DEATH IN THE LEGISLATURE: INVENTING LEGAL TOOLS FOR AUTONOMY

CHARLES P. SABATINO*

INTRODUCTION

> Today we decide only that one State's practice does not violate the Constitution; the more challenging task of crafting appropriate procedures for safeguarding incompetents' liberty interests is entrusted to the 'laboratory' of the States in the first instance.[1]

These closing words of Justice Sandra Day O'Connor best express the United States Supreme Court's desire to maintain the states' responsibility for shaping the law of health care decision making. Indeed, since the 1976 landmark decision in New Jersey regarding Karen Quinlan,[2] most of the formative work has occurred in state courts and legislatures. The Supreme Court prefers to see it continue there, and states have obliged by continuing a veritable legislative frenzy on the topic of health care decision making.

On one level, the law governing patient health care decision making rights is not especially intricate or vast, compared with, for example, tax law or trust and estate law. Yet, cast within the complex interplay of a patient's personal history, technologically powerful medical care systems, and sociocultural demands, the law reflects a formidable, continuing struggle to find clearer pathways for decision making that are both respectful of personal autonomy and protective of patients' well-being.

Courts and legislatures have created a number of principles and tools to enable individuals to exercise their autonomy in health care matters. In the past few years, state legislation defining and redefining these legal tools has been enacted at fever pitch, and the United States Supreme Court stepped cautiously into the eye of the storm in *Cruzan*.[3] This Article provides an analysis of state and federal legislative efforts to define pathways for surrogate

* A.B., 1972, Cornell University; J.D., 1978, Georgetown University Law Center. Assistant Director of the American Bar Association's Commission on Legal Problems of the Elderly which is responsible for research, project development, and education in the areas of health law, long-term care, decision making, and legal services delivery to the elderly; Adjunct Professor at Georgetown University Law Center.

1. Cruzan v. Director, Missouri Dep't of Health, 110 S. Ct. 2841, 2855-56 (1990) (Justice Sandra Day O'Connor, concurring in the Court's decision to affirm Missouri's refusal to allow the withdrawal of a gastrostomy tube from 32 year old Nancy Cruzan, in a persistent vegetative state for over seven years).

2. *In re* Quinlan, 355 A.2d 647, *cert. denied sub nom.* Garger v. New Jersey, 429 U.S. 922 (1976).

3. *Cruzan*, 110 S. Ct. 2841.

decision making on behalf of patients no longer capable of making their own health care decisions.

Section I suggests an organizing framework for analysis of health care decision making options. Section II describes the legislative movement away from living wills and toward the use of durable powers of attorney for health care. Section III discusses new issues posed by recent advance directive legislation. Section IV examines the use of family consent where no advance directive exists, and Section V considers the impact on state law and practice of the federal Patient Self-Determination Act (PSDA).[4] Finally, Section VI reflects briefly upon the role of the courts in resolving health care treatment questions and, specifically, the impact of the Supreme Court's *Cruzan* decision on state legislation.

I
SURROGATE DECISION MAKING PATHWAYS

As Justice Cardozo summarized seventy-eight years ago in his oft-quoted dictum: "Every human being of adult years and sound mind has a right to determine what shall be done with his body."[5] However, when an individual is no longer capable of making health care decisions, the locus of decision making authority necessarily shifts to someone else who either formally or informally assumes this authority in cooperation with health care providers. Theoretically, there are four possible avenues for surrogate decision making. The first allows the individual to direct decisions ahead of time by establishing written instructions, i.e., a "living will." Chart A refers to this pathway as "directed decision making." The second route makes use of "delegated" decision making — the appointment of a proxy or agent by the patient. The primary legal tool for this purpose is the durable power of attorney for health care. Both of these avenues allow the individual to maintain some control over decisions in advance of serious illness.

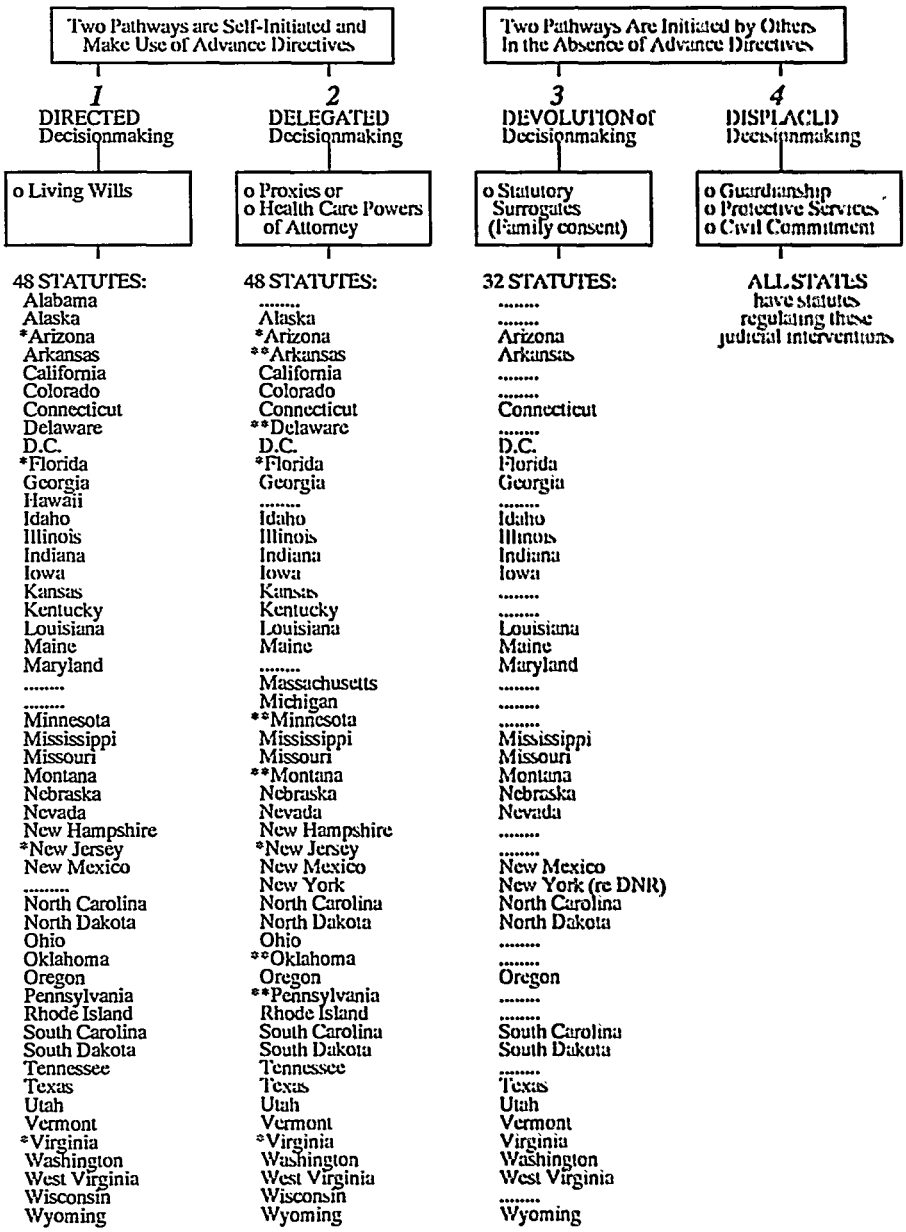
The remaining options are available when advance planning has not taken place or has gone awry. One allows the "devolution" of decision making authority onto permissible surrogates—usually close family members—without court intervention. The other recognizes the State's *parens patriae* power to intervene in the decision making process through guardianship, protective services, or commitment proceedings. This last pathway is the fallback option for decision making. It is important to keep in mind that these options are not mutually exclusive. They may overlap in practice, and depending on the circumstances, may augment or conflict with each other. Even where a patient has a living will, its application to a particular circumstance

4. Omnibus Budget Reconciliation Act of 1990, Pub. L. 101-508, §§ 4206 & 4751 (Medicare and Medicaid, respectively) (codified at 42 U.S.C. §§ 1395cc(a)(1)(Q), 1395mm(c)(8), 1395cc(f), 1396a(a)(57),(58), 1396a(w)). Originally introduced as S. 1766 by Senators Danforth (R-MO) and Moynihan (D-NY), and as H.R. 5067 by Congressman Sander Levin (D-MI).

5. Schloendorff v. Society of New York Hosp., 105 N.E. 92 (N.Y. 1914).

CHART A
PATHWAYS FOR
HEALTH CARE SURROGATE DECISION-MAKING
June 1992

How are health care decisions made for persons unable to speak for themselves?
There are FOUR possible Decisionmaking pathways recognized to differing extents in State Legislation.



* Combined advance directive statute (health care power of attorney & living will)
**A health care proxy is contained within living will statute.

may require an interpreter, decision maker, and/or advocate to implement the patient's wishes. This will involve an appointed proxy (if one exists) or family member, and if they disagree, the courts may intervene.

II
ADVANCE DIRECTIVES: FROM LIVING WILL TO HEALTH CARE POWER OF ATTORNEY

During the decade after the 1976 *Quinlan* case, "living wills" captured a small but tenacious foothold in the public's consciousness as the primary advance directive for health care. In 1985, the majority of states had passed some form of living will or "natural death" legislation. By the beginning of June 1992, the number had risen to forty-eight jurisdictions, including the District of Columbia.[6]

In contrast, at the beginning of 1989, only about a dozen states had legislation specifically addressing the use of durable powers of attorney commonly referred to as a proxy for health care decision making. But by June 1992, that number had leaped to forty-one and the District of Columbia.[7] If one includes

