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Health Care Advance Directives: The Next Generation

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By Prof. Linda S. Whitton

On July 1, 1994, Indiana joined the majority of states that permit their citizens to declare in advance of incurable illness or injury what their preferences concerning artificially supplied nutrition and hydration would be in the event they cannot communicate those desires at the time of treatment.[1] Although these statutory amendments have provided a degree of flexibility previously missing under Indiana law, numerous unresolved statutory ambiguities and inadequacies continue to challenge Indiana practitioners who counsel clients on the use of health care advance directives.

The purpose of this article is to highlight common trouble areas in the drafting and implementation of health care directives and to assess the status of Indiana law in relationship to national developments in advance directive legislation.

Directed, delegated and default decision-making

Three primary classifications of legislation for health care surrogate decision-making have developed in this country. The first, commonly known as living will legislation, provides for directed decision-making by empowering individuals to declare in advance how they would like certain treatment decisions made if they later lose the capacity to give or withhold contemporaneous consent.

The second type, health care proxy and durable powers statutes, permits delegation of health care decision-making authority to a representative or agent conditioned upon the delegating individual's loss of capacity to act on his or her own behalf.

The third form of surrogate decision-making legislation, often known as family consent laws, is a default mechanism that gives health care decision-making authority to specified relatives of an individual who is incapable of giving consent and did not previously appoint a surrogate.

Indiana has provided for all three types of surrogate decision-making through independent legislative enactments. The Living Wills and Life-Prolonging Procedures Act, which provides for directed decision-making,[2] and the Health Care Consent Act, which provides for both delegated decision-making through appointment of a health care representative[3] and default authority for health care consent by family members,[4] appear, as recodified, under Article 36 of Indiana Code Title 16. The Indiana Power of Attorney Act, which authorizes durable health care powers, is separately codified under Article 5 of Title 30.[5]

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Although it might be argued that a person who has qualified relatives under the family consent statute need not execute an advance health care directive, certain aspects of the family consent provisions should be considered before placing full reliance on default decision-making.

Indiana's statute provides that health care consent may be given by a spouse, parent, adult child or adult sibling,[6] but gives no clear order of priority in the event that more than one family member is available to give consent or there is a disagreement among qualified decision-makers. Furthermore, no provision is made for individuals who lack relatives of the degree specified by statute, or who are unmarried but live in non-traditional domestic partnerships.

A final concern with default decision-making is the scope of authority afforded family members. The Supreme Court of Indiana has interpreted this scope to include decisions regarding artificial nutrition and hydration,[7] which may be broader than what an individual would have chosen if able to appoint a health care representative via an advance directive.

Other states have tried a variety of legislative approaches to deal with the unsatisfactory aspects of family consent statutes. These include setting a clear order of priority for default surrogate decision-makers,[8] as well as addressing disputes among classes of decision-makers, such as adult children or siblings, by requiring a majority[9] or consensus[10] decision. In the absence of consensus, the decision may then be referred to an ethics committee,[11] or the dissenting surrogate decision-makers may pursue guardianship proceedings.[12]

Some states even provide for default surrogate decision-making by a "close friend" of the patient when higher-pri-

ority family members are not available.[13] All of these approaches are attempts at balancing the obvious benefits of a flexible default health care consent mechanism with the need for safeguards of the significant interests at stake.

Coordinating three statutes and documents

Probably the best planning strategy for an individual who fears the uncertainty of default provisions is careful delegation of health care authority to selected agents, and coordination of this delegation with a living will or life-prolonging procedures declaration. A written health care directive is advantageous because it can delegate priority decision-making authority to non-relatives if preferred, and even when the preferred agents are family members, it can establish an order of priority among decision-makers as well as delineate the desired scope of authority. A health care advance directive can also be used to disqualify relatives who could otherwise give health care consent in a default situation.[14]

While delegating health care authority via a written directive would be preferable to relying on default provisions for most individuals, the intricacies of Indiana advance directive statutes may hinder the lay public's access to effective directives without the assistance of counsel. For example, a matter of confusion for both clients and practitioners is the distinction between appointment of a health care representative under Indiana Code §16-36-1-7 and delegation of durable health care powers to an attorney-in-fact under Indiana Code §§30-5-5-16 and -17. Review of these statutes reveals that the powers under each are not coextensive.

