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Notes

LIVING WILLS AND ALTERNATIVES TO LIVING WILLS: A PROPOSAL -- THE SUPREME TRUST

INTRODUCTION

A living will is a device by which a competent adult can designate in a legally binding manner, the specific treatment or non-treatment that he wishes to receive should he become terminally ill and incompetent.¹ To date, forty-one states and the District of Columbia have enacted "living will," "death with dignity," "natural death," or "right to die" statutes.² These statutes are

1. Many competent people find abhorrent the prospect of being artificially sustained after all brain activity has ceased and, therefore, desire some assurance that when they reach the point at which their brain activity has ceased someone will be authorized to order the termination of medical treatment on their behalf. The reasons for such a desire may be many. One such reason is that a person may want to die with what such person refers to as dignity. Another reason is that a person may not want his or her loved ones to incur any substantial expense with respect to prolonging such person's life. Conversely, other competent persons desire the assurance that medical treatment be continued for as long as possible. See SENATE FISCAL AGENCY OF MICHIGAN: BILL ANALYSIS, H.B. 4016 (H-6): FIRST ANALYSIS 1 (1990).

2. For purposes of this Note, these forty-two statutes will be referred to as "living will" statutes. These forty-two statutes are as follows: ALA. CODE §§ 22-8A-1 to -10 (1990); ALASKA STAT. §§ 18.12.010 to .100 (1986); ARIZ. REV. STAT. ANN. §§ 36-3201 to -3211 (1986 & Supp. 1991); ARK. CODE ANN. §§ 20-17-201 to -218 (Michie Supp. 1991); CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1991); COLO. REV. STAT. ANN. §§ 15-18-101 to -113 (West 1989 & Supp. 1991); CONN. GEN. STAT. ANN. §§ 19a-570 to -575 (West Supp. 1991); DEL. CODE ANN. tit. 16, §§ 2501-2509 (1983); D.C. CODE ANN. §§ 6-2421 to -2430 (1989); FLA. STAT. ANN. §§ 765.01-765.15 (West 1986 & Supp. 1992); GA. CODE ANN. §§ 31-32-1 to -12 (1991); HAW. REV. STAT. §§ 327D-1 to -27 (Supp. 1990); IDAHO CODE §§ 39-4501 to -4509 (1985 & Supp. 1991); ILL. ANN. STAT. ch. 110 1/2, para. 701-710 (Smith-Hurd Supp. 1991); IND. CODE ANN. §§ 16-8-11-1 to -22 (West 1992); IOWA CODE ANN. §§ 144A.1 to -.11 (West 1989); KAN. STAT. ANN. §§ 65-28,101 to -28,109 (1985); KY. REV. STAT. ANN. §§ 311.622 to -.644 (Baldwin 1991); LA. REV. STAT. ANN. §§ 40:1299.58.1 to -.10 (West Supp. 1992); ME. REV. STAT. ANN. tit. 18-A, §§ 5-701 to -714 (West Supp. 1991); MD. HEALTH-GEN. CODE ANN. §§ 5-601 to -614 (1990); MINN. STAT. ANN. §§ 145B.01 to -.17 (West Supp. 1992); MISS. CODE ANN. §§ 41-41-101 to -121 (Supp. 1991); MO. ANN. STAT. §§ 459.010 to -.055 (Vernon Supp. 1992); MONT. CODE ANN. §§ 50-9-101 to -206 (1991); NEV. REV. STAT. ANN. §§ 449.540 to -.690 (Michie 1991); N.H. REV. STAT. ANN. §§ 137-H:1 to -.16 (1990 & Supp. 1991); N.M. STAT. ANN. §§ 24-7-1 to -10 (Michie 1991); N.Y. PUB. HEALTH LAW §§ 2960-2978 (McKinney Supp. 1992); N.C. GEN. STAT. §§ 90-320 to -323 (1990); OKLA. STAT. ANN. tit. 63, §§ 3101-3111 (West Supp. 1992); OR. REV. STAT. §§ 127.605 to -.650 (1990); S.C. CODE ANN. §§ 44-77-10 to -160 (Law. Co-op. Supp. 1991); TENN. CODE ANN. §§ 32-11-101 to -110 (Supp. 1991); TEX. HEALTH & SAFETY CODE ANN. §§ 672.001 to -.021

premised on the constitutional and common law right to privacy and individual autonomy, often referred to in the living will context more specifically as the "right to die."³ The U.S. Supreme Court's most recent pronouncement with respect to the right to die issue is the Court's decision in *Cruzan v. Director, Missouri Department of Health*.⁴

Section I of this Note will set forth the basic framework of living will statutes.⁵ Section II will examine the provisions typical of most living will statutes and, in so doing, will discuss the major deficiencies inherent in such provisions.⁶ The first of these deficiencies is that the living will statutes do not

(West 1992); UTAH CODE ANN. §§ 75-2-1101 to -1118 (Supp. 1991); VT. STAT. ANN. tit. 18, §§ 5251-5262 (1987); VA. CODE ANN. §§ 54.1-2981 to -2992 (Michie 1991); WASH. REV. CODE ANN. §§ 70.122.010 to -.905 (West Supp. 1991); W. VA. CODE §§ 16-30-1 to -13 (1991 & Supp. 1991); WIS. STAT. ANN. §§ 154.01 to -.15 (West 1989); WYO. STAT. §§ 35-22-101 to -109 (1988).

On December 18, 1990, the Michigan State Legislature enacted the Health Care-Patient Designation of Advocate for Decisions Act. MICH. COMP. LAWS ANN. § 700.496 (West Supp. 1991). This Act is on the cutting edge with respect to the right of self-determination. See *infra* notes 95-114 and accompanying text for a discussion and analysis of this Act.

3. A number of living will statutes recognize the existence of this right to privacy and individual autonomy as grounds for the right to use a living will. See, e.g., CAL. HEALTH & SAFETY CODE § 7186 (West. Supp. 1991) (providing that "[t]he Legislature finds that adult persons have a *fundamental right to control* the decisions relating to the rendering of their own medical care. . . . The Legislature further finds that, in the interest of protecting *individual autonomy*, such prolongation [beyond natural limits] of life for persons with a terminal condition may cause loss of dignity and unnecessary pain and suffering. . . . In recognition of the dignity and *privacy* which patients have a right to expect, the Legislature hereby declares that the laws of the State of California shall recognize the right of an adult person to make a written directive instructing his physician to withhold or withdraw life-sustaining procedures in the event of a terminal condition" (emphasis added)). See also ALA. CODE § 22-8A-2 (1990); ARIZ. REV. STAT. ANN. §§ 36-3201 to -3210 (1986 & Supp. 1991); COLO. REV. STAT. ANN. § 15-18-102(a) (West 1989); DEL. CODE ANN. tit. 16, § 2502 (1983); FLA. STAT. ANN. § 765.02 (West 1986); GA. CODE ANN. § 31-32-1(d) (1991); HAW. REV. STAT. § 327D-1 (Supp. 1990); IDAHO CODE § 39-4502 (Supp. 1991); IND. CODE ANN. § 16-8-11-1 (West 1992); IOWA CODE ANN. § 144A.1 (West 1989); LA. REV. STAT. ANN. § 40:1299.58.1(A)(1) (West Supp. 1992); N.H. REV. STAT. ANN. § 137-H:1 (Supp. 1991); N.Y. PUB. HEALTH LAW § 2960 (McKinney Supp. 1992); N.C. GEN. STAT. § 90-320(a) (1990); S.C. CODE ANN. § 44-77-10 (Law. Co-op. Supp. 1991); UTAH CODE ANN. § 75-2-1102(2) (Supp. 1991); VT. STAT. ANN. tit. 18, § 5251 (1987); WASH. REV. CODE ANN. § 70.122.010 (West Supp. 1991).

4. 110 S. Ct. 2841 (1990). In *Cruzan*, Nancy Cruzan became incompetent as the result of severe injuries sustained in an automobile accident. *Id.* at 2844. After it became apparent that Nancy Cruzan was in a persistent vegetative state, her parents sought a court order directing the withdrawal of Nancy's artificial feeding and hydration equipment. *Id.* at 2845. The U.S. Supreme Court held that since no clear and convincing evidence existed that Nancy would have desired the withdrawal of this equipment, Nancy's parents lacked the authority to effectuate such withdrawal. *Id.* at 2855. The U.S. Supreme Court, however, did recognize the right to privacy in the self-determination context. *Cruzan*, 110 S. Ct. at 2851-52. A discussion of *Cruzan* in any greater depth and a discussion of the constitutional issues with respect to the right to die is beyond the scope of this Note.

5. See *infra* notes 16-26 and accompanying text.

6. See *infra* notes 27-64 and accompanying text.

apply when the declarant is not terminally ill, but is incurably ill.⁷ The second deficiency involves the inadequacy and inflexibility of the living wills drafted under the living will statutes.⁸ A third deficiency involves the medical profession's reluctance to comply with the provisions of living wills.⁹ A final deficiency is that a declarant typically must comply with a number of potentially troublesome and inconvenient formalities in order to validly execute a living will.¹⁰

After a discussion of these deficiencies, Section III will examine the ways in which a number of states have attempted to address these deficiencies.¹¹ Section III will also discuss the shortcomings inherent in the ways in which these states have attempted to address these deficiencies.¹² Section IV proposes a new, more effective and efficient approach by which a declarant can effectuate his wishes with respect to his right of self-determination.¹³ This approach involves what this notewriter refers to as the "supreme trust."¹⁴ Finally, Section V offers a brief summary and conclusion.