6. Living Will Statutes: ALASKA STAT. §§ 22-8A-1 to -10 (1991); ALASKA STAT. §§ 18.12.010-.100 (1991); ARIZ. REV. STAT. ANN. §§ 36-3201 to -3210 (1986) (amended by 1992 Ariz. Sess. Laws 193, approved June 8, 1992); ARK. CODE ANN. §§ 20-17-201 to -218 (Michie Supp. 1991); CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1992); COLO. REV. STAT. §§ 15-18-101 to -113 (1987 & Supp. 1991); CONN. GEN STAT. ANN. §§ 19a-570 to -575 (West 1992); DEL. CODE ANN. tit. 16, §§ 2501-2508 (1983); D.C. CODE ANN. §§ 6-2421 to -2430 (1989); FLA. STAT. ANN. §§ 765.101-.401 (West Supp. 1992); GA. CODE ANN. §§ 31-32-1 to -12 (1985 & Supp. 1992); HAW. REV. STAT. §§ 327D-1 to -27 (Supp. 1991); IDAHO CODE §§ 39-4501 to -4509 (1985 & Supp. 1992); ILL. ANN. STAT. ch. 110 1/2, para. 701-710 (Smith-Hurd Supp. 1989); IND. CODE ANN. §§ 16-8-11-1 to -22 (Burns 1990); IOWA CODE ANN. §§ 144A.1-.11 (West 1989); KAN. STAT. ANN. §§ 65-28,101 to -28,109 (1985); KY. REV. STAT. ANN. §§ 311.622-.644 (Michie/Bobbs-Merrill Supp. 1990); LA. REV. STAT. ANN. §§ 40:1299.58.1-.10 (West 1992); ME. REV. STAT. ANN. tit. 18-A, §§ 5-701 to -714 (West Supp. 1991); MD. CODE ANN., HEALTH-GEN. §§ 5-601 to -614 (1990 & Supp. 1991); MINN. STAT. ANN. §§ 145B.01-.17 (West Supp. 1992); MISS. CODE ANN. §§ 41-41-101 to -121 (Supp. 1992); MO. ANN. STAT. §§ 459.010-.055 (Vernon 1992); MONT. CODE ANN. §§ 50-9-101 to -111, -201 to -206 (1991); 1992 Neb. Laws 671 (enacted February 12, 1992); NEV. REV. STAT. §§ 449.540-.690 (1991); N.H. REV. STAT. ANN. §§ 137-H:1-:16 (1990); N.J. STAT. ANN. §§ 26:2H-53 to -78 (West Supp. 1992); N.M. STAT. ANN. §§ 24-7-1 to -11 (Michie 1991); N.C. GEN. STAT. §§ 90-320 to -322 (1990); N.D. CENT. CODE §§ 23-06.4-01 to -14 (1991); OKLA. STAT. ANN. tit. 63, §§ 3101-3111 (West Supp. 1992) (amended by 1992 Okla. Sess. Law Serv. 114 (West); OR. REV. STAT. §§ 127.065-.650 (1991); 1992 Pa. Legis. Serv. 24 (Purdon); 1991 R.I. GEN. LAWS §§ 23-4.11-1 to -13 (Supp. 1991); S.C. CODE ANN. §§ 44-77-10 to -160 (Law. Co-op. Supp. 1991); S.D. CODIFIED LAWS ANN. §§ 34-12D-1 to -22 (Supp. 1992); TENN. CODE ANN. §§ 32-11-101 to -112 (Supp. 1991); TEX. HEALTH & SAFETY CODE ANN. §§ 672.001-.021 (West 1992); UTAH CODE ANN. §§ 75-2-1101-1118 (Supp. 1992); VT. STAT. ANN. tit. 18, §§ 5251-5262 (1987) and tit. 13, § 1801 (Supp. 1991); VA. CODE ANN. §§ 54.1-2981 to -2993 (Michie Supp. 1992); WASH. REV. CODE ANN. §§ 70.122.010-.905 (West 1992); W. VA. CODE §§ 16-30-1 to -10 (1991 & Supp. 1992) (amended 1991); WIS. STAT. ANN. §§ 154.01-.15 (West 1989); WYO. STAT §§ 35-22-101 to -109 (1988).

7. Health care power of attorney statutes: ALASKA STAT. §§ 13.26.332-.353 (Supp. 1990) (particularly § 13.26.344(l), health care agent authority enacted in 1988); ARIZ. REV. STAT. ANN. §§ 36-3201 to -3262 (1992) (enacted 1992); ARK. CODE ANN. §§ 20-17-201 to -218 (Michie Supp. 1991); CAL. CIV. CODE §§ 2430-2444 (enacted 1983), 2500-2508 (West Supp.

those states with proxy provisions in their living will statute, the number rises to forty-eight, equal to that for living will statutes.[8]

Part of the impetus for this legislative fervor is the realization that conventional living will legislation falls far short of meeting health care decision making needs. Most living will acts originally addressed only terminal illness where death was imminent. Thus, a living will normally would be inopertive where the individual was severely debilitated but not "terminal" under the common understanding of that term. Most living will statutes do not apply to cases of irreversible coma or persistent vegetative state, although since *Cruzan*, several states have amended their living will statutes to apply to permanent unconsciousness.[9] Even when these statutes are amended to include a broader

1992) (enacted 1984); COLO. REV. STAT. §§ 15-14-501, 502 (1987 & Supp. 1991) (enacted 1983); CONN. GEN. STAT. ANN. § 1-43 (West Supp. 1992) (health care agent authority enacted 1990); DEL. CODE ANN. tit. 16, §§ 2501-2508 (1983); D.C. CODE ANN. §§ 21-2201 to -2213 (1989) (enacted 1989); FLA. STAT. ANN. §§ 765.101-.401 (West Supp. 1992) (enacted 1992); GA. CODE ANN. §§ 31-36-1 to -13 (Supp. 1990) (enacted 1990); IDAHO CODE §§ 39-4501 to -4509, specifically § 39-4505 (Supp. 1992) (enacted 1988); ILL. ANN. STAT. ch. 110 1/2, para. 804-1 to -12 (Smith-Hurd Supp. 1990) (enacted 1987); IND. CODE ANN. §§ 30-5-1 to 30-5-10 (Burns Supp. 1992) (particularly § 30-5-17 regarding health care agent authority (enacted in 1991) and *see also* §§ 16-8-12-1 *et seq.* (Burns 1990), regarding health care consent); IOWA CODE ANN. §§ 144B.1-.12 (West Supp. 1992) (enacted 1991); KAN. STAT. ANN. §§ 58-625 to -632 (Supp. 1991) (enacted in 1989); KY. REV. STAT. ANN. §§ 311.970-.986 (Michie/Bobbs-Merrill Supp. 1990) (enacted 1990); LA. REV. STAT. ANN. §§ 2997.A.(7) (West 1992); ME. REV. STAT. ANN. tit. 18A, §§ 5-501 (Supp. 1991) (health care agent authority enacted 1985); MASS. GEN. LAWS ANN. ch. 201D, § 1-17 (West Supp. 1992) (enacted 1990); MICH. COMP. LAWS ANN. 700.496 (West Supp. 1992) (enacted 1990); MISS. CODE ANN. §§ 41-41-151 to -183 (Supp. 1992) (enacted 1990); MO. ANN. STAT. §§ 404.700-.735 (Vernon 1990 & Supp. 1992) (health care agent authority enacted 1991); MONT. CODE ANN. §§ 50-9-101 to -111, -201 to -206 (1991); 1992 Neb. Laws 696 (enacted 1992); NEV. REV. STAT. §§ 449.800-.860 (1991) (enacted 1987); N.H. REV. STAT. ANN. §§ 137-J:1 to -J:16; N.J. STAT. ANN. §§ 26:2H-53 to -78 (West Supp. 1992)(enacted 1991); N.M. STAT. ANN. §§ 45-5-501, -502 (Michie 1989) (health care agent authority enacted in 1989); N.Y. PUB. HEALTH LAW §§ 2980 to 2994 (Consol. Supp. 1991) (enacted 1990); N.C. GEN. STAT. §§ 32A-15 to -26 (1991); N.D. CENT. CODE §§ 23-06.5-01 to -18 (1991) (enacted 1991); OHIO REV. CODE ANN. §§ 1337.11 -.17 (Anderson Supp. 1990) (enacted 1989) (*as amended by* 1991 Ohio Legis. Bull. 36 (Anderson)); 1992 Okla. Sess. Law Serv. 114 (West) (enacted 1992); OR. REV. STAT. §§ 127.505-.585 (1991) (enacted 1989); 20 PA. CONS. STAT. ANN. §§ 5601-5606 (Supp. 1992) (enacted 1982) and *see* 1992 Pa. Legis. Serv. 24 (Purdon); R.I. GEN. LAWS §§ 23-4.10-1 to -2 (1989) (enacted 1986); S.C. CODE ANN. §§ 44-66-10 to -80 (Law. Co-op. Supp. 1991) (regarding adult health care consent (enacted 1990)) and § 62-5-501 (regarding durable power of attorney); S.D. CODIFIED LAWS ANN. §§ 34-12C-1 to -8 and § 59-7-2.1 -.8 (Supp. 1992) (health care agent authority enacted 1990); TENN. CODE ANN. §§ 34-6-201 to -215 (1991) (enacted 1990); TEX. CIV. PRAC. & REM. CODE ANN. §§ 135.001-.018 (West Supp. 1992) (enacted 1991); UTAH CODE ANN. §§ 75-2-1101 to -1118 (Supp. 1992) (enacted 1985); VT. STAT. ANN. tit. 14, § 3451-67 (1989) (enacted 1987); VA. CODE ANN. §§ 54.1-2981 to -2993 (Michie Supp. 1992); WASH. REV. CODE ANN. §§ 11.94.010 to -.900 (West 1987 & Supp. 1992) (health care agent authority enacted 1989); W. VA. CODE §§ 16-30A-1 to -20 (Supp. 1990) (enacted 1990); WIS. STAT. ANN. §§ 155.01-.80, 243.07(6m) (West Supp. 1991) (enacted 1989); WYO. STAT. §§ 3-5-201 to -213 (Supp. 1991) (enacted 1991).

8. *See* ARK. CODE ANN. § 20-17-214 (Michie Supp. 1991); DEL. CODE ANN. tit. 16, § 2502 (1983); MINN. STAT. ANN. § 145B.03 (West Supp. 1992); MONT. CODE ANN. §§ 50-9-101 to -111, -201 to -206 (1991); 1992 Okla. Sess. Law Serv. 114 (West); 1992 Pa. Legis. Serv. 24 (Purdon).

9. *See, e.g.*, 1992 Ga. Laws 1139; 1992 Iowa Legis. Serv. 132 (West); 1992 Me. Legis. Serv.

range of medical conditions, difficulties remain in defining the key terms that trigger their applicability — terms such as "terminal" condition, "imminent death," or "life-sustaining procedure." The fundamental limitation of all living wills is that without a crystal ball, mortals simply cannot foresee and give directions for all possible contingencies related to medical care.

A health care power of attorney takes a critical step beyond the typical living will — it establishes a decision maker, chosen by the principal, who can fully weigh all the circumstances affecting any health care decision at the time they occur and act in accordance with the known wishes and values of the principal. The document may also include instructions or guidelines similar to those contained in a living will, but with the additional advantage that the instructions do not need to be limited to terminal conditions or permanent unconsciousness.

In Chart B, following this Article, the forty-eight health care power of attorney statutes are compared in brief. Twenty-six of the jurisdictions reviewed have either chosen the approach first adopted by California by enacting a special durable power of attorney (DPA) for health care, or a proxy statute that is separate both from the state's general DPA statute and from the state's living will statute.[10] Twelve states have incorporated health care powers into their general DPA statutes which may address property matters as well as health care.[11]

New Jersey's "Advance Directives for Health Care Act," enacted in 1991, is the first example of a third and newer aproach that established a broad, unified advance directive statute encompassing both living wills (referred to as "instruction directives") and health care powers of attorney (referred to as "proxy directives").[12] Following suit in early 1992, Florida and Virginia each revised and combined their multiple existing advance directive laws into comprehensive acts.[13] Arizona followed with its version of a comprehensive advance directive act, thereby replacing its existing living will statute.[14] Significantly, the latter three states also address surrogate consent in the absence of advance directives in the same statute;[15] and, in addition, authorize

719 (West); 1991 N.C. Adv. Legis. Serv. 639, § 3 (West); 1991 S.C. Acts 149; 1992 Wash. Legis. Serv. 98 (West); 1991 W.Va. Acts 416.

10. California, District of Columbia, Georgia, Idaho, Illinois, Iowa, Kansas, Kentucky, Massachusetts, Michigan, Mississippi, Nevada, New Hampshire, New York, North Carolina, North Dakota, Ohio, Oregon, Rhode Island, Tennessee, Texas, Utah, Vermont, West Virginia, Wisconsin, and Wyoming; *see supra* note 7.

11. Alaska, Colorado, Connecticut, Indiana, Louisiana, Maine, Missouri, New Mexico, Pennsylvania, South Carolina, South Dakota, and Washington; *see supra* note 7.

12. 1991 N.J. Sess. Law Serv. 201 (West). "Instruction directive" and "Proxy directive" are defined in Section 3 of the session law.