Indiana's current Power of Attorney Act was enacted subsequent to the provisions of the Health Care Consent Act and contemplates that a principal must properly execute and attach to a health care power of attorney the appointment of a health care representative if the attorney-in-fact is to have authority to consent to or refuse health care on the principal's behalf.[15]

Furthermore, specific statutory language contained in Indiana Code §30-5-5-17 must be included in the appointment to convey authority to withdraw or withhold "health care," which under the Power of Attorney Act is defined to include "the providing of nutrition and hydration through intravenous, endotracheal or nasogastric tubes."[16]

Powers which may be conveyed through the power of attorney, independent of the appointment of a health care representative, include: employing or contracting with ser-

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vants, companions or health care providers for the principal; admitting or releasing the principal from a hospital or health care facility; having access to medical records; making anatomical gifts; requesting an autopsy; and making plans for disposition of the principal's body.[17]

Thus, to achieve maximum flexibility and protection against guardianship, as well as the broadest surrogate health care authority allowed by law, the client needs both a health care representative appointment and a health care durable power of attorney.

Although the health care powers under the Health Care Consent Act and the Power of Attorney Act are not coextensive, the drafter of a durable power of attorney with accompanying health care representative appointment must be careful that both documents contain parallel provisions with respect to who is designated as the agent under each.

The Power of Attorney Act specifically provides for appointment of a successor attorney-in-fact,[18] but the Health Care Consent Act is silent on the issue of successors. Since one of the major reasons for executing advance directives is as a hedge against guardianship, prudent planning would suggest that a health care durable power of attorney name at least one successor attorney-in-fact, and that such appointment be paralleled by a successor health care representative.

Not only should the provisions of the health care representative appointment be carefully coordinated with those of the health care durable power of attorney, but potential conflicts with any statement of directed decision-making – i.e., a living will or life-prolonging procedures declaration – should also be assessed.

An unanswered question under Indiana law is whether a living will or life-prolonging procedures declaration limits or pre-empts the authority of a health care representative who has been given the power to withdraw or withhold health care pursuant to the specified statutory language in Indiana Code §30-5-5-17. Consider the potential dilemma for a health care provider if presented with both a life-prolonging procedures declaration and a valid health care representative appointment containing the authority to withdraw or withhold health care.

The most recent amendments to the living will declaration make a limited attempt at avoiding this type of conflict by giving declarants the following choices concerning artificial nutrition and hydration:

> ___ I wish to receive artificially supplied nutrition and hydration, even if the effort to sustain life is futile or excessively burdensome to me.
>
> ___ I do not wish to receive artificially supplied nutrition and hydration, if the effort to sustain life is futile or excessively burdensome to me.
>
> ___ I intentionally make no decision concerning artificially supplied nutrition and hydration, leaving the decision to my health care representative appointed under I.C. 16-36-1-7 or my attorney-in-fact with health care powers under I.C. 30-5-5.[19]

Of course these choices do not cover other life-prolonging procedures, nor do they address the situation of a client who wishes to express a preference regarding artificial nutrition and hydration in the event the health care representative is unavailable to act, but who in no way wishes to fetter the representative's discretion to use his or her best judgment in unforeseen situations.

The only solution at present to these potential conflicts is to include a statement in the client's advance directive documents that clearly establishes or precludes any limiting effect of a living will or life-prolonging procedures declaration on delegation of health care authority to a representative or attorney-in-fact.

Problems like the foregoing have prompted a number of states to replace piecemeal advance directive legislation with unified acts aimed at recognizing a single legal instrument to address both directed decision-making and delegation of surrogate health care authority.[20] The National Confer-

ence of Commissioners on Uniform State Law has also adopted a comprehensive model act known as the Uniform Health-Care Decisions Act.[21]

However, absent clarifying legislation in Indiana, practitioners are left the uneasy task of reconciling three separate legislative acts, three documents, and a host of statutory ambiguities in order to translate a client's wishes into a comprehensive plan for directed and delegated health care decision-making. Although none of the advance directive statutes in Indiana requires document preparation by legal counsel, as a practical matter the statutory scheme is antithetical to layperson-friendly applications.