I. BASIC FRAMEWORK OF LIVING WILL STATUTES

Under the typical living will statute, a competent, non-pregnant adult¹⁵ may execute a written document in which he,¹⁶ the declarant, states that should the declarant later become incompetent and terminally ill,¹⁷ sustained only by

7. See *infra* notes 27-43 and accompanying text.

8. See *infra* notes 44-49 and accompanying text.

9. See *infra* notes 50-59 and accompanying text.

10. See *infra* notes 60-64 and accompanying text.

11. See *infra* notes 65-141 and accompanying text.

12. See *infra* notes 65-141 and accompanying text.

13. See *infra* notes 142-49 and accompanying text.

14. See *infra* note 142 and accompanying text.

15. See, e.g., IDAHO CODE § 39-4503(2) (Supp. 1991) (defining "competent person" as "any emancipated minor or any person eighteen (18) or more years of age who is of sound mind").

16. The masculine pronouns "he", "him", and "his" encompass the feminine pronouns "she", "her", and "hers." The masculine pronoun will be used to avoid awkward grammatical use of both pronouns.

17. Most living will statutes define what constitutes "terminal illness" or a "terminal condition". Compare VT. STAT. ANN. tit. 18, § 5252(5) (1987) ("'[t]erminal state' means an incurable condition caused by injury, disease or illness which regardless of the application of life-saving procedures would, within reasonable medical judgment, produce death and where application of life-sustaining procedures would only postpone the moment of death.") with GA. CODE ANN. § 31-32-2(10) (1991) ("'[t]erminal condition' means incurable condition caused by disease, illness, or injury which, regardless of the application of life-sustaining procedures, would produce death. The procedure for establishing a 'terminal condition' is as follows: [t]wo physicians who, after personally examining the declarant, shall certify in writing, based upon conditions found during their examination: (A) [t]here is no reasonable expectation for improvement in the condition of the declarant; and (B) [d]eath of the declarant from these conditions is imminent."). Usually, the living

artificial life-prolonging procedures,¹⁸ the declarant chooses not to receive any further medical treatment. Typically, the declarant may indicate a particular type or types of treatment which he chooses not to receive, or the declarant may make a more general statement that he desires no medical treatment whatsoever.¹⁹

The living will statutes differ with respect to a number of their provisions. A number of living will statutes provide a living will form.²⁰ These statutes, however, differ as to whether the use of such a form is mandatory²¹ or

will statutes' definition of "terminal illness" excludes persistent vegetative state conditions, chronic degenerative disease conditions, and conditions that are hopeless but not expected to produce death in the near future.

The New Mexico living will statute is the only living will statute that explicitly provides that a living will can become effective in a situation other than terminal illness. The New Mexico statute provides that a declarant may execute a living will directing that if the declarant is certified as suffering from a terminal illness or being in an irreversible coma, no medical treatment shall be utilized to prolong the declarant's life. N.M. STAT. ANN. § 24-7-3.A (Michie 1991). As used in this statute, "irreversible coma" is defined as "that state of mind in which brainstem functions remain but the major components of the cerebrum are irreversibly destroyed." *Id.* at § 24-7-2.B.

The Idaho living will statute defines "artificial life-sustaining procedure" in a manner that makes it possible for a declarant to execute a living will that would become effective if the declarant either should become terminally ill or fell into a persistent vegetative state. IDAHO CODE § 39-4503(3) (Supp. 1991). Similarly, the Arkansas living will statute defines "terminal condition" and "life-sustaining treatment" in a manner that makes it possible for a declarant to execute a living will that would become effective if the declarant should become terminally ill or permanently unconscious. ARK. CODE ANN. § 20-17-201(4), (5) (Michie Supp. 1991). As used in this statute, "permanently unconscious" is defined as "a lasting condition, indefinitely without change in which thought, feeling, sensations, and awareness of self and environment are absent." *Id.* at § 20-17-201(11).

18. Most living will statutes define what constitutes "life-prolonging procedure" or "life-sustaining procedure." See, e.g., VA. CODE ANN. § 54.1-2982 (Michie 1991) for a typical definition of "life-prolonging procedure". ("Life-prolonging procedure" means any medical procedure, treatment or intervention which (i) utilizes mechanical or other artificial means to sustain, restore or supplant a spontaneous vital function or is otherwise of such a nature as to afford a patient no reasonable expectation of recovery from a terminal condition and (ii) when applied to a patient in a terminal condition, would serve only to prolong the dying process. . . . [H]owever, nothing in this act shall prohibit the administration of medication or the performance of any medical procedure deemed necessary to provide comfort care or to alleviate pain.").

19. See, e.g., UTAH CODE ANN. § 75-2-1104 (Supp. 1991). This statute provides that a declarant may direct that all life-sustaining procedures be withheld or withdrawn if the declarant becomes terminally ill.

20. See, e.g., ALA. CODE § 22-8A-4 (1990); ALASKA STAT. § 18.12.010 (1991); CAL. HEALTH & SAFETY CODE § 7188 (West Supp. 1991); MISS. CODE ANN. § 41-41-107 (Supp. 1991); MONT. CODE ANN. § 50-9-103 (1991); N.C. GEN. STAT. § 90-321 (1990); TENN. CODE ANN. § 32-11-105 (Supp. 1991); VT. STAT. ANN. tit. 18, § 5253 (1987); WIS. STAT. ANN. § 154.03 (West 1989).

21. See, e.g., WIS. STAT. ANN. § 154.03 (West 1989) which provides the following mandatory form:

DECLARATION TO PHYSICIANS

Declaration made this....day of....(month),(year).

optional.²² Moreover, some living will statutes specifically exclude nutrition

1. I, ..., being of sound mind, wilfully and voluntarily state my desire that my dying may not be artificially prolonged if I have an incurable injury or illness certified to be a terminal condition by two physicians who have personally examined me, one of whom is my attending physician, and if the physicians have determined that my death is imminent, so that the application of life-sustaining procedures would serve only to prolong artificially the dying process. Under these circumstances, I direct that life-sustaining procedures be withheld or withdrawn and that I be permitted to die naturally, with only:

- a. The continuation of nutritional support and fluid maintenance;
- and
- b. The alleviation of pain by administering medication or other medical procedure.

2. If I am unable to give directions regarding the use of life-sustaining procedures, I intend that my family and physician honor this declaration as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences from this refusal.

3. If I have been diagnosed as pregnant and my physician knows of this diagnosis, this declaration has no effect during the course of my pregnancy.

4. This declaration takes effect immediately.

I understand this declaration and I am emotionally and mentally competent to make this declaration.

Signed....

Address....

I know the declarant personally and I believe him or her to be of sound mind. I am not related to the declarant by blood or marriage, and am not entitled to any portion of the declarant's estate under any will of the declarant. I am neither the declarant's attending physician, the attending nurse, the attending medical staff nor an employe[e] of the attending physician or of the inpatient health care facility in which the declarant may be a patient and I have no claim against the declarant's estate at this time, except that, if I am not a health care provider who is involved in the medical care of the declarant, I may be an employe[e] of the inpatient health care facility regardless of whether or not the facility may have a claim against the estate of the declarant.

Witness....

Witness....

This declaration is executed as provided in chapter 154, Wisconsin Statutes.

22. See, e.g., ALASKA STAT. § 18.12.010 (1991) which provides the following optional form:

DECLARATION

If I should have an incurable or irreversible condition that will cause my death within a relatively short time, it is my desire that my life not be prolonged by administration of life-sustaining procedures.

If my condition is terminal and I am unable to participate in decisions regarding my medical treatment, I direct my attending physician to withhold or withdraw procedures that merely prolong the dying process and are not necessary to my comfort or to alleviate pain.

I do [] do not [] desire that nutrition or hydration (food and water) be provided by gastric tube or intravenously if necessary.

Signed this _____ day of _____, _____.

Signature _____

Place _____

The declarant is known to me and voluntarily signed or voluntarily directed

and hydration or medicine, or both, from the definition of that which constitutes life-prolonging procedures.²³ Other living will statutes do not explicitly state whether or not nutrition and hydration or medicine constitutes life-prolonging procedures.²⁴ Still other living will statutes do provide a life-prolonging procedures definition which may include nutrition and hydration and medicine.²⁵ Furthermore, the living will statutes of Florida, Indiana, and Maryland are the only living will statutes that provide for the alternative of a binding life-prolonging declaration in which the declarant states that should the declarant later become incompetent and terminally ill, the declarant chooses to receive life-prolonging medical treatment.²⁶

II. DEFICIENCIES INHERENT IN THE PROVISIONS OF LIVING WILL STATUTES

Typical living will statutes have four basic deficiencies. The first deficiency is that most living will statutes do not apply when the declarant is not terminally ill, but is incurably ill. The second deficiency involves the inadequacy and inflexibility of the living wills executed under the living will statutes. The third deficiency involves the medical profession's reluctance to comply with the provisions of living wills. The fourth deficiency is that a declarant must comply with a number of potentially inconvenient formalities in order to validly execute a living will.

another to sign this document in my presence.

Witness _____

Address _____

State of _____

_____ Judicial District

The foregoing instrument was acknowledged before me this (date) by (name of person who acknowledged).

Signature of Person Taking Acknowledgement

Title or Rank

Serial Number, if any

23. See, e.g., IND. CODE ANN. § 16-8-11-4 (West 1992) (explicitly excluding from the definition of "life-prolonging procedure" the provision of appropriate nutrition and hydration, the administration of medication, or the performance of any medical procedure necessary to provide comfort care or to alleviate pain).

24. See, e.g., N.M. STAT. ANN. § 24-7-2(C) (Michie 1991) (defining "maintenance medical treatment" as "medical treatment designed solely to sustain the life processes" without any further explanation).