13. FLA. STAT. ANN. §§ 101-401, 744.3115-345, 709.08 (West 1992); 1992 VA. CODE ANN. §§ 54.1-2981 to -2993 (1992).

14. ARIZ. REV. STAT. ANN. §§ 36-3201 to -3262 (1992).

15. *See* ARIZ. REV. STAT. ANN. § 36-3231 (1992); FLA. STAT. ANN. § 765.401 (West Supp. 1992); VA. CODE ANN. § 54.1-2986 (Michie Supp. 1992).

recognition of advance directives by emergency medical services personnel,[16] thus creating fairly comprehensive health decisions statutes. The advance directive legislation illustrates the direction that state law reform will take over the next few years.

Finally, six states lacking special health care power of attorney legislation either authorize or acknowledge "proxy" decision makers in their living will statutes: Arkansas, Delaware, Minnesota, Montana, Oklahoma, and Pennsylvania.[17] The National Conference of Commissioners on Uniform State Laws also took this approach in the 1989 amendments to the Uniform Rights of the Terminally Ill Act.[18] The major problem with this form of legislation is that it limits the scope of the proxy's authority to the same range of decisions to which the statutory living will applies. Thus, to the extent that the living will applies only to terminal conditions where death is imminent and life-sustaining treatments are at issue, so too will the proxy be limited. Decisions for non-terminal, incompetent patients about matters such as placement, elective surgery, or non-life sustaining care may be beyond the statutory proxy's authority. Of course, it can (and should) be argued that the intent and policy behind these statutes, as well as the constitutional principles acknowledged in *Cruzan*, demand a broader construction of the proxy's authority. That these statutes leave this question open to argument is their very flaw.

Absent special legislation creating powers of attorney for health care, other sources of state law may directly or indirectly acknowledge their validity. For example, Arizona's Supreme Court has looked favorably upon the use of durable powers of attorney for health care despite the fact that the state has had no special authorizing statute until 1992.[19] Similarly, New Jersey's Supreme Court, even prior to the passage of the state's advance directives act, asserted that the state's general durable power of attorney statute should be interpreted to authorize medical decision making by an agent.[20]

The common acceptance of health care powers of attorney in Maryland relies upon another source of law, or more accurately, source of legal interpretation. A 1988 Attorney General opinion expressly recognized the legal effectiveness of durable powers of attorney that specifically delegate medical decision making authority.[21] While an Attorney General opinion is only interpretive, it nevertheless exerts a tremendous influence on state practice and statutory interpretation and to a great extent has obviated the need for special legislation.

Thus, except for Alabama, every state and the District of Columbia now has some form of affirmative legislative, executive, or judicial recognition of

16. *See* ARIZ. REV. STAT. ANN. § 36-3251 (1992); FLA. STAT. ANN. § 765.307 (West 1992); VA. CODE ANN. §§ 54.1-2982, 54.1-2987 to -2989 (Michie Supp. 1992).

17. *See supra* note 8.

18. UNIFORM RIGHTS OF THE TERMINALLY ILL ACT (1989).

19. Rasmussen v. Flemming, 741 P.2d 674, 688 n.21 (Ariz. 1987).

20. *In re* Peter, 529 A.2d 419, 426 (N.J. 1987).

21. 73 Op. Md. Att'y Gen. No. 88-046 (Oct. 17, 1988).

durable powers of attorney for health care.[22] Even in the absence of express authority, most legal commentators have long agreed with the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, which believes that existing durable power of attorney statutes, on the books in all fifty states, are broad enough to permit the delegation of discretionary health care decision making powers within their scope.[23] Regardless of this affirmation of advance directives, legislators in virtually every state have felt increasing pressure to remedy uncertainties about the use of advance directives. The public wants assurance that these documents will be considered "legal." Healthcare providers want some assurance of protection if they heed the instructions of health care agents. Other advocates seek procedural protections to limit the likelihood of misuse.

III

NEW ISSUES POSED BY HEALTH CARE POWER LEGISLATION

Health care power of attorney statutes in no way solve all the problems inherent in surrogate decision making. Indeed, a substantial portion of the population will simply not execute advance directives, even under the most optimistic scenarios. One reason is the growing variability and complexity in advance directive legislation. For example, these laws increasingly include a variety of procedural rules — especially extensive witness exclusion rules,[24] mandatory warning notices explaining principals' rights,[25] or other required language for delegating certain powers (such as the power to withhold nutrition or hydration).[26] While justifiable in purpose, the expansion of substantive

22. Two states, Oklahoma and New York, had previously rejected this view through attorney general opinions but have since passed legislation remedying the restrictive opinions. Op. Okla. Att'y Gen. No. 91-2 (May 6, 1991) (concluding that the legislature had intended the Oklahoma Natural Death Act, last amended in 1990, to be the exclusive method by which individuals may request that they be denied life-sustaining treatment, including nutrition and hydration); Op. N.Y. Att'y Gen. No. 84-F16 (Dec. 28, 1984) (concluding that the durable power of attorney is not a valid means to delegate general authority for medical decisions in New York, although it can be used to delegate responsibility to carry out particular decisions anticipated by the principal).

23. PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 145-47 (1983); FRANCIS J. COLLIN, JR., JOHN L. LOMBARD, JR., ALBERT L. MOSES & HARLEY J. SPITLER, DRAFTING THE DURABLE POWER OF ATTORNEY: A SYSTEMS APPROACH 32-38 (2d ed. 1987).

24. *See, e.g.*, the Nebraska health care power of attorney statute, which prohibits the following persons from acting as a witness: "The principal's spouse, parent, child, grandchild, sibling, presumptive heir, known devisee at the time of the witnessing, attending physician, or attorney in fact; or an employee of a life or health insurance provider for the principal. No more than one witness may be an administrator or employee of a health care provider who is caring for or treating the principal." 1992 Neb. Laws 696, § 5 (enacted Feb. 12, 1992).

25. *See, e.g.*, MISS. CODE ANN. § 41-41-163 (Supp. 1990); OHIO REV. CODE ANN. § 1337.17 (Anderson Supp. 1992). These statutes have a mandatory disclosure statement to principals but not a mandatory form for the power of attorney.

26. *See, e.g.*, N.H. REV. STAT. ANN. § 137-J:3 (Supp. 1991); OKLA. STAT. ANN. tit. 63, §§ 3101-3111 (West Supp. 1991), *as amended by* 1992 Okla. Sess. Law Serv. 114 § 4(West)); OR.

and procedural requirements results in increasing complexity. The complexity inevitably deters more individuals from ever taking the initiative to execute a durable power.

This complexity is due in part to the piecemeal, incremental approach that legislation has taken in addressing health care decision making. Multiple statutes, regulations, and court cases dealing with the same or related issues create even more wrinkles of confusion. For example, in its 1990 legislative session, Florida adopted a "Health Care Surrogate Act" which in essence created a special power of attorney for health care.[27] At the same time, it amended its existing durable power of attorney law to allow the delegation of health care consent authority to agents.[28] Florida already had a living will law including a provision enabling individuals to name health care proxies to act on a patient's behalf in circumstances where a living will would apply.[29] Finally, the Florida Supreme Court, in the case, *In re Guardianship of Browning*,[30] reaffirmed its view that a written statement of one's wishes or the naming of a proxy is a constitutionally protected mode of decision making, even with respect to life-sustaining care.

Thus, Florida had at least four different sources of authority on which to base the drafting of a health care power of attorney. Each source differed in terms of the scope of permissible agency authority and the procedures for creating the legal instrument. As a result, no one was quite sure which pathway best ensured a valid and comprehensive delegation of decision making authority. As one Florida attorney quipped, "Instead of having a camel with no humps, Florida residents are trying to make sense out of a camel with too many humps."[31] In early 1992, the legislature went back to the drawing board and rewrote these disparate acts into one comprehensive health decisions law which, though not a perfect example of legislative drafting, was a workable and fairly comprehensive step forward.[32]

Perhaps the most common complication caused by the incremental growth of legislation in this field is the perception that at least two separate documents are needed to protect oneself — a living will *and* a durable power of attorney. People seeking to establish an advance directive rightfully complain about the confusing multiplicity of documents. The law should be interpreted to be flexible enough to allow a single advance directive document that combines both a statement of one's wishes concerning medical care and the appointment of an agent. Unfortunately, this is not always advisable under literal interpretations of many existing state statutes, especially where statutes

REV. STAT. § 127.530 (1990). These statutes contain form language regarding authority to refuse nutrition and hydration which must be substantially followed.

27. FLA. STAT. ANN. §§ 641.61-.72 (West 1991).

28. *Id.* § 709.08.

29. *Id.* § 765.07(1) (West 1986).

30. 568 So. 2d 4, 13 (Fla. 1990).

31. Interview with attorney (name withheld) (May 30, 1991) (on file with author).

32. FLA. STAT. ANN. §§ 765.101-.410 (West Supp. 1992).

prescribe forms that must be substantially followed. As of June 1992, only Arizona, Florida, New Jersey, and Virginia have expressly merged both kinds of documents under single advance directive statutes that cover the full range of health decisions, and not just those decisions relating to terminal or permanently comatose conditions.[33]

The proliferation of differing state requirements exacerbates another problem. It is not clear whether documents executed in one state will be recognized in another unless the second state's statute expressly provides for recognition of out-of-state instruments. Of the forty-eight existing health care proxy statutes, only twenty-two expressly recognize the validity of an out-of-state document that complies with the law of the state of origin.[34] Most of these grants of comity simply recognize the validity of the out-of-state execution. They do not guarantee that the substance of a document that does not comply with the host state's law will be enforceable. The problem is especially troublesome in a society as mobile as ours. Those who winter in the south, summer in the north, and spend time in between visiting children or other relatives may be best advised to execute advance directives specific to each of the locations travelled — advice that would be nonsense in a more patient-friendly legal system.

Ultimately, legislation in this area should seek to balance simplicity and ease of use with legitimate concerns about patient abuse. Regrettably, the process is sometimes ideologically polarized by factions wielding intractable pro-life vs. pro-choice labels. In the midst of these frays, it is important to understand that neither living will nor durable power of attorney statutes create new substantive rights. They merely attempt to define some practical pathways for decision making that providers, patients, and families may use. Nearly all these statutes expressly acknowledge the fact that they neither alter nor preempt any pre-existing rights under the common law or constitution.[35]

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33. *See supra* nn. 12-14.

34. ARIZ. REV. STAT. ANN. § 36-3208 (1992); ARK. CODE ANN. § 20-17-212 (Michie Supp. 1989); D.C. CODE ANN. § 21-2202 (1989); FLA. STAT. ANN. § 765.112 (West Supp. 1992); IND. CODE ANN. § 30-5-3 (Burns 1991); IOWA CODE ANN. § 144B.3 (West Supp. 1992); KAN. STAT. ANN. § 58-630 (Supp. 1991); MASS. GEN. LAWS ANN. ch. 201D, § 11 (West Supp. 1992); MINN. STAT. § 145B.16 (Supp. 1990); MO. ANN. STAT. § 404.703(4) (Vernon Supp. 1992) (incorporated into durable powers of attorney for health care by § 404.805.2); MONT. CODE ANN. § 50-9-111 (1991); 1992 Neb. Laws 696, § 8 (enacted Feb. 12, 1992); 1991 Nev. Stat. 258, § 26 (applicable to durable powers for health care by § 6); N.H. REV. STAT. ANN. § 137-J:10 (Supp. 1991); 1991 N.J. Sess. Law Serv. 201, § 24 (West); N.Y. PUB. HEALTH LAW § 2990 (McKinney Supp. 1991); 1991 N.D. Laws 266, § 11; OHIO REV. CODE ANN. § 1337.16(G) (Anderson Supp. 1990); TEX. REV. CIV. STAT. ANN. art. 4590h-1, § 13 (West Supp. 1990) (enacted 1989); VT. STAT. ANN. tit. 14, § 3461 (1989); VA. CODE ANN. § 54.1-2993 (Michie Supp. 1992); W. VA. CODE § 16-30A-17 (Supp. 1990) (enacted in 1990).