Access and implementation

Access to advance directives is a particularly significant concern given the context in which the need usually arises. When illness, injury or impending surgery precipitates the need for a health care directive, the person requiring treatment may not be able to visit an attorney's office or wait several days for document preparation.

Notwithstanding the requirement of The Patient Self-Determination Act of 1990[22] that all Medicare and Medicaid provider organizations inform patients of their respective state-law rights to formulate advance directives, hospital admissions personnel are usually not legally trained to explain the nuances of Indiana's health care directive laws. Hospitals may have fill-in-the-blank health care directive forms that patients can execute upon admission, but often these forms are outdated or offer less than the full range of legally available options for health care decision-making.[23] Whether due to the difficulty of access or the emotionally unappealing nature of the task, it has been estimated that only 15 percent of Americans have executed any sort of written health care directive.[24]

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Even for individuals who have executed well-prepared advance directives, there are a number of impediments to effective implementation. One is notice to the appropriate health care providers that such documents exist. This is especially problematic in situations of emergency hospital admissions. Hospitals may refuse to accept advance directives from an individual prior to an actual admission for treatment, and a patient admitted on an emergency basis may be unconscious or in no condition to locate copies of the directives before being taken to the hospital.[25] To date, no workable central repository for health care directives has been established. However, several states have amended their driver's license statutes to provide notice of advance directives.[26]

Another difficulty with implementation of valid health care directives is varying hospital policies regarding the withdrawal or withholding of life-prolonging procedures, especially artificial nutrition and hydration. Indiana law provides that an attending physician may refuse to honor a patient's living will or life-prolonging procedures declaration, but must attempt to transfer the patient to another physician who will honor the declaration.[27]

Because decisions to withdraw or withhold life-prolonging procedures usually occur in a hospital setting, the physician's willingness to honor an advance directive may be determined by hospital policy. Federal law requires that Medicaid and Medicare provider organizations not only provide written information to adult individuals about their state-law rights to formulate advance directives, but that the organization also provide written information about the organization's policies respecting implementation of such rights.[28]

Unfortunately this does not always happen in practice, or if in fact such written information is provided, a patient or the patient's health care representative may not understand the full import of the information until treatment such as artificial nutrition and hydration becomes an issue. In these situations, a patient may be subjected to unwanted life-prolonging procedures pending transfer to a facility that will honor the advance directive.

A similar problem may occur with respect to emergency medical services (EMS) personnel and advance directives. Absent legislation permitting EMS to follow advance directives requesting no resuscitation, EMS personnel are required to administer life-saving treatment.[29] Indiana has yet to address this problem legislatively, but 20 other states now have "non-hospital, do-not-resuscitate" laws that apply to emergency medical services.[30] For a terminally ill patient, unwanted intervention by emergency medical personnel could create exactly the scenario that an advance directive was executed to avoid – that of placing the patient's family in the position of having to request the removal of life support systems.

Conclusion

In some respects Indiana has been a forerunner in the field of advance directives, enacting legislation for directed, delegated and default surrogate decision-making. However, experience with attempting to coordinate these separately enacted laws into a comprehensive scheme for health care planning has revealed numerous problems and pitfalls. States nationwide are beginning to reassess their advance directive and family consent laws in order to make them more accessible and responsive to the needs of their citizenry. Perhaps it is time for Indiana to join these efforts to develop the next generation of health care advance directives.

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1. The 108th General Assembly approved Pub. L. No. 99-1994 on March 18, 1994, which amended Ind. Code §§16-36-4-1, 16-36-4-10 and 16-36-4-13 effective July 1, 1994. Other jurisdictions that explicitly permit advance directives regarding the use of artificially supplied nutrition and hydration include Alaska, Arizona, California, Colorado, Connecticut, Georgia, Hawaii, Idaho, Illinois, Iowa, Kentucky, Louisiana, Maine, Maryland, Minnesota, Nevada, New Hampshire, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Utah, Virginia, Washington and Wyoming.
2. Ind. Code §§16-36-4-1 to -21 (Supp. 1994).
3. Ind. Code §16-36-1-7 (Supp. 1994).
4. Ind. Code §16-36-1-5(a)(2) (Supp. 1994).
5. Ind. Code §§30-5-1-1 to 30-5-10-4 (1994).