25. See, e.g., ME. REV. STAT. ANN. tit. 18-A, § 5-701(d)(4) (West 1981) ("Life-sustaining treatment does not include artificially administered nutrition and hydration unless the declarant elects in the declaration to include artificially administered nutrition and hydration in the definition of life-sustaining treatment").

26. FLA. STAT. ANN. § 765.02 (West 1986); IND. CODE ANN. §§ 16-8-11-11, 16-8-11-12 (West 1992); MD. HEALTH-GEN. CODE ANN. § 5-611 (1990).

A. Living Will Statutes Only Apply When the Declarant is Terminally Ill

A major deficiency of living will statutes is that usually such statutes only apply when the declarant is terminally ill.²⁷ Typically, living will statutes provide that a living will is effective only after the declarant becomes terminally ill.²⁸ For example, a living will would become effective if the declarant had Acquired Immune Deficiency Syndrome and death therefrom was diagnosed to occur within a relatively short period of time. The New Mexico living will statute is the only living will statute that provides that a living will is effective in a non-terminally ill situation.²⁹ However, this statute limits such a situation to an irreversible coma.³⁰

Living will statutes provide that an illness is terminal only if the illness will result in death despite the use of available medical care.³¹ Furthermore, a significant number of living will statutes provide that death must be imminent before the living will becomes effective.³² For example, Connecticut's living will statute provides that, before a living will becomes effective, the declarant must be in the "final stage of an incurable or irreversible medical condition which, in the opinion of the attending physician, will result in death."³³ Similarly, Maryland's living will statute states that, before a living will becomes effective, the declarant must suffer from an incurable condition which "makes death imminent" and further describes life-prolonging procedures as those which

27. Linda C. Fentiman, *Privacy and Personhood Revisited: A New Framework for Substitute Decisionmaking for the Incompetent, Incurably Ill Adult*, 57 GEO. WASH. L. REV. 801, 823-24 (1989); Leslie P. Francis, *The Evanescence of Living Wills*, 14 J. CONTEMP. L. 27, 35-38 (1988); Gregory Gelfand, *Living Will Statutes: The First Decade*, 1987 WIS. L. REV. 737, 740-47.

28. See, e.g., WYO. STAT. § 35-22-102 (1988).

29. N.M. STAT. ANN. § 24-7-3 (Michie 1991). Non-terminally ill situations include situations in which a patient is in a persistent vegetative state, suffering from a chronic degenerative disease, or suffering from a condition that is *hopeless* but not expected to produce death in the near future. See Francis, *supra* note 27, at 37.

30. N.M. STAT. ANN. § 24-7-3 (Michie 1991).

31. In other words, an illness is not terminal even if death would result therefrom within a relatively short period of time when the patient's life can be prolonged with the use of life prolonging procedures. See, e.g., ALA. CODE § 22-8A-3(6) (1990); D.C. CODE ANN. § 6-2421(6) (1989); IND. CODE ANN. § 16-8-11-9 (West 1992); IOWA CODE ANN. § 144A.2(8) (West 1989); MD. HEALTH-GEN. CODE ANN. § 5-601(g) (1990); NEV. REV. STAT. ANN. § 449.590 (Michie 1991); OKLA. STAT. ANN. tit. 63, § 3102(8) (West Supp. 1992); TEX. HEALTH & SAFETY CODE ANN. § 672.002(8) (West 1992); WASH. REV. CODE ANN. § 70.122.020(7) (West Supp. 1991); W. VA. CODE § 16-30-2(6) (Supp. 1991).

32. See, e.g., MD. HEALTH-GEN. CODE ANN. § 5-601(g) (1990) ("Terminal condition' means an incurable condition . . . which, to a reasonable degree of medical certainty, makes death imminent and from which, despite the application of life sustaining procedures, there can be no recovery.") (emphasis added); S.C. CODE ANN. § 44-77-20(4) (Law. Co-op. Supp. 1991).

33. CONN. GEN. STAT. ANN. § 19a-572 (West Supp. 1991).

"serve to secure only a precarious and burdensome prolongation of life."³⁴

Moreover, and in a similar vein, Oklahoma's living will statute requires that, before a living will becomes effective, the declarant must be in an incurable and irreversible condition which will result in the death of the declarant from such "condition or a complication arising from that condition within hours or days."³⁵ Furthermore, Mississippi's living will statute provides no definition of "terminal illness," but provides that the living will directives should be implemented only if there is no possibility of meaningful recovery and "but for the use of life-sustaining mechanisms the declarant would immediately die."³⁶

A number of living will statutes do not explicitly provide that death must be imminent, but do provide that an illness is terminal if life sustaining procedures only postpone death.³⁷ Moreover, a few living will statutes provide that an illness is terminal if such illness will result in death despite the use or maintenance of life-sustaining treatment.³⁸

The living will statutes of California and Idaho stress the terminal nature of the patient's condition even more so than the aforementioned statutes.³⁹ These two statutes expressly provide that the declarant cannot execute a living will until his attending physician has diagnosed the declarant's condition as terminal.⁴⁰

The major deficiency of living will statutes when such statutes are limited to terminal illness in the manner described above is that such statutes are ineffective with respect to many situations in which living wills may well be

34. MD. HEALTH-GEN. CODE ANN. § 5-601(e), (g) (1990).

35. OKLA. STAT. ANN. tit. 63, § 3102(8) (West Supp. 1992).

36. MISS. CODE ANN. § 41-41-113 (Supp. 1991).

37. CAL. HEALTH & SAFETY CODE § 7187(f) (West Supp. 1991); COLO. REV. STAT. ANN. § 15-18-103(10) (West 1989); D.C. CODE ANN. § 6-2421(6) (1989); ILL. ANN. STAT. ch. 110 1/2, para. 702(h) (Smith-Hurd Supp. 1991); MINN. STAT. ANN. § 145B.02(8) (West Supp. 1992); NEV. REV. STAT. ANN. § 449.590 (Michie 1991); OR. REV. STAT. § 127.605(6) (1990); TEX. HEALTH & SAFETY CODE ANN. § 672.002(8) (West 1992); UTAH CODE ANN. § 75-2-1103(7) (Supp. 1991); VT. STAT. ANN. tit. 18, § 5252(5) (1987); WASH. REV. CODE ANN. § 70.122.020(7) (West Supp. 1991).

38. ARIZ. REV. STAT. ANN. § 36-3201(6) (1986 & Supp. 1991); DEL. CODE ANN. tit. 16, § 2501(c) (1983); GA. CODE ANN. § 31-32-2(10) (1991).

39. CAL. HEALTH & SAFETY CODE § 7188 (West Supp. 1991); IDAHO CODE § 39-4504 (1985 & Supp. 1991).

40. *Id.* All other living will statutes allow a declarant to execute a living will before a physician has diagnosed the declarant's condition as terminal.

desired.⁴¹ These situations include situations in which a patient is in a persistent vegetative state, suffering from a chronic degenerative disease, or suffering from a condition that is hopeless but not expected to produce death in the near future.⁴² In other words, a number of incurably ill patients, who are not terminally ill, may well desire the implementation of living will directives but are precluded from such implementation due to living will statute limitations.⁴³

B. Living Wills Are Often Inadequate and Inflexible

Another major deficiency of living will statutes involves the inadequacy and inflexibility of the living wills drafted under these statutes.⁴⁴ A living will is often inadequate because the will does not encompass the patient's specific situation. If the living will does not encompass the patient's specific situation, a directive to terminate medical treatment will not be carried out.⁴⁵ Moreover, a living will is inherently inflexible. Flexibility is necessitated because it is difficult, if not virtually impossible, for any adult to indicate with specificity the type of medical treatment he may wish to forego should he become incompetent and terminally ill.⁴⁶ Furthermore, flexibility is necessitated because medical technology is changing so rapidly and thus new forms of medical treatment may become available between the making and the effective date of a living will.⁴⁷

If the declarant deals with this uncertainty by using a sweeping living will that refuses all forms of treatment under any circumstances, the declarant runs the risk that the living will may be medically inappropriate and dishonored by the attending physician under a kind of medical "void for overbreadth"

41. A number of incurably ill patients are not terminally ill. See Alexander M. Capron, *The Development of Law on Human Death*, 315 ANNALS N.Y. ACAD. SCI. 45, 54-55 (1978) in which the commentator, referring to the California Natural Death Act, stated "[t]he only patients covered by this statute are those who are on the edge of death despite the doctors' efforts. The very people for whom the greatest concern is expressed about a prolonged and undignified dying process are unaffected by the statute because their deaths are not imminent."

42. More specifically, these situations include situations in which a patient is suffering from Multiple Sclerosis, Muscular Dystrophy, Alzheimer's Disease, and Amyotrophic Lateral Sclerosis in its earlier stages. See Francis, *supra* note 27, at 37. These situations also include situations in which a patient has a stable disability, such as brain damage from stroke or accident. *Id.*

43. A number of incurably ill patients may desire the implementation of living will provisions directing the termination of medical treatment, such as dialysis, transfusions, chemotherapy, or transplant surgery. See Francis, *supra* note 27, at 32.

44. See Fentiman, *supra* note 27, at 824-25; Gelfand, *supra* note 27, at 753-55.

45. See Fentiman, *supra* note 27, at 824-25; Gelfand, *supra* note 27, at 753-55.

46. *In re Westchester County Medical Center*, 531 N.E.2d 607, 625 (N.Y. 1988) (Simons, J., dissenting). See Fentiman, *supra* note 27, at 824.