35. *See, e.g.*, MD. CODE ANN., HEALTH-GEN. § 5-610(1) (1985), which states: "The provisions of this subtitle: (1) Are cumulative and may not be construed to impair or supersede any legal right or responsibility that any person may have to effect the initiation, continuation, withholding, or withdrawal of life-sustaining procedures."

IV
WHERE THERE IS NO ADVANCE DIRECTIVE: FAMILY CONSENT

As noted earlier, two basic legal options apply where advance planning has not taken place or where the process, for any reason, has gone awry. The first of these surrogate statutes, sometimes called "family consent" laws, allows the devolution of decision making authority to specified surrogates without court intervention. The second option provides a fall-back whereby the state may intervene in the decision making process, usually through guardianship or protective services proceedings. This section examines the family consent option.

Family consent is perhaps the most common yet most misunderstood practice in surrogate decision making for incapacitated persons. Many of us assume that if we are not able to make health care decisions on our own, then the right to consent to or refuse suggested health care interventions devolves upon a spouse, parent, adult child, or other relative. Indeed, this assumption rests on strong cultural norms and is borne out everyday in the practice of medicine. Doctors and hospitals routinely solicit and rely on consent from family members.[36]

But from an historical perspective, the common law has been remarkably silent on the question of whether family members, even spouses, have a presumptive right to make non-emergency health care decisions for their loved ones. The historical silence may, in part, be a function of the cultural and professional acceptance of family consent. If pushed to decide such questions, courts will normally accord substantial deference to customary professional practices.[37] Another factor may be that, outside the context of medical malpractice, judicial scrutiny of health care decision making has become visible only since the mid-1970s. This is still a relatively new area of jurisprudence. As a practical matter, informal family consent works fine, as long as family and physician agree on the course of care — it is only when family members disagree with doctors that the family's legal authority to make decisions is likely to be called into question. A strict construction of the law would lead to the conclusion that unless state law expressly provides for family consent authority, the common law status of family members as automatic surrogates is, at best, unclear. While state constitutions may sometimes provide an independent basis for family consent,[38] the United States Supreme Court's majority opinion in *Cruzan* found no special constitutional status attributable

36. *See* J. Hardwig, *What About the Family?* 20 HASTINGS CENTER REPORT 5 (March/April 1990); Judith Areen, *The Legal Status of Consent Obtained from Families of Adult Patients to Withhold or Withdraw Treatment*, 258 JAMA 229 (1987); 1 PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, MAKING HEALTH CARE DECISIONS, 126-28, 182-84 (1982).

37. ALAN MEISEL, THE RIGHT TO DIE § 8.7 (1989).

38. For example, Florida's Supreme Court found that the state's constitutional right of privacy extends to health care decisions and may be exercised by proxies or surrogates such as close family members or friends. *In re* Guardianship of Browning, 568 So. 2d 4 (Fla. 1990).

to family members to act as surrogate decision makers for incapacitated members.[39]

Until recently, the laws in more than half of the states did not explicitly give family members, even a spouse, the right to make health care decisions for other family members in non-emergency situations. Since the *Cruzan* decision, legislators have begun to focus far more attention on family consent. As of June 1992, thirty-one states and the District of Columbia have statutes providing this authority to varying extents in non-emergency situations.[40]

Court decisions in a few other states without such legislation condone, or at least view favorably, family consent.[41] Some other states provide for family consent in their living will statutes as an alternative decision making procedure where no living will has been executed.[42] In these instances, authority may be limited to decisions about life-support for terminally ill patients. The limitation is somewhat odd, since if family decision making is permitted in life and death situations, it would seem even more appropriate in situations of less consequence. In other states, authority is even more decision-specific. A New York law applies only to "do-not-resuscitate" decisions, and, until recently, a West Virginia law applied only to admission into nursing and personal care homes.[43]

Common to all family consent statutes is some designated order of priority of permissible family surrogates, who are authorized to act on behalf of an incapacitated patient who has no guardian or appointed proxy. The District of Columbia's Health Care Decisions Act provides a fairly typical example:

39. Cruzan v. Director, Missouri Dep't of Health, 110 S. Ct. 2841, 2855-56 (1990).

40. Family consent statutes: ARIZ. REV. STAT. ANN. § 36-3231 (Supp. 1992); ARK. CODE ANN. § 20-9-602 (Michie 1991); CONN. GEN. STAT. ANN. §§ 19a-570 to -571 (West Supp. 1992); D.C. CODE ANN. § 21-2210 (Supp. 1992); FLA. STAT. ANN. § 765.401 (Supp. 1992); GA. CODE ANN. § 31-9-2 (1991); IDAHO CODE § 39-4303 (1985); 1991 Ill. Laws 87-0749; IND. CODE ANN. § 16-8-12-4 (West 1992); IOWA CODE ANN. § 144A.7 (West 1989); LA. REV. STAT. ANN. § 40:1299.53 (West 1992); ME. REV. STAT. ANN. tit. 24, § 2905 (West 1990); MD. CODE ANN., HEALTH-GEN. § 20-107(d) (Supp. 1991); MISS. CODE ANN. § 41-41-3 (Supp. 1992); MO. ANN. STAT. § 431.061 (Vernon 1992); MONT. CODE ANN. § 50-9-106 (1991); NEB. REV. STAT. § 44-2808 (1988); 1991 Nev. Stat. 258, § 10; N.M. STAT. ANN. § 24-7-8.1 (Michie 1984); N.Y. PUB. HEALTH LAW § 2965 (Consol. Supp. 1991) (restricted to do-not-resuscitate decisions); N.C. GEN. STAT. § 90-322 (1990); N.D. CENT. CODE § 23-12-13 (1992); OR. REV. STAT. § 127.635 (1991); S.C. CODE ANN. § 62-5-311 (Law. Co-op. Supp. 1991); S.D. CODIFIED LAWS ANN. § 34-12C-3 (Supp. 1992); TEX. HEALTH & SAFETY CODE ANN. § 672.009 (West 1992); UTAH CODE ANN. § 78-14-5(4) (1992); VT. STAT. ANN. tit. 12, § 1901(c)(3), (d) (1985); VA. CODE ANN. § 54.1-2986 (Michie Supp. 1992); WASH. REV. CODE ANN. § 7.70.065 (West 1992); 1992 W. Va. Acts 94 (enacted March 17, 1992); and W. VA. CODE § 16-5C-5a (1991) (restricted to nursing home and personal care home residents).

41. *See, e.g.*, Rasmussen v. Fleming, 741 P.2d 674 (Ariz. 1987); Bartling v. Superior Court, 209 Cal. Rptr. 220 (Cal. Ct. App. 1984); Foody v. Manchester Memorial Hospital, 482 A.2d 713 (Conn. Super. Ct. 1984); *In re* Dinnerstein, 380 N.E.2d 134 (Mass. App. Ct. 1978); *In re* Conroy, 486 A.2d 1209 (N.J. 1985).

42. *See, e.g.*, IOWA CODE ANN. § 144A.7 (West 1991); N.C. GEN. STAT. § 90-322 (1991); OR. REV. STAT. § 127.635 (1989).

43. N.Y. PUB. HEALTH LAW § 2965 (McKinney Supp. 1988); W. VA. CODE § 16-5C-5a (1991). A new West Virginia act provides for much broader family consent, see W. VA. CODE § 16-5B-8a (Supp. 1992).

> In the absence of a durable power of attorney for health care and provided that the incapacity of the principal has been certified in accordance with section 5, the following individuals, in the order of priority set forth below, shall be authorized to grant, refuse or withdraw consent on behalf of the patient with respect to the provision of any health-care service, treatment, or procedure:
>
> (1) A court-appointed guardian or conservator of the patient, if the consent is within the scope of the guardianship or conservatorship;
> (2) The spouse of the patient;
> (3) An adult child of the patient;
> (4) A parent of the patient;
> (5) An adult sibling of the patient; or
> (6) The nearest living relative of the patient.[44]

This statute allows providers to rely on only one person as surrogate from any priority level. Some states require consent by a majority of those reasonably available.[45] For decisions about terminating life-sustaining procedures, New Mexico is more demanding, requiring the unanimous consent of all available family members.[46] At the opposite extreme is the approach used in the Model Health Care Consent Act, created in 1982 by the National Commission on Uniform State Laws.[47] If there is no appointed agent or guardian, this act permits anyone in the class of family members to make decisions. The class consists of the spouse, parents, adult children, and adult siblings. All are ranked equally, and any member is authorized to act.[48]

Most family consent statutes rely on a judicial procedure for challenging the authority of presumed decision makers if an interested party believes that the decision maker is not acting in the best interest of the patient.[49] However, the effectiveness of this protection depends on the interest and ability of a third party to initiate a challenge to the decision maker.

A major problem with these laws is their failure to address nontraditional family situations. Family consent is of little help if the individual's "significant other" is a friend, mate, or other person outside the traditional kinship scheme. As of June 1992, only Arizona, Florida, Illinois, New York, and North Dakota include "close friend" in the list of permissible surrogates.[50] Arizona's new statute goes one step further by adding to the list of permissible

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44. D.C. CODE ANN. § 21-2210(a) (Supp. 1989).
45. *See, e.g.*, ARIZ. REV. STAT. ANN. § 36-3231 (1992).
46. N.M. STAT. ANN. § 24-7-8.1 (Michie 1990).
47. MODEL HEALTH CARE CONSENT ACT (1982).
48. *Id.* § 4.
49. *See, e.g.*, ARIZ. REV. STAT. ANN. § 36-3206 (1986) (codified in 1992 Ariz. Legis. Serv. 193 (West)).
50. ARIZ. REV. STAT. ANN. § 36-3231 (in 1992 Ariz. Laws 193 (approved June 8, 1992)); FLA. STAT. ANN. § 765.401 (Supp. 1992); 1991 Ill. Laws 87-0749 (enacted Sept. 26, 1991); N.Y. PUB. HEALTH LAW § 2965.4(a) (McKinney Supp. 1991).

surrogates, "the patient's domestic partner," if the patient is unmarried. However, a trade-off in the Arizona statute is that it precludes surrogates who are not an appointed agent or guardian from making decisions about the artificial administration of food or fluids.

A variety of other questions have yet to be thoroughly examined in legislatively crafting family consent procedures. To what extent are providers responsible for seeking out and identifying family relationships? If a "close friend" is a permissible decision maker, what is the provider's authority and responsibility to confer this status upon someone? The Illinois statute, for example, allows providers to request an affidavit from the putative close friend setting forth facts to substantiate the claimed relationship.[51] Is this sufficient?

