predefined list of qualifying conditions.

The law includes important safeguards designed to protect patients and respect personal beliefs, including a required waiting period, documented patient requests, residency requirements, and the ability for health care providers and religiously affiliated hospice programs to decline participation. For those exploring all available options, this law is intended to support personal choice while maintaining careful oversight and respect for individual values.

New York will be the 13th U.S. state to authorize medical aid in dying as a legally recognized end-of-life care option. Previously, medical aid in dying was authorized in 12 states and the District of Columbia under similar laws that allow terminally ill adults to request and self-administer prescribed life-ending medication under defined criteria.

## Conclusion

If nothing else, this Guide should be a wake-up call to protecting yourself from the consequences of failure to plan ahead. It is critical to execute advance directives: a Health Care Proxy, Health Care Declaration and if hospitalized, a MOLST. Doing so will maintain your independence and control over critical health care decisions to the maximum extent possible.

This Guide has not touched on other extremely important issues: establishing systems to manage your financial affairs if you become incapacitated - planning through trusts, wills and powers of attorney, and estate planning and estate and gift tax issues. Dealing with how to pay for the costs of long-term care must be considered, including purchasing long term care insurance and the new “hybrid” policies, using existing life insurance and home equity as funding sources and Medicaid, which in New York, unlike most states, has a generous home care program.

The attorneys at Pierro, Connor & Strauss, LLC, are available to assist our clients at any time with issues related to the subjects discussed in this Guide.

## Specialized Planning Resources

Pierro, Connor & Strauss offers detailed guides on specialized planning topics:

- **Long-Term Care & Medicaid Planning Guide:** Comprehensive strategies for protecting assets while qualifying for benefits
- **Special Needs Planning Guide:** Detailed roadmap for families with disabled loved ones
- **Estate Planning Guide:** A practical overview of how to organize assets, plan for the future, and ensure your wishes are carried out while protecting loved ones
- **Medicaid Planning Guide:** A clear, step-by-step overview of strategies to preserve assets, plan for long-term care, and navigate Medicaid eligibility with confidence.

*Request these guides during your consultation or visit [www.pierrolaw.com/resources](http://www.pierrolaw.com/resources)*

*This Guide was based in part on *The Complete Retirement Survival Guide: Everything You Need to Know to Safeguard Your Money, Your Health and Your Independence (Second Edition, 2003, revised and updated November 2016, authored by Senior Partner Peter J. Strauss and Nancy M. Lederman.**



**PIERRO, CONNOR  
& STRAUSS, LLC**

*Trusted Counsel*

**LOCATIONS**

**CAPITAL REGION**

43 British American Boulevard  
Latham, NY 12100  
Phone: (518) 459-2100

**NEW YORK CITY**

260 Madison Avenue, 16th Floor  
New York, NY 10016  
Phone: (212) 661-2480

**HUDSON, NY**

**GARDEN CITY, NY**

**AFFILIATE OFFICE: RONKONKOMA, NY**

**OF COUNSEL OFFICE: UTICA, NY**

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**CONTACT US**

**[www.pierrolaw.com](http://www.pierrolaw.com) | [info@pierrolaw.com](mailto:info@pierrolaw.com) | (866) 951-PLAN**