47. See Fentiman, *supra* note 27, at 824.

principle.⁴⁸ If, on the other hand, the declarant includes in his advance directive provisions addressing specific situations, the declarant runs the risk either that the predicted illness will not materialize, thus rendering the living will inapplicable, or that his individualization of the living will renders it unenforceable in his jurisdiction.⁴⁹

C. Physicians Are Often Reluctant to Comply With the Provisions of a Living Will

Another problem with the effective use of living wills involves the medical profession's reluctance to comply with the provisions of living wills.⁵⁰ Most living will statutes provide that if the attending physician complies with the living will statute in effect in the jurisdiction in which the physician practices, the physician will not be subject to criminal or civil liability for withdrawing or withholding life-sustaining procedures from qualified patients who have properly executed living wills in accordance with such living will statute.⁵¹ A number of these living will statutes further provide that, under such circumstances, the physician shall not be found to have committed an act of unprofessional conduct.⁵² Despite this exculpation from criminal and civil liability and professional wrongdoing, physicians are still in some situations nonetheless apprehensive about complying with the provisions of a living will. This apprehension may stem from the physician's fear that he may be subject to

48. *Id.*

49. *See id.*

50. Fentiman, *supra* note 27, at 823-35; Gelfand, *supra* note 27, at 771-78.

51. *See, e.g.*, ALA. CODE § 22-8A-7 (1990) (providing that "[n]o physician, licensed health care professional, medical care facility or employee thereof who in good faith and pursuant to reasonable medical standards causes or participates in the withholding or withdrawing of life-sustaining procedures from a qualified patient pursuant to a declaration made in accordance with this chapter shall, as a result thereof, be subject to criminal or civil liability . . ."). *See also* ARK. CODE ANN. § 20-17-208 (Michie Supp. 1991); DEL. CODE ANN. tit. 16, § 2505 (1983); GA. CODE ANN. § 31-32-7 (1991); ILL. ANN. STAT. ch. 110 1/2, para. 707 (Smith-Hurd Supp. 1991); LA. REV. STAT. ANN. § 40:1299.58.8 (West Supp. 1992); MISS. CODE ANN. § 41-41-117 (Supp. 1991); N.H. REV. STAT. ANN. § 137-H:9 (1990 & Supp. 1991); OKLA. STAT. ANN. tit. 63, § 3106 (West Supp. 1992); UTAH CODE ANN. § 75-2-1114 (Supp. 1991); WIS. STAT. ANN. § 154.07 (West 1989).

52. *See, e.g.*, ARK. CODE ANN. § 20-17-208 (Michie Supp. 1991) (providing that "[a] physician or other health care provider, whose actions under this subchapter are in accord with reasonable medical standards, is not subject to criminal or civil liability or discipline for unprofessional conduct with respect to those actions."). *See also* ALA. CODE § 22-8A-7 (1990); GA. CODE ANN. § 31-32-7 (1991); ILL. ANN. STAT. ch. 110 1/2, para. 707 (Smith-Hurd Supp. 1991); LA. REV. STAT. ANN. § 40:1299.58.8 (West Supp. 1992); UTAH CODE ANN. § 75-2-1114 (Supp. 1991).

criminal or civil liability even though the living will statute provides otherwise.⁵³ This apprehension may also stem from the physician's notion of what his ethical obligation is to his patient.⁵⁴

In light of these apprehensions on the part of physicians, many living will statutes now provide that a physician is not obligated to withdraw or withhold life-sustaining procedures in compliance with a validly executed living will. If the physician does not so withdraw or withhold, he must transfer the patient to another physician.⁵⁵ The shortcoming with this transfer provision is that its mere inclusion in the statute does not obviate what the physician may perceive as his ethical or moral obligation.⁵⁶ In other words, the physician may still feel that he has an ethical or moral obligation to implement or continue life-sustaining treatment even though a transfer provision is in effect.⁵⁷

Furthermore, many physicians are uncomfortable about discussing death and, therefore, may be reluctant to inform a patient that he is terminally ill.⁵⁸

53. See Gelfand, *supra* note 27, at 774-75 (stating that "physicians quite understandably fear litigation itself. Even when they are not liable, there is always great expense for lawyers' fees and expert witnesses, and the great inconvenience and embarrassment of being sued. A plaintiff, on the other hand, has little to lose by suing. A provision awarding attorneys' fees to physicians if they are held not liable would go a long way toward righting this imbalance and encouraging physicians to act boldly when necessary.").

54. A living will provision directing a physician to discontinue life-prolonging procedures may well be in conflict with the physician's Hippocratic Oath to prolong and protect life. See Norman L. Cantor, *A Patient's Decision to Decline Lifesaving Medical Treatment: Bodily Integrity Versus the Preservation of Life*, in *ETHICAL ISSUES IN DEATH AND DYING* 241-47 (Robert F. Weir ed., 1977); see also JOSEPH FLETCHER, *MORALS AND MEDICINE* 172 (1954).

55. See, e.g., ARIZ. REV. STAT. ANN. § 36-3204 (C) (1991) (providing that "[a]n attending physician is not required to comply with a declaration if to do so is contrary to the physician's religious beliefs or sincerely held moral convictions" and further providing that "[i]n this event, the attending physician shall promptly transfer responsibility for care of the qualified patient to another physician who will effectuate the declaration of the qualified patient."). See also ALASKA STAT. § 18.12.050 (1991); ARK. CODE ANN. § 20-17-207 (Michie Supp. 1991); FLA. STAT. ANN. § 765.09 (West 1986); GA. CODE ANN. § 31-32-8 (1991); HAW. REV. STAT. § 327D-11 (Supp. 1990); IOWA CODE ANN. § 144A.8 (West 1989); ME. REV. STAT. ANN. tit. 18-A, § 5-708 (West Supp. 1991); MINN. STAT. ANN. § 145B.07 (West Supp. 1992); MO. ANN. STAT. § 459.030 (Vernon Supp. 1992); MONT. CODE ANN. § 50-9-203 (1991).

56. See *supra* note 54.

57. See *supra* note 54. Another criticism of living will statute exculpation clauses comes from a quite different perspective. Some commentators suggest that these exculpation clauses "may encourage physicians to be negligent in the diagnosis or prognosis of terminal illnesses, or in their treatment of the elderly or incompetent." Fentiman, *supra* note 27, at 825; Arnold S. Relman, *The Saikewicz Decision: A Medical Viewpoint*, 4 AM. J.L. & MED. 233, 241-42 (1978); Janice G. Murphy, Comment, *The Virginia Natural Death Act - A Critical Analysis*, 17 U. RICH. L. REV. 863, 872-73 (1983).

58. For a criticism of living wills that emphasizes their limits as a method of dialogue between patients and physicians, see Sandra H. Johnson, *Sequential Domination, Autonomy and Living Wills*, 9 W. NEW ENG. L. REV. 113 (1987).

Hence, a number of patients are unlikely to recognize the need to execute a living will, or to have the time to execute a living will before they lapse into unconsciousness.⁵⁹

D. Living Wills Often Involve Troublesome and Inconvenient Formalities

To execute a valid living will, a declarant typically must comply with a number of potentially troublesome and inconvenient formalities.⁶⁰ Many jurisdictions require that the living will be in writing and witnessed by two disinterested persons, who may not be relatives of the declarant, potential beneficiaries of the declarant's estate, persons financially responsible for the declarant's medical care, or the declarant's health care providers.⁶¹ All living will statutes require that at least one, and usually two, physicians certify that the declarant is terminally ill.⁶² As mentioned, some living will statutes require the use of a mandatory living will declaration form.⁶³ However, a number of other living will statutes merely permit the use of a suggested living will declarant form.⁶⁴

In summary, living will statutes have four deficiencies. First, the living will statutes are not applicable to declarants who are incurably ill, but not terminally ill. Second, the living wills executed under the living will statutes are often inadequate and inflexible. Third, physicians and health care providers are often reluctant to comply with the provisions of living wills. Fourth, a declarant must comply with a number of inconvenient formalities in order to validly execute a living will.

III. NEW APPROACHES IN THE RIGHT TO AUTONOMY AREA

Recognizing the deficiencies inherent in living will statutes, several states have adopted new approaches in the right to autonomy area. Eight states have adopted an approach under which a declarant can designate a medical treatment agent in his living will to make medical treatment decisions on behalf of the declarant. Five states have adopted another approach under which a declarant can designate a medical treatment agent in a separate document, which provides for a durable power of attorney for health care decisionmaking. One state has

59. Diane L. Redleaf et al., Note, *The California Natural Death Act: An Empirical Study of Physicians' Practices*, 31 STAN. L. REV. 913, 928, 938 (1979).

60. Fentiman, *supra* note 27, at 822; Gelfand, *supra* note 27, at 755-59.

61. See, e.g., ALA. CODE § 22-8A-4(a) (1990).

62. See, e.g., ARK. CODE ANN. § 20-17-203 (Michie Supp. 1991); COLO. REV. STAT. ANN. § 15-18-107 (West 1989).

63. See *supra* note 21 and accompanying text.

64. See *supra* note 22 and accompanying text.

adopted a third approach under which a declarant can appoint a patient advocate to make medical treatment decisions on behalf of the declarant. While all three approaches overcome at least one of the deficiencies inherent in living will statutes, each approach still suffers from at least one of these deficiencies.

A. The Use of a Living Will to Designate a Medical Treatment Agent -- Simple Designation Statutes

Eight states have enacted statutes under which a competent adult may designate an agent to make medical treatment decisions on his behalf should he become incompetent⁶⁵ and, in some cases, terminally ill.⁶⁶ These simple designation statutes stem from the same desire to protect the patient's right to autonomy in the making of medical treatment decisions that underlies the living will statutes,⁶⁷ but these statutes achieve their goal more effectively.