What flexibility does one have to modify the priority order of surrogates if someone at a lower priority is a more appropriate decision maker based upon their knowledge of and closeness to the patient? What protections against potential abuse by family members are needed? And finally, how should decisions be made for those patients who have no appropriate family surrogates?[52]

Until recently, family consent has been routine in practice, undefined in procedure, and invisible in the law. It is almost certain that as legislatures reexamine their statutory schemes for health care decisions, family consent, as well as non-family variants of surrogate decision making, will emerge as the next focus of state legislative activity. These efforts will have to take into account the reality of non-traditional family involvement in decision making.[53]

V

CONGRESS STEPS IN: THE PATIENT SELF-DETERMINATION ACT

The impetus for federal legislation dealing with health care decision making arose largely from public sentiment around the case of Nancy Cruzan, a Missouri resident and constituent of the legislation's chief Senate sponsor, John Danforth. Senator Danforth and other sponsors hoped to enable individuals to avoid the kind of technological imprisonment experienced by Nancy Cruzan by ensuring that all adults were sufficiently aware of the availability of advance directives. The Medicare and Medicaid programs were used as the springboard by which to require widespread dissemination of state-specific information.

The Patient Self-Determination Act (PSDA) was enacted as part of the Omnibus Budget Reconciliation Act of 1990, which was signed by the President on November 5, 1990.[54] It is a fairly modest amendment to federal Medi-

51. 1991 Ill. Laws 87-0749, § 10.

52. *See supra* note 40.

53. NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN OTHERS MUST CHOOSE: DECIDING FOR PATIENTS WITHOUT CAPACITY (1992).

54. Omnibus Budget Reconciliation Act (OBRA) of 1990, Pub. L. No. 101-508, §§ 4206 & 4751 (Medicare and Medicaid, respectively) (codified in part at 42 U.S.C. §§ 1395cc(a)(1)(Q), 1395cc(f), 1395mm(c)(8), 1396a(a)(57), 1396a(a)58, 1396a(w)).

care and Medicaid law, but it could have a profound effect on the way most adults make and plan for health care decisions. Its key provisions became effective December 1, 1991.

At its heart, the Act is an information and education mandate. It requires all Medicare and Medicaid provider organizations (specifically, hospitals, skilled nursing facilities, home health agencies, hospices, and prepaid health care organizations) to take five steps:

1. "provide written information" to patients at the time of admission concerning "an individual's right under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives";
2. "maintain written policies and procedures" with respect to advance directives (e.g., living wills and health care powers of attorney) and to "provide written information" to patients about such policies;
3. "document in the individual's medical record whether or not the individual has executed an advance directive";
4. "ensure compliance with the requirements of State law (whether statutory or as recognized by the courts of the State) respecting advance directives at facilities of the provider or organization"; and
5. "provide (individually or with others) for education for staff and the community on issues concerning advance directives."[55]

The Act specifically prohibits providers from doing anything that would "condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive."[56] States will be expected to monitor these new requirements as part of the Medicare and Medicaid survey and certification process.

Of special importance to the informational goal of the Act is the one mandate that the Act imposes upon states — the development of a written description of state law. Specifically, the Act requires:

> that the State, acting through a State agency, association, or other private nonprofit entity, develop a written description of the law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives that would be distributed by providers or organizations under the requirements of [the Act].[57]

Finally, the Act requires the United States Department of Health and Human Services (DHHS) to undertake a public education campaign. This

55. *Id.* §§ 4206(a)(1), 4207(a)(1).
56. *Id.*
57. *Id.* § 4751(a)(1).

includes developing or approving national educational materials, assisting states in developing state-specific documents, and mailing information to social security recipients. The Act authorizes no additional funds for any of these activities.

Significantly, the PSDA provides no guidelines to states for the process of developing this "written description of the law of the state." Legally, the obligation is a Medicaid state plan requirement, although the written descriptions are to be distributed by all participating provider organizations to all adult patients, not just to Medicaid patients.[58] The state agency responsible for Medicaid bears the ultimate responsibility for issuing or approving a description. Under the operative language, states are free to develop the description of state law in any manner they choose. The American Bar Association, through a project of its Commission on Legal Problems of the Elderly, has urged states to establish broadly inclusive working groups to accomplish this particular task. This strategy is intended to increase the likelihood that a multiplicity of authorities and viewpoints are taken into account, so that the final product becomes a more widely accepted and practical guide.[59] Whether or not this goal is achieved is the focus of an inquiry by the Center for Evaluative Clinical Science at Dartmouth Medical School with the assistance of the American Bar Association's Commission on Legal Problems of the Elderly. Preliminary data from the project confirm that every state has produced at least a tentative description of the law for distribution by providers to the public.[60]

Somewhat remarkably, the PSDA has enjoyed considerable support since its inception from both the medical and legal professions, although some have criticized it for focusing too heavily on inpatient admissions, a time when individuals are under a great deal of stress, while ignoring more routine doctor-patient office contacts.[61] While almost everyone agrees that discussions about the patient's wishes and the use of advance directives ought to take place between patient and doctor during more routine medical experiences, Congress needed a practical administrative hook on which to hang the Act's mandates. Within the Medicare and Medicaid scheme, the point of admission for care emerged as the most feasible strategy, since it is more easily documentable and reviewable by survey and certification officials.

The Act is vague about the range of health care decisions and decision making rights that must be encompassed in patient disclosures. While obvi-

58. *See Hearings on S. 1766 Before the Subcommittee on Medicare and Long-Term Care of the Senate Committee on Finance*, 101st Cong., 2d Sess. 4 (1990) (Opening Statement of Hon. John C. Danforth) [hereinafter *Hearings*].

59. COMM'N ON LEGAL PROBLEMS OF THE ELDERLY, PATIENT SELF-DETERMINATION ACT STATE LAW GUIDE (1991).

60. Unpublished data from Charles P. Sabatino, American Bar Association, Commission on Legal Problems of the Elderly, December 1991.

61. *Hearings*, *supra* note 58 at 103 (testimony of Nancy W. Dickey, American Medical Association).

ously focusing on advance directives, the Act mandates providers to inform all adults receiving medical care about their rights "to make decisions concerning such medical care."[62] Read broadly, this would encompass a totally unmanageable range of decisions about which special rights and protections apply — for example, involuntary commitment, the administration of psychotropic drugs, sterilization, abortion decisions, HIV testing, organ donation, or experimental treatment. However, the sponsors of the Act consciously chose general language, preferring to leave it to the states to craft the specifics. The crux of the Act is that the states and providers must act to inform the public. Assuming that the Act engenders the activity hoped for, its most profound potential may be its long-range effect on the public's consciousness.

Realistically, one additional piece of paper, given at the time of admission and describing advance directives, will capture the attention of few people. Yet over time, disseminating such information at admission; asking individuals whether they or family members have an advance directive; publicizing facility policies on advance directives; and initiating institutional and community-wide educational initiatives concerning advance directives, may ultimately transform health care decision planning into a virtually universal component of adult affairs, in much the same way that we approach health or life insurance. However, because these effects would take considerable time, short term surveys on the use of advance directives are unlikely to show significant change.

A creative extension of this strategy is represented by recent Illinois and South Dakota amendments to their state's motor vehicle laws.[63] The Illinois amendment requires the Secretary of State to "designate on the reverse side of a driver's license issued, a space where the licensee may indicate that he or she has drafted a living will in accordance with the Illinois Living Will Act."[64] The South Dakota amendment adds to the information to be included on an operator's license "an indication if the licensee has a living will pursuant to chapter 34-12D or a durable power of attorney for health care pursuant to chapter 59-7."[65] The placement of anatomical gifts forms on drivers' licenses has been a widespread practice for years. These two amendments simply extend this strategy to advance directives, although in Illinois, the amendment is oddly limited to living wills; Illinois has both a living will and a power of attorney for health care statute.[66] California considered a similar bill in 1991, except that it proposed to require the Department of Motor Vehicles to provide each recipient of a driver's license with a durable power of attorney for

62. OBRA, *supra* note 54, §§ 4206(a)(1), 4207(a)(1).

63. 1991 Ill. Legis. Serv. 87-590 (West) (amending ch. 95 1/2, para. 6-110) (enacted September 18, 1991, effective January 1, 1992); 1992 S.D. Laws 207 (approved March 10, 1992).

64. 1991 Ill. Laws 6-110(g).

65. 1992 S.D. Laws 32-12-17.

66. *See* ILL. ANN. STAT. ch. 110 1/2, para. 701-710, 804-1 to -12 (Smith-Hurd Supp. 1990) (regarding living wills and powers of attorney for health care, respectively).

health care form.[67]

Unfortunately, the attempted transformation of health decisions planning into a common responsibility of adulthood is not necessarily good news for all segments of society. For poor, uneducated, or isolated individuals and families, mere access to basic care is a far higher priority than concerns about refusing life-sustaining treatment. If institutions and health care professional practice give special attention to advance directives and the right to refuse treatment, while giving comparatively less attention to concerns about access to care and the quality of care, then the message to these groups is harmfully skewed. This is especially so for individuals with significant disabilities who need extensive long-term care. Under a system that supports refusals of care but not access to high quality long-term care, opting out of care would be easier than opting for care, in which case the implicit message is that it is more socially appropriate for individuals to refuse care than to insist on care.

Under these circumstances, those with sufficient economic resources and a strong social network would be the most able to make personally authentic care choices. Indigent, poorly educated, and isolated individuals, especially those in nursing homes and other institutional settings, would be particularly vulnerable to facile execution of documents urged upon them by institutions or caretakers who are strangers.

The Act clearly states that facilities cannot "condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive."[68] However, even in the absence of explicit discrimination by a facility, actions of providers can convey subtle or not so subtle messages. Well-meaning institutions face persistent economic pressures that do not always work in favor of the best interests of patients or residents, and providers understandably prefer clearly designated decision makers and definite boundaries on the limits of care. Consequently, health care facilities have a tough balancing act to perform. They must take a neutral position respectful of individual choice, but they must also provide information and access to counseling resources on advance directives to assist those who want and need help. In many communities, the facility and its staff are the only practical resources for information available to the patient.

Although research on advance directives is quite limited, there is a fairly clear preference on the part of the public for their physicians to initiate discussions about advance directives.[69] Patient advocates, patient representatives,

67. California Assembly Bill 1907, introduced March 8, 1991.

68. *See supra* note 54.

69. Linda L. Emanuel, Michael J. Barry, John D. Stoeckle, Lucy M. Ettelson & Ezekiel J. Emanuel, *Advance Directives for Medical Care — A Case For Greater Use*, 324 NEW ENG. J. MED. 889, 891 (1991), reported that 93% of a patient cohort wanted any one of three forms of advance directive, but the most frequently cited barrier to completing one was the patient's expectation that the physician should take the initiative. *See also* Robert H. Shmerling, Susanna E. Bedell, Armin Lilienfeld & Thomas L. Delbanco, *Discussing Cardiopulmonary Resuscitation: A Study of Elderly Outpatients*, 3 J. GEN. INTERN. MED. 317-21 (1988).

medical social workers, or volunteer service organizations may also provide appropriate counseling resources within a facility. However, admissions staff and other administrative personnel should be limited to conveying basic information. They should not be handing out advance directive forms or suggesting that patients sign them at the time of admission. The inclusion of an advance directive form in admission materials unavoidably gives an impression that the facility expects the patient to sign it, and it does so at the time when the patient is typically least able to consider his or her options.