6. Ind. Code §16-36-1-5(a)(2) (Supp. 1994).
7. *See In re Lawrence*, 579 N.E.2d 32 (1991).
8. *See, e.g.*, Ariz. Rev. Stat. Ann. §36-3231(A) (1993); Fla. Stat. Ann. §765.401(1) (West Supp. 1995); 755 Ill. Comp. Stat. 40/25(a) (1992); Md. Health-Gen. Code Ann. §5-605(a)(2) (1994).
9. *See, e.g.*, Ariz. Rev. Stat. Ann. §36-3231(A)(2) (1993); Fla. Stat. Ann. §765.401(1)(c), (e) (West Supp. 1995).
10. *See, e.g.*, 755 Ill. Comp. Stat. 40/25(a) (1992).
11. *See, e.g.*, Md. Health-Gen. Code Ann. §5-605(b) (1994).
12. *See, e.g.*, Colo. Rev. Stat. §15-18.5-103(4) (Supp. 1994); 755 Ill. Comp. Stat. 40/25 (d) (1992).
13. *See, e.g.*, Ariz. Rev. Stat. Ann. §36-3231(A)(6) (1993); Colo. Rev. Stat. §15-18.5-103(3) (Supp. 1994); Fla. Stat. Ann. §765.401(1)(g) (West Supp. 1995); 755 Ill. Comp. Stat. 40/25(a)(7) (1992); Md. Health-Gen. Code Ann. §5-605(a)(2)(vi) (1994).
14. Ind. Code §16-36-1-9 (Supp. 1994).
15. Ind. Code §30-5-5-16(b)(2) (1994).
16. Ind. Code §30-5-2-4 (1994).
17. Ind. Code §30-5-5-16(b) (1994).
18. Ind. Code §30-5-4-4(c) (1994).
19. Ind. Code §16-36-4-10 (Supp. 1994).
20. *See* Charles Sabatino et al., *Legislative Developments in Advance Directive & Family Consent Law*, 1994 ABA Joint Conference on Law & Aging 235, 236; *see, e.g.*, Ariz. Rev. Stat. Ann. §§36-3201 to -3262 (1993); Md. Health-Gen. Code Ann. §§5-601 to -618 (1994 & Supp. 1994); N.J. Stat. Ann. §§26:2H-53 to -78 (West Supp. 1994).
21. 9 U.L.A. 94 (Supp. 1994).
22. Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, §§4206, 4751, 104 Stat. 1388 (codified in scattered sections of 42 U.S.C.).
23. For the past four years the author has supervised a *pro bono* program to provide advance directives to senior citizens and clients of the AIDS Care Coordination Program in Porter and Lake counties. The observations concerning hospital-provided advance directive forms are based on numerous sample documents brought by *pro bono* clients to their initial in-take interviews.
24. Charles P. Sabatino, *Surrogate Decision-Making in Health Care: A Legislative Overview*, ABA Bioethics Bulletin 1, 2 (Summer 1993).
25. One of the author's *pro bono* clients, a cardiac patient, relayed an account of the hospital refusing his request to place his advance directives on file because he was not presently admitted to the hospital, although he had been a patient on numerous occasions, including emergency admissions.
26. *See, e.g.*, 625 Ill. Comp. Stat. §5/6-110(g) (1992); Minn. Stat. Ann. §171.07(7) (West Supp. 1995); S.D. Codified Laws Ann. §32-12-17 (Supp. 1994); Tex. Rev. Civ. Stat. Ann. art. 6687b(11D) (West Supp. 1995).
27. Ind. Code §16-36-4-13(e) (Supp. 1994).
28. 42 U.S.C. §§1395cc(f) (1992), 1396a(w) (Supp. 1994).
29. *See* Sabatino et al., *supra* note 20, at 237.
30. *Id.*; *see, e.g*, Alaska Stat. §§18.12.010-.100 (1994); Ariz. Rev. Stat. Ann. §36-3251 (1993); N.Y. Pub. Health Law §§2960-2979 (McKinney 1993 & Supp. 1995).