The Utah simple designation statute, which is typical of most simple designation statutes, provides that the patient will select a medical treatment agent "with confidence in the belief that this person's familiarity with [the patient's] desires, beliefs, and attitudes will result in directions to attending physicians and providers of medical services which would probably be the same as [the patient] would give if able to do so."⁶⁸ Similarly, the Florida and Iowa simple designation statutes expressly provide that in making their medical decisions, the treatment agent and attending physician are to be "guided by the express or implied intentions of the patient."⁶⁹

These simple designation statutes have two basic advantages over the living will statutes. First of all, since a competent adult, under a simple designation statute, can appoint in advance a person whom he trusts and who knows him well, he is given a peace of mind that comes from knowing that the ultimate treatment decision will be one that is both consonant with his moral and religious beliefs and as close as possible to the one that he would have made

65. These eight statutes are as follows: DEL. CODE ANN. tit. 16, § 2502 (1983); FLA. STAT. ANN. §§ 765.02, 765.05(2) (West 1986); IOWA CODE ANN. § 144A.7 (West 1989); LA. REV. STAT. ANN. § 40:1299.58.1(A)(3)(a) (West Supp. 1992); TEX. HEALTH & SAFETY CODE ANN. § 672.003(d) (West 1992); UTAH CODE ANN. § 75-2-1106 (Supp. 1991); VA. CODE ANN. § 54.1-2983 (Michie 1991); WYO. STAT. § 35-22-102(d) (1988). It is important to realize that the patient is usually unable to communicate when the medical decisions must be made.

66. See FLA. STAT. ANN. §§ 765.02, 765.05(2) (West 1986); IOWA CODE ANN. § 144A.7 (West 1989); LA. REV. STAT. ANN. § 40:1299.58.1(A)(3)(a) (West Supp. 1992); TEX. HEALTH & SAFETY CODE ANN. § 672.003(d) (West 1992); VA. CODE ANN. § 54.1-2984 (Michie 1991); WYO. STAT. § 35-22-102(d) (1988).

67. See *supra* notes 3-4 and accompanying text.

68. UTAH CODE ANN. § 75-2-1106 (Supp. 1991).

69. FLA. STAT. ANN. § 765.07(1) (West 1986); IOWA CODE ANN. § 144A.7 (West 1989).

himself.⁷⁰ This appointment of a medical treatment agent to make decisions on behalf of the declarant promotes flexibility absent in living will statutes. Under the living will statutes, the competent adult is not given the same peace of mind because he does not make an appointment of a medical treatment agent.

Secondly, unlike living will statutes,⁷¹ simple designation statutes provide for intelligent and informed discussion between the treatment agent and the attending physician.⁷² Since the treatment agent can both provide the attending physician with important background information concerning the patient's health and life habits, increasing the accuracy of the diagnosis and prognosis made, and can also consider the medical information conveyed by the physician in light of the totality of the patient's life, values, and beliefs, the treatment agent can carefully tailor a treatment decision to be consistent with the patient's medical and moral needs.⁷³ Moreover, the designation statute eliminates or at least lessens the risk inherent in living will statutes⁷⁴ that the attending physician will refuse to comply with an advance treatment directive that he believes to be too sweeping in scope.⁷⁵

These eight simple designation statutes, however, do have their limitations. These eight simple designation statutes provide that the patient may make this designation in the same document that the patient would use to execute a living will.⁷⁶ To the extent that the patient makes this designation in his living will, this designation suffers from the same weaknesses as a living will⁷⁷ because such living will is subject to the provisions of the applicable living will statute.

Furthermore, the Florida, Iowa, Louisiana, Texas, Virginia, and Wyoming statutes provide that the designation of a medical treatment agent is effective only when the patient becomes terminally ill.⁷⁸ To the extent that these statutes exclude patients who are incurably but not terminally ill, the advance designation of a medical treatment agent also suffers from at least one of the same

70. See Fentiman, *supra* note 27, at 828.

71. See *supra* note 58 and accompanying text.

72. See Fentiman, *supra* note 27, at 828.

73. See *id.*

74. See *supra* note 48 and accompanying text.

75. See Fentiman, *supra* note 27, at 828.

76. DEL. CODE ANN. tit. § 2502 (1983); FLA. STAT. ANN. §§ 765.02, 765.05(2) (West 1986); IOWA CODE ANN. § 144A.7 (West Supp. 1989); LA. REV. STAT. ANN. §§ 40:1299.58.1(B)(3)(a) and 58.3(C)(1) (West Supp. 1992); TEX. HEALTH & SAFETY CODE ANN. § 672.003(d) (West 1992); UTAH CODE ANN. § 75-2-1106 (Supp. 1991); VA. CODE ANN. § 54.1-2984 (Michie 1991); WYO. STAT. § 35-22-102(d) (1988).

77. See *supra* notes 27-64 and accompanying text.

78. See *supra* note 66 and accompanying text.

weaknesses as a living will.⁷⁹

In summary, the simple designation statutes overcome two of the four basic deficiencies inherent in living wills. These statutes promote flexibility in medical treatment decisionmaking and lessen the risk that a physician will refuse to comply with an advance directive. These simple designation statutes, however, still suffer from two of the four basic deficiencies. These statutes are not applicable to declarants who are incurably but not terminally ill. Also, under these statutes, the declarant must still comply with a number of potentially troublesome and inconvenient formalities.

B. The Use of a Durable Power of Attorney to Designate a Medical Treatment Agent

Recognizing the deficiencies of the living will statutes and the simple designation statutes, five states have developed a somewhat unique approach.⁸⁰ Alaska, California, Nevada, Rhode Island, and Vermont have enacted statutes under which a competent adult may make the designation of a medical treatment agent in a separate document, which provides for a durable power of attorney for health care decisionmaking.⁸¹ Unlike the simple designation statutes, these durable power of attorney designation statutes provide a medical treatment agent with the authority to determine, subject to certain limitations,⁸² the treatment the patient will receive or forego even if the patient is incurably but not terminally ill.⁸³ This authority is precisely what makes durable power of attorney designation statutes more appealing than simple designation statutes. This medical treatment agent steps into the shoes of the patient and makes medical decisions on behalf of the patient in accordance with the known desires of the patient and, if such desires are not known, in accordance with the best

79. See *supra* notes 27-43 and accompanying text.

80. See ALASKA STAT. §§ 13.26.332-.356 (Supp. 1991); CAL. CIV. CODE §§ 2410-2450 (West Supp. 1992); NEV. REV. STAT. ANN. §§ 449.800-.860 (Michie 1991); R.I. GEN. LAWS §§ 23-4.10-1 to -2 (1989); VT. STAT. ANN. tit. 14, §§ 3451-3467 (1989 & Supp. 1990).

81. See, e.g., NEV. REV. STAT. ANN. § 449.810 (Michie 1991) (providing that an adult can execute a power of attorney under which the attorney in fact is allowed to make health care decisions on behalf of the adult who executed the power if the adult becomes incapable of giving informed consent concerning health care decisions). See also BLACK'S LAW DICTIONARY 1055 (6th ed. 1990) (defining "power of attorney" as "an instrument authorizing another to act as one's agent or attorney. The agent is attorney in fact and his power is revoked on the death of the principal by operation of law.").

82. See *infra* notes 85-86 and accompanying text.

83. Typically these statutes provide that a medical treatment agent has the power to consent, refuse to consent, or withdraw a consent to care, treatment, service, or procedure implemented to maintain, diagnose, or treat a physical or mental condition. See, e.g., NEV. REV. STAT. ANN. § 449.830 (Michie 1991).

interests of the patient.⁸⁴

As mentioned, under these durable power of attorney statutes a treatment agent is subject to certain limitations in exercising his authority to determine the treatment the patient will receive or forego. The durable power of attorney statutes either expressly provide that a treatment agent may not decide to forego treatment that would result in death or are silent on the issue of whether a treatment agent may decide to forego such treatment.⁸⁵ For example, Alaska's statute permits a competent adult to appoint an agent to make medical decisions on his behalf should he become incompetent, but does not authorize the agent to seek the termination of medical treatment unless the patient has also executed a living will specifically directing the refusal of such treatment.⁸⁶ This limitation is the major problem with respect to the use of a durable power of attorney in the context of appointing a medical treatment agent.

In addition to the five states of Alaska, California, Nevada, Rhode Island, and Vermont, the states of Colorado, Pennsylvania, and Maine have enacted durable power of attorney statutes.⁸⁷ These statutes, however, are flawed in the same manner as the other five states' statutes. Both Colorado and Pennsylvania have enacted durable power of attorney statutes under which a competent adult may appoint a treatment agent who is authorized to consent to medical treatment.⁸⁸ But these two statutes appear to preclude the treatment agent from refusing medical treatment.⁸⁹ Maine's durable power of attorney statute expressly permits a treatment agent to consent to or to refuse treatment for the patient, but is silent as to whether such a refusal could be made when the consequences would be the patient's death.⁹⁰

Furthermore, in addition to the above sixteen states, thirty other states and

84. The Nevada durable power of attorney statute provides that "the person you designate in this document has a duty to act consistent with your desires as stated in this document or otherwise made known or, if your desires are unknown, to act in your best interests." NEV. REV. STAT. ANN. § 449.830 (Michie 1991).

85. See, e.g., ALASKA STAT. §§ 13.26.332, .335, .344(j)(2) and (l) (1991).

86. ALASKA STAT. §§ 13.26.332, .335, .344(j)(2) and (l) (1991).

87. These three statutes are as follows: COLO. REV. STAT. ANN. § 15-14-501 (West 1989 & Supp. 1991); ME. REV. STAT. ANN. tit. 18-A, § 5-501 (West Supp. 1991); 20 PA. CONS. STAT. ANN. § 5603(h) (Purdon Supp. 1990).