The PSDA is merely the most recent newcomer in a growing constellation of nursing home residents' rights.[70] Federal nursing home regulations address in considerable detail many facets of resident autonomy, dignity, quality of life, and quality of care. The fundamental mandate behind the regulations is stated as follows:

> The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident.[71] . . . Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.[72]

Among the specific rights itemized is "the right to refuse treatment, and to refuse to participate in experimental research."[73] The way a facility interprets, communicates, and supports the full panoply of patients' and residents' rights, not just the Patient Self-Determination Act, will ultimately determine the viability of authentic personal autonomy.

VI

THE ROLE OF THE COURTS AND IMPACT OF *CRUZAN*

When other means of surrogate decision making are unavailable or unsuccessful, resort to the courts traditionally is available through guardianship or protective services proceedings. "Protective services" usually refers to emergency health or social service interventions, while guardianship involves the judicial appointment of an individual or organization to manage the property or personal affairs of an incapacitated person.[74]

Most of the case law on this subject has arisen in the context of guardian-

70. *See, e.g.*, Nursing Home Reform Amendments of 1987, Omnibus Budget Reconciliation Act of 1987 (OBRA), Pub. L. No. 100-203, §§ 4201-4206, 4211-4216, 42 U.S.C. §§ 1395i-3(a)-(h), 1396r(a)-(h) (Medicare and Medicaid respectively) (extensive residents' rights); §§ 4021-4027, 42 U.S.C. § 1395bbb (home health care patient/client rights).

71. 56 Fed. Reg. 48,867 (to be codified at 42 C.F.R. § 483.10).

72. 56 Fed. Reg. 48,873 (to be codified at 42 C.F.R. § 483.25).

73. 56 Fed. Reg. 48,867 (to be codified at 42 C.F.R. § 483.10(b)(4)).

74. *See generally* SAMUEL J. BRAKEL, JOHN PARRY & BARBAR A. WEINER, THE MENTALLY DISABLED AND THE LAW (3rd ed. 1985).

ship proceedings. The primary advantage of guardianship, at least in theory, is that it protects the rights of the incapacitated person through judicial oversight and monitoring. However, courts have been reluctant to get involved in health care decision making except where intractable conflicts or questions arise,[75] and as a practical matter, most courts have neither the capacity nor the expertise to become routinely involved in significant numbers of health care decisions.[76] Nevertheless, courts struggled with these issues long before legislators took pen in hand, and courts will continue to bear the burden of resolving the most difficult, and usually poignant, individual controversies.

Many case decisions have set up procedures or guidelines for the termination of treatment, either filling a void where no legislation existed or supplementing existing legislation.[77] Sometimes the courts have been criticized for mandating procedures considered burdensome or unrealistic by the health care community or by patients and their families. The Missouri Supreme Court's decision in the case of Nancy Cruzan is one example.[78]

Nancy Cruzan had been sustained in a persistent vegetative state through the administration of artificial nutrition and hydration from the time of a tragic auto accident in 1983 when she was twenty-five years old until her death on the day after Christmas 1990. She died a few days after her gastrostomy tube was removed, pursuant to a trial court's order issued after hearing a new petition and new evidence of her wishes. The petition was filed by her parents who were her co-guardians.

The first petition of Nancy Cruzan's parents had met a quite different and precedent-setting fate. The Missouri Supreme Court held that Nancy Cruzan's subjective intent to have her gastrostomy tube removed had to be proven by "clear and convincing" evidence before the court would order termination of tube feeding.[79] While other courts have imposed clear and convincing evidence standards, they have been more willing to accept inferential evidence of what the patient *would have* decided had he or she acted. The Missouri Supreme Court, to the contrary, virtually insisted that the evidence prove that the patient had *actually* made a treatment-specific decision in ad-

75. *See, e.g., In re* Conservatorship of Drabick, 245 Cal. Rptr. 840 (Cal. Ct. App.), *cert. denied sub nom.* Drabick v. Drabick, 488 U.S. 958 (1988); Rasmussen v. Fleming, 74 P.2d 674 (Ariz. 1987); *In re* Jobes, 529 A.2d 434 (N.J. 1987).

76. For guidelines regarding judicial involvement in decisions about life-sustaining treatment, *see* NATIONAL CENTER FOR STATE COURTS, GUIDELINES FOR STATE COURT DECISION MAKING IN AUTHORIZING OR WITHHOLDING LIFE-SUSTAINING MEDICAL TREATMENT (1991).

77. *See, e.g., In re* Jobes, 529 A.2d 434 (N.J. 1987); *In re* Peter 529 A.2d 419 (N.J. 1987); *In re* Guardianship of Browning, 568 So.2d 4 (Fla. 1990).

78. Cruzan v. Harmon, 760 S.W.2d 408 (Mo. 1988), *aff'd sub nom.* Cruzan v. Director, Missouri Dep't of Health, 110 S. Ct. 2841 (1990).

79. The Missouri court stated, "[N]o person can assume that choice [to refuse life-sustaining treatment] for an incompetent in the absence of the formalities required under Missouri's Living Will statutes or the clear and convincing, inherently reliable evidence absent here." 760 S.W.2d at 425.

vance of her demise.[80] Moreover, the state court ruled that her parents, as co-guardians, had no inherent right to make this decision on her behalf.[81]

The United States Supreme Court affirmed the Missouri high court's decision. However, the Supreme Court decision is unusually malleable, providing possible precedent for courts and state legislatures to move in quite diverse directions. The decision finds a constitutional foundation for a competent person's right to refuse treatment in the right to liberty under the Due Process Clause of the Fourteenth Amendment.[82] The Court noted, "The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions."[83]

The Court rejected any legal distinction between artificially supplied nutrition and hydration and other forms of medical treatment: "[F]or purposes of this case, we assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition."[84] This supports the view of the majority of state courts that have considered this question. In recent years, most right-to-refuse cases in the courts have involved disputes about withholding or withdrawing this particular medical intervention.[85]

Finally, the Court held that the United States Constitution allows states considerable leeway in establishing, as Missouri did, a "procedural safeguard" for incompetent persons who cannot exercise the right to refuse treatment on their own.[86] Specifically, the Court held Missouri's clear and convincing evidence standard to be constitutionally permissible. This finding sets up an inevitable tension between the recognition of a constitutional individual right and state authority to impose procedural requirements; these two rights are certain to clash in the future. State decisions could place greater emphasis on one right or the other, thus producing dramatically different outcomes.

Despite its malleability, the decision has been widely viewed as a sobering admonition to all adults to execute health care advance directives, drafted in as much detail as possible. While this may be good general advice, it must be kept in mind that Missouri's stringent clear and convincing burden of proof

80. *Id.* at 417, 424. In applying an informed consent standard in analyzing Nancy Cruzan's intent, the court concluded, "Our earlier discussion about informed consent noted the requirements for consent or refusal to be truly informed. A decision to refuse treatment, when that decision will bring about death, should be as informed as a decision to accept treatment. If offered to show informed refusal, the evidence offered here 'would be woefully inadequate. . . .'" *Id.* at 424 (citation omitted).

81. *Id.* at 424-426.

82. The Court declined the opportunity to base its analysis on a constitutional privacy right, instead explaining that: "We believe this issue is more properly analyzed in terms of a Fourteenth Amendment liberty interest." Cruzan v. Director, Missouri Dep't of Health, 110 S. Ct. 2841, 2851 n.7 (1990).

83. *Id.* at 2851.

84. *Id.* at 2852.

85. *See* NATIONAL CENTER FOR STATE COURTS, *supra* note 76, App. A.

86. *Cruzan*, 110 S. Ct. at 2852.

requirement for establishing the subjective intent of incompetent patients is virtually unique to Missouri. The United States Constitution permits, but does not require this standard.

Of greater consequence is the Supreme Court's recognition of a constitutional base to the right to refuse life-sustaining treatment. While the Court limited its finding by framing it as an assumption "for purposes of this case," it provided no hint of limitation in its underlying reasoning and summary of the case law. The Court's acceptance of such a constitutional right is likely to result in greater deference to all expressions of patient wishes, regardless of their strict compliance with formalities prescribed by state law. Indeed, we may see more constitutional challenges to state statutes that restrict the content of advance directives or dictate strict formalities for advance directives.

In challenging strict formalities of execution, litigants are likely to argue that the constitutional protection afforded competent persons requires states to give greater cognizance to any form of written advance directive, as long as the document's authenticity is not in question. Thus, one's wishes scrawled on the back of a paper napkin may, as a practical matter, be deserving of as much deference as a statutory advance directive, assuming authenticity is not at issue. Opponents of this view, of course, will assert that the state's insistence on prescribed formalities is a proper procedural safeguard.

As to substantive restrictions, advance directive statutes frequently include some prohibition or limitation on consent to or refusal of certain treatments. These provisions commonly prohibit consent to interventions such as civil commitment, psychosurgery, sterilization, abortion, or experimental treatment.[87] These particular limitations have not been especially controversial. The more contentious limitations have dealt with withholding or withdrawal of life-sustaining treatments, particularly nutrition and hydration. A number of early living will statutes banned the withdrawal of nutrition and hydration outright.[88] Under *Cruzan*, an outright ban on withdrawal, despite a patient's wishes to the contrary, would almost certainly fail under constitutional scrutiny.

However, some recent statutes have imposed various procedural conditions on withholding or withdrawal, the most common being the requirement that individuals expressly state their intentions regarding nutrition and hydration in a prescribed manner, and that the patient's physician certify that nutrition and hydration are not needed for comfort care. For example, if an Oregonian wants to "clearly and specifically state" his or her desire to refuse nutrition and hydration through a durable power of attorney for health care, Oregon's Act requires that it "shall be in the following form [prescribed in the

87. *See, e.g.*, CAL. CIV. CODE § 2435 (West 1990); WIS. STAT. ANN. § 155.20 (West 1990).

88. *See, e.g.*, GA. CODE ANN. § 31-32-2(5) (1985); MO. REV. STAT. § 459.010(3) (1985); WIS. STAT. ANN. § 154.01(5) (West Supp. 1986).

statute]:"[89]

> It shall be presumed that every person who is temporarily or permanently incapable has consented to artificially administered hydration and nutrition, except hyperalimentation, that are necessary to sustain life unless:
>
> (a) The person while a capable adult clearly and specifically stated that the person would have refused artificially administered hydration or nutrition; or
>
> (b) Administration of such nutrition and hydration is not medically feasible or would itself cause severe, intractable or long-lasting pain; or
>
> (c) The person:
>
> (A) Is permanently incapable;
>
> (B) Is in the final stage of a terminal condition; and
>
> (C) Will die within a reasonable short period of time whether or not such hydration or nutrition is administered.[90]

The constitutional vulnerability of these procedural restrictions is probably quite low, since the Supreme Court has been staunchly deferential to state discretion in establishing any "procedural safeguard," as it referred to Missouri's clear and convincing evidentiary standard.[91] However, applying these procedural restrictions to instances where the patient's wishes are fairly clear, yet lacking the proper formalities, is where problems arise. The story of James Robert Rhea's death is a case in point.[92]

Mr. Rhea, a mentally alert, eighty-three year old retired railroad worker, knew he had metastatic cancer in his liver, lungs, colon, and stomach, but he wanted to die peacefully without any "heroic" measures. After he entered a nursing home in Hondo, Texas, he properly executed a Texas living will, and gave it to the nursing home. In addition, his wife Bernice signed her consent to an anti-CPR document provided by the nursing home.