88. COLO. REV. STAT. § 15-14-501 (1989 & Supp. 1991); 20 PA. CONS. STAT. ANN. § 5603(h) (Supp. 1990).

89. *Id.*

90. ME. REV. STAT. ANN. tit. 18-A, § 5-501 (West Supp. 1991).

the District of Columbia have enacted durable power of attorney statutes.⁹¹ These statutes, however, are silent as to whether a competent adult can appoint an agent to make medical treatment decisions.⁹² Finally, Wisconsin has also enacted a durable power of attorney statute.⁹³ This statute, however, expressly provides that it is not an appropriate vehicle by which an adult can designate a medical treatment agent.⁹⁴

In summary, the durable power of attorney designation statutes overcome at least two of the four basic deficiencies inherent in living will statutes. First, these statutes promote flexibility in medical treatment decisionmaking. Second, these statutes may lessen the risk that a physician will refuse to comply with an advance directive. Furthermore, these statutes may eliminate some of the compliance with troublesome formality. These statutes, however, suffer from one very important flaw. Namely, these statutes do not authorize a medical decision to forego treatment that would result in the death of the declarant.

91. These 31 statutes are as follows: ALA. CODE § 26-1-2 (1986); ARIZ. REV. STAT. ANN. §§ 14-5501 to -5502 (1975); ARK. CODE ANN. §§ 28-68-201 to -203, -301 to -313 (Michie 1987); D.C. CODE ANN. §§ 21-2081 to -2085 (1989); GA. CODE ANN. § 10-6-36 (1989); HAW. REV. STAT. §§ 551D-1 to -6 (Supp. 1990); IDAHO CODE ANN. §§ 15-5-501 to -507 (Supp. 1991); IND. CODE ANN. §§ 30-5-1-1 to -19 (West 1991); KAN. STAT. ANN. §§ 58-610 to -617 (1983); KY. REV. STAT. ANN. § 386.093 (Baldwin 1987); LA. CIV. CODE ANN. art. 3002 (West 1952); MD. CODE ANN., EST. & TRUSTS § 13-601 to -603 (1974 & Supp. 1990); MASS. GEN. LAWS ANN. ch. 201B, §§ 1-7 (West 1990); MICH. COMP. LAWS ANN. § 565.631 (West 1988); MISS. CODE ANN. §§ 87-3-1 to -17 (1972 & Supp. 1991); MO. ANN. STAT. §§ 404.700-735 (Vernon 1990 & Supp. 1991); NEB. REV. STAT. §§ 30-2664 to -2672 (1989); N.H. REV. STAT. ANN. §§ 506:5 to :7 (1983 & Supp. 1991); N.J. STAT. ANN. § 46:2B-8 (West 1989); N.M. STAT. ANN. §§ 45-5-501 to -502 (Michie 1989); N.Y. GEN. OBLIG. LAW §§ 5-1501 to -1602 (Consol. 1989 & Supp. 1991); N.C. GEN. STAT. §§ 32A-1 to -14 (1987 & Supp. 1991); N.D. CENT. CODE §§ 30.1-30-01 to -05 (Supp. 1989); OHIO REV. CODE ANN. §§ 1337.01 to .10 (Baldwin 1988); OKLA. STAT. ANN. tit. 58, §§ 1051-1063 (West Supp. 1991); OR. REV. STAT. §§ 126.407, 413 (1987); S.C. CODE ANN. §§ 62-5-501 to -502 (Law. Co-op. 1987 & Supp. 1991); S.D. CODIFIED LAWS ANN. §§ 59-7-2.1 to .4 (1978 & Supp. 1991); TENN. CODE ANN. §§ 34-6-101 to -107 (1984 & Supp. 1991); WASH. REV. CODE ANN. §§ 11.94.010 to .060 (West 1987 & Supp. 1991); W. VA. CODE §§ 39-4-1 to -7 (Supp. 1991).

92. *Id.* (out of these thirty states and the District of Columbia, only New Jersey has, through its Supreme Court, recognized its durable power of attorney statute as an appropriate vehicle by which an adult can designate a medical treatment agent. *See In re Peter*, 529 A.2d 419, 426 (N.J. 1987)). *But see* IND. CODE ANN. § 30-5-1-17 (West 1991). The Indiana State Legislature recently amended its durable power of attorney statute so as to allow an adult to appoint an agent to make medical treatment decisions. Under the amended statute, a medical treatment agent may refuse medical treatment for the patient even if the consequences of such refusal would be the patient's death.

93. WIS. STAT. ANN. § 243.07 (West 1987 & Supp. 1990).

94. *Id.*

C. Michigan's Approach: The "Patient Advocate" Act

1. The Basic Statutory Framework

Recognizing the shortcomings of the living will statutes, the designation statutes, and the durable power of attorney statutes, Michigan recently enacted a statute known as the Patient Advocate Act.⁹⁵ Under the Act, a competent, non-pregnant adult may make a written designation under which he, the declarant, appoints another competent adult to exercise powers relating to the care, custody, and medical treatment decisions of the declarant.⁹⁶ For purposes of the Act, the adult who is appointed to exercise these powers is known as the patient advocate and, as such, is subject to the same standards of care applicable to fiduciaries.⁹⁷ Under the Act, the patient advocate may exercise the powers relating to the medical treatment decisions of the declarant only when the declarant is unable to make his own medical treatment decisions.⁹⁸

Moreover, under the Act, a declarant may authorize a patient advocate to exercise a broad range of powers relating to the declarant's care, custody, and

95. MICH. COMP. LAWS ANN. § 700.496 (West Supp. 1991). The full title of this statute is the Health Care-Patient Designation of Advocate for Decisions Act.

96. See MICH. COMP. LAWS ANN. § 700.496(1) (West Supp. 1991) (providing that "[a] person 18 years of age or older who is of sound mind at the time a designation is made may designate in writing a person who is 18 years of age or older to exercise powers concerning care, custody, and medical treatment decisions for the person who made the designation."). See also MICH. COMP. LAWS ANN. § 700.496(2) (West Supp. 1991) (providing that "[a] designation shall be in writing, signed, witnessed pursuant to subsection (3), dated, executed voluntarily, and before its implementation shall be made part of the patient's medical record with the patient's attending physician and, if applicable, with the facility where the patient is located.") and MICH. COMP. LAWS ANN. § 700.496(7)(c) (West 1990) (providing that "[t]his designation cannot be used to make a medical treatment decision to withhold or withdraw treatment from a patient who is pregnant that would result in the pregnant patient's death.").

97. See MICH. COMP. LAWS ANN. § 700.496(1) (West Supp. 1991) (providing that "a person who is named in a designation to exercise powers concerning care, custody, and medical treatment decisions shall be known as a patient advocate . . ."). See also MICH. COMP. LAWS ANN. § 700.496(7)(f) (West Supp. 1991) (providing that "[a] patient advocate shall act in accordance with the standards of care applicable to fiduciaries when acting for the patient and shall act consistent with the patient's best interests. The known desires of the patient expressed or evidenced while the patient is able to participate in medical treatment decisions are presumed to be in the patient's best interests.").

98. See MICH. COMP. LAWS ANN. § 700.496(2) (West Supp. 1991) (providing that the powers conferred under the designation shall be exercisable only when the declarant is unable to participate in his own medical treatment decisions). See also MICH. COMP. LAWS ANN. § 700.496(10) (West Supp. 1991) (providing that the powers conferred under the designation are suspended when the declarant regains the ability to participate in his own medical treatment decisions and providing that such suspension is effective, as long as the declarant is able to participate in his own medical treatment decisions).

medical treatment.⁹⁹ Most importantly, the declarant may authorize a patient advocate to make a decision to withhold or withdraw treatment which would allow the declarant to die.¹⁰⁰ Furthermore, the declarant may authorize a patient advocate to exercise such powers as the power to make the decision to withhold or withdraw certain medical treatment in certain situations or the power to make the decision not to withhold or withdraw certain medical treatment in certain situations.¹⁰¹

Furthermore, under the Act, a physician withholding or withdrawing medical treatment as a result of the patient advocate's decision is liable simply in the same manner and to the same extent as if the declarant had made his own

99. MICH. COMP. LAWS ANN. § 700.496(4) (West Supp. 1991) (providing that "[a] designation may include a statement of the patient's desires on care, custody, and medical treatment. The patient may authorize the patient advocate to exercise one or more powers concerning the patient's care, custody, and medical treatment, that the patient could have exercised on his or her own behalf.>").

100. MICH. COMP. LAWS ANN. § 700.496(9)(e) (West Supp. 1991). *See also* MICH. COMP. LAWS ANN. § 700.496(9) (West Supp. 1991). This subsection sets forth the patient advocate's authority, rights, responsibilities, and limitations. The exact language of this subsection is as follows:

(9) An individual designated as a patient advocate under this section shall have the following authority, rights, responsibilities, and limitations:

(a) A patient advocate shall act in accordance with the standards of care applicable to fiduciaries in exercising his or her powers.

(b) A patient advocate shall take reasonable steps to follow the desires, instructions, or guidelines given by the patient while the patient was able to participate in care, custody, or medical treatment decisions, whether given orally or as written in the designation.

(c) A patient advocate shall not exercise powers concerning the patient's care, custody, and medical treatment that the patient, if the patient were able to participate in the decision, could not have exercised on his or her own behalf.

(d) This designation cannot be used to make a medical treatment decision to withhold or withdraw treatment from a patient who is pregnant that would result in the pregnant patient's death.

(e) *A patient advocate may make a decision to withhold or withdraw treatment which would allow a patient to die* only if the patient has expressed in a clear and convincing manner that the patient advocate is authorized to make such a decision, and that the patient acknowledges that such a decision could or would allow the patient's death.

(f) A patient advocate under this section shall not delegate his or her powers to another individual without prior authorization by the patient. (emphasis added).