Three weeks later, Mr. Rhea stopped breathing, but instead of letting him die peacefully, the nursing staff began cardio-pulmonary resuscitation and called emergency medical services, with the result that Mr. Rhea was rushed to the local hospital where he was pronounced dead on arrival. All this happened despite the fact that the facility's doctor gave two telephone orders "not to resuscitate." Unfortunately, state law requires a doctor to be physically present to order CPR stopped. The state living will statute also requires two physicians to certify the patient's terminal condition in the medical record before a living will can be carried out. Because of an oversight unknown to

89. OR. REV. STAT. § 127.530 (1990).

90. OR. REV. STAT. §§ 127.505-.585 (1990).

91. Cruzan v. Director, Missouri Dep't of Health, 110 S. Ct. 2841, 2852 (1990).

92. Denise Gamino, *A Living Will Fails To Ensure Dignified Death*, AUSTIN AMERICAN-STATESMAN, May 15, 1992, at A1, A12.

the couple, Mr. Rhea's medical record contained only one physician's certification. Consequently, the Texas Health Department found that the nursing home acted properly, and that the family had the responsibility to obtain the signatures of two physicians, despite the fact that everyone clearly knew Mr. Rhea's wishes.

Mr. Rhea's case painfully illustrates the worst kind of administrative preoccupation with form over substance, as well as a decisive slash at the soft underbelly of patient autonomy. Health care providers should keep decision making firmly focused on the patient's values and on the communication process between provider, patient, and family. If that is done, most problems will be resolved informally and ethically. However, if this new breed of formalized, statute-intensive decision making is taken too literally, then every flaw in advance directive documentation runs the risk of obstructing, rather than promoting, personal choice. Secondarily, it runs the risk of promoting a new generation of litigation, focused not on any query about the existence of an underlying right to self-determination, liberty, or privacy, but instead on the enforcement of this right in a hostile, bureaucratic environment.

CONCLUSION

In truth, the *Cruzan* decision had no dramatic, immediate impact on the existing law of any state. Yet its significance has not been lost to legislators. Since *Cruzan*, legislatures have redoubled efforts to enact new health care power of attorney legislation and to remedy perceived flaws in existing living will statutes.[93] By affirming a delicate brew of individual autonomy and state discretion, the long-term impact of *Cruzan*, as well as the Patient Self-Determination Act, will lie in their success or failure to raise public consciousness. Clearly, more attention is being given to advance directives, and this is beneficial for everyone if advance directives are kept in proper perspective. Ultimately, advance directives should be tools for facilitating better communication, not substitutes for it. If form becomes more important than the communication process itself, then we will have converted the profound experience of dying into an exercise in legal draftsmanship and administrative precision. Only those with the most accurate and precise writers and flexible administrators "win." If on the other hand, the goal of better communication and understanding is kept in the forefront, then the emergence of advance directive laws can tangibly and unobtrusively enhance individual dignity and autonomy.

93. Several recent living will amendments have clarified the applicability of state living will statutes to patients, like Nancy Cruzan, who are permanently unconscious, and some have clarified the definition of life-sustaining treatment to expressly include nutrition and hydration, except when they are necessary for comfort care. *See, e.g.*, 1991 Ariz. Sess. Laws 91-163 (enacted May 23, 1991); 1991 Tenn. Pub. Acts 91-344 (enacted May 14, 1991); W. Va. Acts 414 (enacted March 9, 1991).

APPENDIX A

CHART B

STATE CHART ON HCPA LAWS

Health Care Power of Attorney Legislation -- as of June 1992

State	Type	Form	Limits on Agent's Powers	Prohibited Agents	Formalities of Execution	Prohibited Witnesses	Can Include Living Will Directive?	Provider Immunity
ALASKA Alaska Stat. §§13.26.332 to .356 (Supp. 1990) Specifically §§13.26.344(f). Health powers enacted 1988.	General DPA	YES Must be substantially followed	•Life-sustaining procedures •Mental health facility Admission •Electro-convulsive therapy •Psycho-surgery •Sterilization •Abortion	None specified	•Notarized	N/A	NO	YES
ARIZONA Ariz. Rev. Stat. Ann. §36-3201 to -3262, in 1992 Ariz. Laws ch. 193 (H.B. 2247) Enacted 6/8/92 See Notes 1, 2 & 3	Combined Advance Directive	YES Optional	None specified	• Agent • Provider	• 1 witness or notarized	If only one witness, person may not be • Relative • Heir	YES	YES
ARKANSAS Ark. Code Ann. §§20-17-201 to -218 (Supp. 1989) Enacted 1987 See Note 3	Proxy contained in Living Will statute	YES Optional	•Unclear. May be co-extensive with Living Will Declaration •Pregnancy limitation	None specified	•2 witnesses	None specified	YES	YES
CALIFORNIA Cal. Civ. Code §§2430 to -44 (West Supp. 1990) Enacted 1983. Last amended by 1991 Cal. Legis. Serv. Ch. 896 (A.B. 793) See Note 2	Special DPA	YES Optional—but has mandatory disclosure to principal	•Civil commitment •Electro-convulsive therapy •Psycho-surgery •Sterilization •Abortion	•Provider •Facility •Conservator	•Warning disclosure •2 witnesses or notarized •Special institutional requirements	•Agent •Provider •Facility	Form allows special instructions	YES
COLORADO Colo. Rev. Stat. §§15-14-501, 502 (1537) Enacted 1633	General DPA	NO	None specified	None specified	None specified	N/A	Not addressed	
CONNECTICUT Conn. Gen. Stat. Ann. §1-43 (West 1992) Health powers enacted 1990 Amended by 1991 Conn. Pub. Acts 91-332 (H.B. 6710)	General DPA	YES Optional	•Life sustaining procedures* •Nutrition & hydration* *Does not allow consent to "withdrawal" - However "withholding" of life support and nutrition & hydration is not addressed	None specified	•2 witnesses and notarized	N/A	NO	NO
DELAWARE Del. Code Ann. tit. 16, §§2501 to 2509 (1983) Enacted 1982	Proxy contained in Living Will statute	NO	•Pregnancy limitation	None specified	•2 witnesses •Special institutional requirements	•Facility •Relative •Heir •Creditor •Person responsible for care costs	YES	YES
DISTRICT OF COLUMBIA D.C. Code Ann. §§21-2201 to -2213 Enacted 1989 *See Note 3	Special DPA	YES Optional	None specified	•Provider	•2 witnesses	•Principal •Provider •One may not be relative or heir	Form allows special instructions	NO

State	Type	Form	Limits on Agent's Powers	Prohibited Agents	Formalities of Execution	Prohibited Witnesses	Can Include Living Will Directive?	Provider Immunity
FLORIDA Fla. Stat. Ann. §765.101 to -.401 (West 1992) Enacted 1990, amended 1992 See Notes 1, 3 & 4	Combined Advance Directive	YES Optional	•Mental health facility admission •Electro-convulsive therapy •Psycho-surgery •Sterilization •Abortion •Experimental treatments •Life-sustaining procedures* *Refusal permissible if expressly authorized	•Provider •Facility	•2 witnesses	•Agent •One may not be spouse or relative	Form allows special instructions	YES
GEORGIA Ga. Code Ann. §§31-36-1 to -13 (1990) Enacted 1990 See Note 2	Special DPA	YES Optional	•Mental health facility admission •Psycho-surgery •Sterilization •Treatments under Title 37 of Code	•Provider	•2 witnesses plus attending physician if in hospital or Skilled Nursing Facility	None	YES, offers language	YES
IDAHO Idaho Code §§39-4501 to -4509 (Supp. 1990) Specifically §39-4505 Enacted 1988	Special DPA	YES Optional	None Specified	•Provider •Facility	•2 witnesses or notarized	•Agent •Provider •Facility •One may not be relative or heir	Form allows special instructions	YES
ILLINOIS Ill. Stat. Ann. ch. 110-1/2 §§804-1 to -12 (Smith-Hard Supp. 1990) Enacted 1987 See Note 2	Special DPA	YES Optional	None specified	•Provider	None specified	None specified	YES, offers language	YES
INDIANA Ind. Code Ann. §§30-5-1 to 30-5-10 (West 1991) Specifically §30-5-5-17. Enacted 1991 See also §16-8-12 See Note 3	General DPA	YES (or grant of authority	None specified	None specified	•Notarized §30-5-3-3(d) •1 witness §16-8-12-8(c)	Agent	Probably yes, since Pr. is permitted to modify powers §30-5-5-1(d)	YES
IOWA Iowa Code Ann. §§144B.1 to .12 (West Supp. 1991) Enacted 1991 See Note 3	Special DPA	YES Optional	None specified	•Provider	•2 witnesses or notarized	•Agent •Provider •Person under 18 •One may not be relative	YES	YES
KANSAS Kan. Stat. Ann. §§58-625 to -632 (Supp. 1989) Enacted 1989 See Notes 2 and 3	Special DPA	YES Must be substantially followed	•Cannot revoke previous living will	•Provider •Facility	•2 witnesses or notarized	•Relative •Heir •Person responsible for care costs	Form allows special instructions	NO
KENTUCKY Ky. Rev. Stat. §§311.970 to .986 (Supp. 1990) Enacted 1990	Special DPA	YES Optional	•Nutrition & hydration* •Pregnancy limitation *Refusal permissible if specified conditions are met	•Facility	•2 witnesses or notarized	•Facility	Not addressed	YES

State	Type	Form	Limits on Agent's Powers	Prohibited Agents	Formalities of Execution	Prohibited Witnesses	Can Include Living Will Directive?	Provider Immunity
LOUISIANA La. Civ. Code Ann. Art. 2997 (West 1990) Enacted 1990	General DPA	NO	•Cannot execute a living will	None specified	None Specified* •Only requires that powers affecting real estate be signed before notary and 2 witnesses	N/A	Not addressed	NO
MAINE Me. Rev. Stat. Ann. tit. 18A, §5-501 to 5-506 (Supp. 1992) Enacted 1985, 1992.	Special DPA	NO	None specified	None specified	•2 witnesses	•Agent	Not addressed	NO
MASSACHUSETTS Mass. Gen. Laws Ann. ch. 201D (West Supp. 1991) Enacted 1990 See Note 3	Special DPA	NO	None specified	•Facility	•2 witnesses	•Agent	YES	YES
MICHIGAN Mich. Comp. Laws Ann. §700.496 (West 1991) Enacted 1990	Special DPA	Only for agent's acceptance	•Pregnancy limitation •Life-sustaining procedures* •Refusal permissible if expressly authorized	None specified	•2 witnesses Agent must accept in writing	•Agent •Relative •Heir •Provider •Facility •Employee of life/health insurance provider	YES	NO
MINNESOTA Minn. Stat. §§145B.01 to -.17 (Supp. 1992) Enacted 1989 See Note 3	Proxy contained in Living Will statute	YES Must be substantially followed	•Unless: May be co-extensive with Living Will Declaration •Pregnancy limitation	None specified	•2 witnesses or notarized	•Agent •Heir	YES	NO
MISSISSIPPI Miss. Code Ann. §§41-41-151 to -183 (Supp. 1992) Enacted 1990 See Note 2	Special DPA	Only for mandatory disclosure to principal	None specified	•Provider	•2 witnesses or notarized	•Agent •Provider •Facility •One may not be relative or heir	Notice form allows special instructions	YES
MISSOURI Mo Ann Stat §§404.700 to 735 (West 1991) Health powers enacted 1991. See Notes 2 and 3	Special DPA (within general DPA statute)	NO	•Nutrition & hydration* •Refusal permissible if expressly authorized	•Physician •Facility	•Must be acknowledged as conveyance of real estate (§404.705)	N/A	Not addressed, although agent may •execute powers conferred according to the principal's instructions •(§404.710(5))	YES
MONTANA Mont. Code Ann. §§50-9-101 to -111, 50-10-106 (1991) Enacted 1985 Proxy added 1991 See Notes 1 and 3	Proxy contained in Living Will statute	YES Optional	•Co-extensive with Living Will Declaration •Pregnancy limitation	None specified	•2 witnesses	None specified	YES	YES