101. For example, a cancer patient may authorize a patient advocate the power to make a decision to withhold or withdraw life-prolonging treatment only if the cancer patient's incapacitated state is not the result of cancer. Hence, the patient advocate may make a decision to withhold or withdraw life-prolonging treatment if the cancer patient's incapacitated state is the result of injuries sustained in an automobile accident. MICH. COMP. LAWS ANN. § 700.496(4) (West Supp. 1991) allows a patient to confer such a power on the patient advocate.

decision.¹⁰² Also, a physician is bound by sound medical practice and, as long as the patient advocate is in compliance with the Act, by the decisions of the patient advocate.¹⁰³ If a physician questions whether the patient advocate's decision is consistent with the best interests of the declarant or is in compliance with the Act, the physician may file a petition in the probate court in the county in which the declarant resides.¹⁰⁴

Still further, under the Act, a declarant must comply with a number of formalities in order to validly effectuate his desires relating to his care, custody, and medical treatment. As mentioned, a declarant must execute a designation of a patient advocate in writing.¹⁰⁵ The declarant must also execute this designation in the presence of two disinterested witnesses.¹⁰⁶ Furthermore, the two disinterested witnesses must sign the designation.¹⁰⁷

Since, under the Act, the patient advocate may exercise the powers conferred upon him only when the declarant is unable to make his own medical treatment decisions,¹⁰⁸ a determination as to whether the declarant is unable

102. See MICH. COMP. LAWS ANN. § 700.496(14) (West Supp. 1991) (providing that “[a] person providing, performing, withholding, or withdrawing care, custody, or medical treatment as a result of the decision of an individual who is reasonably believed to be a patient advocate and who is reasonably believed to be acting within the authority granted by the designation, is liable in the same manner and to the same extent as if the patient had made the decision on his or her own behalf.”).

103. See MICH. COMP. LAWS ANN. § 700.496(15) (West Supp. 1991) (providing that “[a] person providing care, custody, or medical treatment to a patient is bound by sound medical practice and by the instructions of a patient advocate if the patient advocate complies with this section, and is not bound by the instructions of a patient advocate if the patient advocate does not comply with this section.”).

104. See MICH. COMP. LAWS ANN. § 700.496(16) (West Supp. 1991) (providing that “[i]f a dispute arises as to whether a patient advocate is acting consistent with the patient's best interests, or is otherwise not complying with this section, a petition may be filed with the probate court in the county in which the patient resides or is found requesting the court's determination as to the continuation of the designation or the removal of the patient advocate.”).

105. MICH. COMP. LAWS ANN. § 700.496(2) (West Supp. 1991).

106. MICH. COMP. LAWS ANN. § 700.496(3) (West Supp. 1991) (providing that “[a] designation shall be executed in the presence of and signed by 2 witnesses.”). Under the Patient Advocate Act, disinterested persons are those persons who are not the declarant's spouse, parent, child, grandchild, sibling, presumptive heir, known devisee at the time of the witnessing, physician, patient advocate, an employee of a life or health insurance provider for the declarant, an employee of a health facility that is treating the declarant, or an employee of a home for the aged where the declarant resides. *Id.* It is important to realize, however, that the Patient Advocate Act does not preclude the declarant from designating one of the above persons as the patient advocate. In fact, since the declarant's spouse, parent, or child may well know more about the declarant's desires relating to medical treatment than anyone else, the declarant may be wise to designate his spouse, parent, or child as the patient advocate.

107. *Id.*

108. See *supra* note 98 and accompanying text.

to make his own medical decisions must be made. The Act provides that the declarant's attending physician and another physician or a licensed psychologist shall make this determination.¹⁰⁹ If any person disagrees with this determination, such person may file a petition in the probate court in the county in which the declarant resides.¹¹⁰ Once a petition is filed, the probate court is required to appoint a guardian *ad litem* to represent the declarant.¹¹¹ The probate court is also required to conduct a hearing on the petition within seven days after the court's receipt of the petition.¹¹² The probate court is then required to make a determination as to whether the declarant is unable to make his own medical decisions.¹¹³ This court determination must be made within seven days after the hearing.¹¹⁴

2. A Comparison of the "Patient Advocate" Act With the Living Will Statutes, the Simple Designation Statutes, and the Durable Power of Attorney Designation Statutes

Unlike the living will statutes¹¹⁵ and the simple designation statutes,¹¹⁶ but similar to the durable power of attorney designation statutes,¹¹⁷ the Act is applicable to declarants who are incurably ill, but not terminally ill.¹¹⁸ More specifically, the Act is applicable to declarants in a persistent vegetative state,

109. MICH. COMP. LAWS ANN. § 700.496(8) (West Supp. 1991) (providing that "[t]he patient's attending physician and another physician or licensed psychologist shall determine upon examination of the patient when the patient is unable to participate in medical treatment decisions, shall put the determination in writing, shall make the determination part of the patient's medical record, and shall review the determination not less than annually."). If the attending physician and such other physician or psychologist determine that the declarant is unable to participate in his own medical treatment decisions, the patient advocate's authority, rights, and responsibilities become effective.
Id.

110. *Id.*

111. *Id.*

112. *Id.*

113. MICH. COMP. LAWS ANN. § 700.496(8) (West Supp. 1991).

114. *Id.*

115. See *supra* notes 27-43 and accompanying text.

116. See *supra* notes 76-79 and accompanying text.

117. See *supra* note 83 and accompanying text.

118. House Bill 4016 was the bill that led to the eventual enactment of the Patient Advocate Act. In the analysis of this bill, the legislators made a number of references to *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841 (1990) (the patient in *Cruzan* was in a persistent vegetative state) and, in making such references, noted that it was the legislators' intent that the Patient Advocate Act apply to a factual situation similar to the one in *Cruzan*. See SENATE FISCAL AGENCY OF MICHIGAN: BILL ANALYSIS, H.B. 4016 (H-6): FIRST ANALYSIS 1-5 (1990). See also *Durable Power of Attorney for Health Care and Appointment of a Patient Advocate* (State Bar of Michigan, Michigan Association of Osteopathic Physicians & Surgeons, Inc., Michigan Hospital Association, Michigan State Medical Society) (stating that "[u]nlike either the 'living will' or 'medical directive', the Durable Power of Attorney for Health Care applies in *all* situations in which you are unable to make health care decisions for yourself, not just when you are terminally ill.").

suffering from a chronic degenerative disease, or suffering from a condition that is hopeless but not expected to produce death in the near future.¹¹⁹

Moreover, unlike the durable power of attorney designation statutes,¹²⁰ the Act even more importantly provides that a patient advocate may decide to forego treatment that would result in the death of the declarant.¹²¹ This provision of the Act is precisely what makes this act a more effective means by which a declarant can effectuate his desires relating to medical treatment decisions.

Furthermore, unlike the living will statutes,¹²² but similar to the simple designation statutes¹²³ and the durable power of attorney designation statutes,¹²⁴ the Act provides for flexibility with respect to the patient advocate's medical treatment decisions made on behalf of the declarant.¹²⁵ The Act provides for this flexibility by allowing the patient advocate to exercise a broad range of powers relating to the declarant's care, custody, and medical treatment.¹²⁶ The Act further provides for this flexibility by allowing the patient advocate to exercise his authority in the best interests of the declarant.¹²⁷

Still further, unlike the living will statutes¹²⁸ but, to a certain extent,

119. See *supra* note 118.

120. See *supra* notes 85-86, 88-90 and accompanying text.

121. See MICH. COMP. LAWS ANN. § 700.496(9)(e) (West Supp. 1991) (providing that "[a] patient advocate may make a decision to withhold or withdraw treatment which would allow a patient to die") (emphasis added).

122. See *supra* notes 44-49 and accompanying text.

123. See *supra* note 70 and accompanying text.

124. See *supra* notes 81, 84 and accompanying text.

125. See SENATE FISCAL AGENCY OF MICHIGAN: BILL ANALYSIS, H.B. 4016 (H-6): FIRST ANALYSIS 5 (1990) (providing that "[t]he patient advocate approach would provide more flexibility than would be available under a so-called 'living will' in which a person would have to spell out explicitly what he or she wanted done or not done under specific circumstances and which would limit the appointed person to making only those decisions. In the case of a patient advocate designation, on the other hand, the patient could but would not be required to state his or her desires on care, custody, and medical treatment, and the advocate would be required to follow the desires, instruction, or guidelines given by the patient either orally or in the designation. If the patient did not spell out his or her wishes, however, the advocate still could make decisions on behalf of the patient as long as the advocate acted consistently with the patient's best interests and did not make any decision that the patient could not make himself or herself if competent.").

126. See *supra* note 99 and accompanying text.

127. See MICH. COMP. LAWS ANN. § 700.496(7)(f) (West Supp. 1991) (providing that "[a] patient advocate . . . shall act consistent with the patient's best interests. The known desires of the patient expressed or evidenced while the patient is able to participate in medical treatment decisions are presumed to be in the patient's best interests.").

128. See *supra* notes 50-59 and accompanying text.

similar to the simple designation statutes¹²⁹ and durable power of attorney designation statutes,¹³⁰ the Act promotes intelligent and informed discussion between the patient advocate and the attending physician.¹³¹ Since the patient advocate can provide the attending physician with important information relating to the patient's health and life habits, increasing the accuracy of the diagnosis and prognosis made, and can also consider the medical information conveyed by the physician in light of the totality of the patient's life, values, and beliefs, the patient advocate can carefully tailor a treatment decision to be consistent with the patient's medical and moral needs.¹³² Also, even more so than the simple designation statutes and the durable power of attorney designation statutes,¹³³ the Act lessens the risk inherent in living will statutes that the attending physician will refuse to comply with an advance directive that the attending physician believes to be too sweeping in scope.¹³⁴

Finally, similar to the living will statutes¹³⁵ and the simple designation statutes,¹³⁶ the Act involves a number of potentially troublesome and inconvenient formalities. As mentioned, under the Act, the declarant must comply with these potentially troublesome and inconvenient formalities in order to validly effectuate his desires relating to his care, custody, and medical treatment.¹³⁷ The declarant must execute a designation of a patient advocate in writing.¹³⁸ The declarant must also execute this designation in the presence of two disinterested persons.¹³⁹ Also, the two disinterested persons must sign the designation.¹⁴⁰ Furthermore, if a dispute arises as to what is in the best

129. See *supra* notes 72-75 and accompanying text.

130. See *supra* note 84 and accompanying text.

131. See SENATE FISCAL AGENCY OF MICHIGAN: BILL ANALYSIS, H.B. 4016 (H-6): FIRST ANALYSIS 4-5 (1990). See also *Durable Power of Attorney for Health Care and Appointment of a Patient Advocate* (State Bar of Michigan, Michigan Association of Osteopathic Physicians & Surgeons, Inc., Michigan Hospital Association, Michigan State Medical Society).

132. See MICH. COMP. LAWS ANN. § 700.496(7)(f), (8), (9)(b) (West Supp. 1991).

133. See *supra* notes 72-75, 83 and accompanying text.

134. See SENATE FISCAL AGENCY OF MICHIGAN: BILL ANALYSIS, H.B. 4016 (H-6): FIRST ANALYSIS 4-5 (1990) (providing that "[w]hile a durable power of attorney is sufficiently general to grant authority to make medical decisions, its very generality can create problems. Doctors and hospital staff often doubt the authority of the attorney in fact, and the statute contains no specific safeguards against liability for following his or her instructions. Also, the law does not make as clear as some would like the limits of authority regarding medical decisions. Under the [patient advocate] bill, however, instead of appointing an attorney in fact whose authority might be questioned and decisions disregarded, an individual could designate a patient advocate specifically for the purpose of making medical decisions if the patient became incapacitated.").

135. See *supra* notes 60-64 and accompanying text.

136. See *supra* note 79 and accompanying text.

137. See *supra* notes 105-14 and accompanying text.

138. See MICH. COMP. LAWS ANN. § 700.496(2) (West Supp. 1991).

139. See *id.* at § 700.496(3).

140. See *id.*

interest of the declarant or the state of the declarant's mind, the interested parties must resort to the probate court.¹⁴¹

In summary, the Patient Advocate Act has a number of advantages over the living will statutes, the simple designation statutes, and the durable power of attorney designation statutes. First, the Act is applicable to declarants who are incurably ill, but not terminally ill. Even more importantly, the Act provides that a patient advocate may decide to forego treatment that would result in the death of the declarant. Second, the Act provides for flexibility with respect to the patient advocate's medical treatment decisions made on behalf of the declarant. Third, the Act promotes intelligent and informed discussion between the patient advocate and the attending physician and, thereby, lessens the likelihood that the attending physician will refuse to comply with an advance directive. The Act, however, has at least one deficiency. The Act involves a number of potentially troublesome and inconvenient formalities.

IV. A NEW PROPOSAL: THE "SUPREME TRUST"

This Note now proposes the use of a supreme trust¹⁴² as an alternative means by which a declarant can more effectively effectuate his desires concerning his care, custody, and medical treatment decisions. By using a supreme trust, a declarant can take advantage of the favorable provisions of Michigan's Patient Advocate Act and, at the same time, avoid complying with the potentially troublesome and inconvenient formalities of this Act.¹⁴³

The use of a supreme trust is appealing in two respects. First, in states without a Patient Advocate Act,¹⁴⁴ a declarant can take advantage of the favorable elements of the patient advocate act by including such elements in the supreme trust agreement.¹⁴⁵ Second, in all states including Michigan, a declarant can avoid complying with the potentially troublesome and inconvenient

141. See *id.* at § 700.496(8), (16).

142. The use of the term "supreme" to describe this trust does not necessarily have any special significance.

143. The supreme trust could be used in any state, including Michigan, to effectuate more effectively a declarant's desires concerning his medical treatment decisions.

144. Such states include all states except Michigan.

145. As explained in Section III, Subsection C of this Note, the favorable provisions of the Patient Advocate Act include the following. First, the Act is both applicable to declarants who are incurably ill, and terminally ill. Second, the Act provides for flexibility with respect to the patient advocate's medical treatment decisions made on behalf of the declarant. Third, the Act promotes intelligent and informed discussion between the patient advocate and the attending physician and, thereby, lessens the likelihood that the attending physician will refuse to comply with an advance directive.

formalities inherent in living will statutes,¹⁴⁶ designation statutes,¹⁴⁷ and the Patient Advocate Act.¹⁴⁸

A supreme trust agreement might read as follows:

SUPREME TRUST AGREEMENT

I, (declarant's name), hereinafter referred to as the Settlor, on this _____ day of _____, 19 __, execute this Supreme Trust Agreement entered into between the Settlor and (*medical treatment agent's name*), hereinafter referred to as the Medical Treatment Trustee.

Section One: General Authorization

In the event that the Settlor is unable to participate in medical treatment decisions, the Settlor hereby authorizes the Medical Treatment Trustee to exercise, in accordance with the terms of this Supreme Trust Agreement, all powers conferred upon the Medical Treatment Trustee under this Supreme Trust Agreement concerning the care, custody, and medical treatment decisions for the Settlor. In the event that the Settlor regains the ability to participate in medical treatment decisions, the Settlor hereby suspends said authorization until such time the Settlor is no longer able to participate in his own medical treatment decisions.

Section Two: Specific Powers

. . .¹⁴⁹

Section Three: The Medical Treatment Trustee's Authority, Rights, Responsibilities and Limitations

Under this Supreme Trust Agreement, the Medical Treatment Trustee shall have the following authority, rights, responsibilities, and limitations:

- (a) This Supreme Trust Agreement shall not become effective unless the Settlor is unable to participate in medical treatment

146. See *supra* notes 60-64 and accompanying text.
147. See *supra* notes 76-77 and accompanying text.
148. See *supra* notes 105-07 and accompanying text. The Statute of Wills, which requires compliance with certain formalities in order to validly execute a testamentary document, is inapplicable to trusts because trusts are non-testamentary documents.
149. In this section, the settlor could authorize the medical treatment trustee to make certain decisions in certain specific situations.

decisions.

(b) The Medical Treatment Trustee shall not exercise powers concerning the Settlor's care, custody, and medical treatment that the Settlor, if the Settlor were able to participate in the decision, could not have exercised on his own behalf.

(c) The Medical Treatment Trustee shall act in accordance with the standards of care applicable to fiduciaries when acting for the Settlor and shall act consistent with the Settlor's best interests. The known desires of the Settlor expressed or evidenced while the Settlor is able to participate in medical treatment decisions are presumed to be in the Settlor's best interests.

(d) The Medical Treatment Trustee shall take reasonable steps to follow the desires, instructions, or guidelines given by the Settlor while the Settlor was able to participate in care, custody, or medical treatment decisions, whether given orally or as written in this Supreme Trust Agreement.

(e) The Medical Treatment Trustee may make a decision to withhold or withdraw treatment which would allow the Settlor to die.

(f) The Medical Treatment Trustee shall not delegate any powers conferred upon him under this Supreme Trust Agreement to another individual without prior authorization by the Settlor.

(g) The Medical Treatment Trustee shall not receive any compensation for the performance of his authority, rights, and responsibilities, but the Medical Treatment Trustee may be reimbursed for actual and necessary expenses incurred in the performance of his authority, rights, and responsibilities.

(h) The Settlor may revoke this Supreme Trust Agreement at any time and in any manner sufficient to communicate an intent to revoke.

Section Four: Relationship Between the Medical Treatment Trustee and the Attending Physician and Health Care Provider

(a) A person providing, performing, withholding, or withdrawing care, custody, or medical treatment, as the result of the decision of the Medical Treatment Trustee, is liable in the same manner and to the same extent as if the Settlor had made the decision on his own behalf.

(b) A person providing care, custody, or medical treatment to the Settlor is bound by sound medical practice and by the instructions of the Medical Treatment Trustee if the Medical Treatment Trustee complies with this Supreme Trust Agreement, and is not bound by the instructions of the Medical Treatment Trustee if the Medical Treatment Trustee does not comply with this Supreme Trust Agreement.

Section Five: Successor Medical Treatment Trustee

If for any reason (*medical treatment agent's name*) is unable to act as the Medical Treatment Trustee, the Settlor, hereby appoints (*alternate medical treatment agent's name*) as the Successor Medical Treatment Trustee.

V. CONCLUSION

The use of this supreme trust overcomes all of the deficiencies inherent in the living will statutes, the simple designation statutes, and the durable power of attorney designation statutes. First, this supreme trust is applicable to declarants who are incurably ill, but not terminally ill. More specifically, this supreme trust provides that the medical treatment trustee may decide to forego treatment that would result in the death of the settlor. Second, this supreme trust provides for flexibility with respect to medical decisionmaking.

Furthermore, this supreme trust promotes intelligent and informed discussion between the medical treatment trustee and the attending physician and health care provider and thereby lessens the risk that the attending physician and health care provider will refuse to comply with an advance directive. Moreover, this supreme trust eliminates many of the formalities required by the living will statutes, the simple designation statutes, and the durable power of attorney designation statutes. Such formalities eliminated include the execution of the document in the presence of witnesses, the signature of witnesses, and the need to resort to probate court. Finally, this supreme trust would be valid in all states, thus eliminating the concern that a living will, a designation form, or durable power of attorney form executed in one state will not be valid in another state.

CRAIG K. VAN ESS