State	Type	Form	Limits on Agent's Powers	Prohibited Agents	Formalities of Execution	Prohibited Witnesses	Can Include Living Will Directive?	Provider Immunity
NEBRASKA 1992 Neb. Laws L.B. 696 Enacted 2/12/92 See Note 3	Special DPA	YES Must be substantially followed	•Life-sustaining procedures* •Nutrition & hydration* •Pregnancy limitation *Refusal permissible if expressly authorized	•Provider •Facility •Any agent serving 10 or more principals	•2 witnesses	•Agent •Spouse •Relative •Heir •Provider •Insurer •One may not be administrator or employee of provider	Form allows special instructions	YES
NEVADA Nev. Rev. Stat. §§449.800 to .860 (Supp. 1989) Enacted 1987 Amended by 1991 Nev. Laws Ch. 505 (S.B. 576) See Note 3	Special DPA	YES Must be substantially followed	•Mental health facility admission •Electro-convulsive therapy •Psycho-surgery •Sterilization •Abortion	•Provider •Facility	•2 witnesses or notarized	•Agent •Provider •Facility •One may not be relative or heir	YES Offers language	NO
NEW HAMPSHIRE 1991 N.H. Laws Ch. 146 Enacted 5/20/91 Codified at N.H. Rev. Stat. Ann §§137-J:1 to -J:16 See Note 3	Special DPA	Form and disclosure to principal. Must be substantially followed	•Mental health facility admission •Sterilization •Pregnancy limitation •Nutrition & hydration* *Refusal permissible if expressly authorized	•Provider •Facility	•2 witnesses •Principal must acknowledge receipt of mandatory notice	•Agent •Spouse •Heir •One may not be provider or facility	YES	YES
NEW JERSEY 1991 N.J. Sess. Law Serv. Ch. 201 (Sen. 1211) Enacted 1991 See Notes 3 and 4	Comined Advance Directive	NO	None specified	•Physician •Facility	•2 witnesses or notarized	•Agent	[Living will] may be "executed ... with, or be attached to, a proxy directive."	YES
NEW MEXICO N.M. Stat. Ann. §§45-5-501, -502 (1989) Health powers enacted 1989.	General DPA	YES Optional	None specified	None specified	•Notarized	N/A	Not addressed	NO
NEW YORK N.Y. Pub. Health Law §§2980 to 2994 (McKinney Supp. 1991) Enacted 1990 See Notes 3 and 4	Special DPA	YES Optional	•Nutrition & hydration* *Principal must make his/her wishes "reasonably known."	•Provider •Facility	•2 witnesses •Special institutional requirements	•Agent	Form allows special instructions	YES
NORTH CAROLINA N.C. Gen. Stat. §32A-15 to -26 (1991) Enacted 1991 See Note 2	Special DPA	YES Optional	None specified	•Provider	•2 witnesses and notarized	•Relative •Heir •Provider •Facility •Creditor	Expressly allows combined Living Will/DPA	YES

State	Type	Form	Limits on Agent's Powers	Prohibited Agents	Formalities of Execution	Prohibited Witnesses	Can Include Living Will Directive?	Provider Immunity
NORTH DAKOTA N.D. Cent. Code §§23-06.5-01 to -18 Enacted 1991 See Note 3	Special DPA	YES Optional	•Mental health facility admission > 45 days •Psycho-surgery •Abortion •Sterilization	•Provider •Facility	•2 witnesses •Agent must accept in writing •Special institutional requirements	•Agent •Provider •Facility •Spouse •Heir •Relative •Creditor	Form allows special instructions	YES
OHIO Ohio Rev. Code §§1337.11 to .17 (Anderson Supp. 1989) Enacted 1989. Amended by 1991 Ohio Laws File 36(S.B.1) See Note 3	Special DPA	Only for mandatory disclosure to principal	•Life-sustaining procedures** •Nutrition & hydration** •Pregnancy Limitation **Refusal permissible if specified conditions are met	•Physician •Facility	•2 witnesses or notarized	•Agent •Relative •Physician •Nursing Home Administrator	Notice form allows expression of desires	YES
OKLAHOMA 1992 Okla. Sess. Law Serv. Ch. 114 (H.B. 1883) See Note 1	Combined Advance Directive	YES Must be substantially followed	•Nutrition & hydration* •Pregnancy limitation *Refusal permissible if expressly authorized	None specified	•2 witnesses	•Heirs	Form allows special instructions	YES
OREGON Or. Rev. Stat. §§127.505 to .585 (1990) Enacted 1989 See Note 1	Special DPA	YES Must be substantially followed	•Mental health facility admission •Electro-convulsive therapy •Psycho-surgery •Sterilization •Abortion •Life-sustaining procedures* •Nutrition & hydration* *Refusal permissible if expressly authorized	•Provider •Facility	•Warning disclosure •2 witnesses •Agent must accept in writing	•Agent •Attending physician	Form allows special instructions	YES
PENNSYLVANIA 1992 Pa. Laws 24 (SB 3) Enacted 4/16/92 20 Pa Cons. Stat Ann §§5601 to 5607 (Purdon's Supp 1990), enacted 1982	Living Will Statute	YES Optional	•Authorizes agent to act only if principal is in a •terminal condition, or •state of permanent unconsciousness •Nutrition & hydration* •Pregnancy limitation *Refusal permissible if expressly authorized	None specified	•2 witnesses	•Person who signs declaration on declarant's behalf	YES	YES
RHODE ISLAND R I Gen Laws §23-4 10 1 and 2 (Supp 1989) Enacted 1989	Special DPA	YES Must be substantially followed	None specified	•Provider •Facility	•2 witnesses •Principal must be Rhode Island resident	•Agent •Provider •Facility •Currently the relative of the?	Form allows special instructions	NO
SOUTH CAROLINA S.C. Code §§44-66 10 to -80 (Law Co-op 1990) Enacted 1990 See also §62-5-501	General DPA	NO	None specified	None specified	•2 witnesses	None specified	Not addressed	NO
SOUTH DAKOTA S.D. Codified Laws Ann §§34-12C-1 to -8, and §§59-7-2.1 to -2.8 (Supp 1992) Health powers enacted 1990	Special DPA	NO	•Pregnancy limitation •Nutrition & hydration* *Refusal permissible if specified conditions are met	None specified	None specified	N/A	Not addressed	YES

State	Type	Form	Limits on Agent's Powers	Prohibited Agents	Formalities of Execution	Prohibited Witnesses	Can Include Living Will Directive?	Provider Immunity
TENNESSEE Tenn. Code Ann. §§34-6-201 to -214 (Supp. 1991) Enacted 1990. Amended by 1991 Tenn. Laws Pub. Ch. 167 (S.B. 914) See Note 2	Special DPA	Only for disclosure to principal	•Nutrition & hydration* •Refusal permissible if expressly authorized. However, cannot withhold "simple nourishment or fluids ..."	•Provider •Facility •Conservator* •Unless certain conditions are met	•2 witnesses and notarized	•Agent •Provider •Facility •One may not be relative or heir	Notice form allows special instructions	YES
TEXAS Tex. Rev. Civ. Stat. Ann. art. 4590h-1 (Vernon Supp. 1990) Enacted 1989 See Note 3	Special DPA	YES Must be substantially followed	•Mental health facility admission •Electro-convulsive therapy •Psycho-surgery •Abortion •Comfort care	•Provider •Facility	•Warning disclosure •2 witnesses	•Agent •Provider •Spouse •Heir •Creditor	Form allows special instructions	YES
UTAH Utah Code Ann. §75-2-1101 to -1118 (Supp. 1990) Enacted 1985 See Note 3	Special DPA	YES Must be substantially followed	•Life-sustaining procedures* •Pregnancy limitation •Agent makes health care decisions by executing a medical directive. Decisions may include the withholding of life-sustaining procedures unless principal is pregnant	None specified	•Notarized	N/A	NO, but agent may execute a directive	YES
VERMONT Vt. Stat. Ann. tit. 14, §3451 to 3467 (1989) Enacted 1988 See Note 3	Special DPA	YES Must be substantially followed	•Mental health facility admission •Sterilization	•Provider •Facility	•Warning disclosure •2 witnesses •Special institutional requirements	•Agent •Provider •Facility •Relative •Heir •Creditor	YES Offers language	YES
VIRGINIA Va. Code §54.1-2981 to -2993 (Supp. 1992) 1992 enactment replaces 1989 act See Notes 1 and 3	Combined Advance Directive	YES Optional	•Mental health facility admission •Psycho-surgery •Sterilization •Abortion	None specified	None specified	•Spouse •Relative	YES	YES
WASHINGTON Wash. Rev. Code Ann. §§11.94.010 to .900 (Supp. 1990) Health powers enacted 1989.	General DPA	NO	•Electro-convulsive therapy •Psycho-surgery •Other psychiatric •Amputation	•Provider •Facility	None specified	N/A	Not addressed	NO
WEST VIRGINIA W. Va. Code §16-30A-1 to -20 (Supp. 1990) Enacted 1990 See Notes 2 and 3	Special DPA	YES Must be substantially followed	•Life-sustaining procedures (Refusal permissible if specified conditions are met.)	•Provider •Facility	•2 witnesses *and* notarized	•Agent •Attending Physician •Principal's signator •Relative •Heir •Person responsible for care costs	Form allows special instructions	YES

State	Type	Form	Limits on Agent's Powers	Prohibited Agents	Formalities of Execution	Prohibited Witnesses	Can Include Living Will Directive?	Provider Immunity
WISCONSIN Wis.Stat.Ann.§§155.01 to.80 and 11.243.07 (6m) (West 1990) Enacted 1990	Special DPA	YES Optional—but disclosure to principal is mandatory	•Mental health facility admission •Electro-convulsive therapy •Mental health research •Drastic mental health treatment •Nutrition & hydration* •Admission to nursing home or residential facility *Refusal permissible only if specified conditions are met	•Provider •Facility	•2 witnesses	•Agent •Provider •Relative •Heir •Person responsible for care costs	Form allows special instructions	YES
WYOMING Wyo.Stat.Ann.§§33-5-201 to -214 (Supp. 1991) Enacted 1991 See Note 2	Special DPA	NO	•Mental health facility admission •Electro-convulsive therapy •Psycho-surgery	•Provider •Facility	•2 witnesses or notarized	•Agent •Provider •Facility •One may not be relative or heir	Not addressed	YES

NOTE 1: Addresses emergency medical services.
NOTE 2: Agent can act after death regarding anatomical gifts, autopsy and disposal of remains.
NOTE 3: Includes comity provision recognizing out-of-state instruments.
NOTE 4: Requires facilities to give notice of rights on admission

Prepared by Charles Sabatino, American Bar Association, Commission on Legal Problems of the Elderly.