

January 1988

The Right of the Elderly to Self-Determination and New York's Legislative Imperative

A. Kathleen Tomlinson

Follow this and additional works at: <http://digitalcommons.pace.edu/plr>

Recommended Citation

A. Kathleen Tomlinson, *The Right of the Elderly to Self-Determination and New York's Legislative Imperative*, 8 Pace L. Rev. 63 (1988)

Available at: <http://digitalcommons.pace.edu/plr/vol8/iss1/2>

The Right of the Elderly to Self-Determination and New York's Legislative Imperative

A. Kathleen Tomlinson†

I. Introduction

In an era when the average life expectancy and the normal period of physical vitality have increased dramatically,¹ the law has become a more important influence during the aging of the individual human being. Improvements in technology and public health, as well as shifting demographic trends, have raised entirely new sets of questions for society to confront and resolve. For the first time in our history, large numbers of older persons are still alive, active, and vigorous — they have survived the task of raising the next generation and they are beyond the daily demands of making a living.²

By the year 2000, 13% of Americans will be aged sixty-five and over.³ The full impact of the population increase among the elderly is expected to be felt keenly between the years 2010 and 2030 when the post-World War II baby boom population begins to retire. At that time, the elderly will comprise an estimated 20% of the total population.⁴ Presently, among those individuals in the general population as a whole, the seventy-five-and-over age cohort is the fastest growing age segment in the United

† Assistant Dean, Faculty of Liberal Arts and Sciences, Long Island University. B.A., *magna cum laude*, Rutgers University; M.A., *with distinction*, Long Island University; J.D., St. John's University.

Copyright © 1988 A. Kathleen Tomlinson All Rights Reserved.

1. See generally G. BARROW, *AGING, THE INDIVIDUAL, AND SOCIETY* (3rd ed. 1986).

2. Levine, *Introduction: The Frame of Nature, Gerontology, and Law*, 56 S. CAL. L. REV. 261, 262 (1982).

3. J. KRAUSKOPF, *ADVOCACY FOR THE AGING* § 1.7 (1st ed. 1983 & Supp. 1984).

4. *Senior Citizens in the 1980s: Hearings Before the Subcomm. on Human Services of the Select Comm. on Aging*, 96th Cong., 2nd Sess. 83 (1980) (statement of Norman D. Shumway, Chairman).

States.⁵

Within New York State, there were 2,254,000 persons aged sixty-five or over in 1985.⁶ This was 12.7% of the population of New York State; it has been estimated that in 2010, the figure will be 15.5%.⁷ For example, in Suffolk County presently, it is estimated that 20% of the population is over age sixty-five.⁸

“Law is . . . a mechanism through which society adapts its institutions to the increasing number and proportion of older Americans.”⁹ Laws outline how the elderly can retain control of their property as well as control to whom their property will go after their death. Yet, property determinations are only one aspect of the concerns faced by the elderly. Perhaps the more fundamental issue is the effort to preserve the personal autonomy of elderly persons — a vital concern reflected in the ongoing debates concerning the right to treatment, the right to refuse treatment, and the right to due process for guardianship proceedings.¹⁰ As one commentator has noted, “[t]he law seeks to preserve the integrity of the autonomy of elderly persons, to guarantee them fair procedures, and to promote their liberty, while it also seeks to protect them if their capacities should fade.”¹¹

Therefore, a basic issue in the law which is critically important to aging individuals (and to the attorneys who represent them) is the need to balance autonomy and paternalism. This Article will address “advance directives” legislation from the perspective of the autonomy-paternalism tension. It will focus on the decisionmaking process and on how an individual’s liberty is enhanced by such legislation. With the recent tenth anni-

5. J. KRAUSKOPF, *supra* note 3, at § 1.7 (1st ed. 1983).

6. STATISTICAL ABSTRACT OF THE UNITED STATES 1987, at 23 (107th ed. 1986).

7. Telephone interview with New York State Office for the Aging, Research Unit (Jan. 26, 1988) (figures developed by New York State Dep’t of Commerce).

8. Population estimates supplied by the Suffolk County Department of Aging and the Long Island Regional Planning Board.

9. Levine, *supra* note 2, at 274. See generally YOUNG LAWYERS DIVISION, A.B.A. COMMISSION ON LEGAL PROBLEMS OF THE ELDERLY AND THE COMMITTEE ON DELIVERY OF LEGAL SERVICES TO THE ELDERLY, THE LAW AND AGING RESOURCE GUIDE (1981) (discussing the legal needs of an aging population and the critical areas of interaction between identifiable needs of the elderly and available legal services).

10. See generally R. BROWN, THE RIGHTS OF OLDER PERSONS — AN AMERICAN CIVIL LIBERTIES UNION HANDBOOK (1979).

11. Levine, *supra* note 2, at 277.

versary of the first natural death act, in California,¹² it is an appropriate time to assess the impact of such legislation which has, as of this writing, been adopted in some form in thirty-eight states and the District of Columbia.¹³

Advance directives have been given legal recognition in several forms, the most common of which are durable power of attorney statutes and living will legislation. In reviewing the history and present status of these devices, this Article will also address the lack of legally cognizable advance directives in New York. Rather than focus on the "right to die" controversy, attention will be directed to the decisionmaking process, particularly within the framework of the elderly client and his family. Primary emphasis is given to situations in which the individual concerned has been competent at some time in his or her life. The need and accompanying problems of surrogate decisionmaking, the failure of the proposed uniform "Rights of the Terminally Ill Act,"¹⁴ and the inadequacy of the recently enacted New

12. CAL. HEALTH & SAFETY CODE §§ 7185 to 7195 (West Supp. 1987).

13. ALA. CODE § 22-8A-1 to 22-8A-10 (1981); ALASKA STAT. § 18.12.010 (1986); ARIZ. REV. STAT. ANN. §§ 36-3201 to 36-3210 (1986); ARK. STAT. ANN. §§ 82-3801 to 82-3804 (Supp. 1987); CAL. HEALTH & SAFETY CODE §§ 7185 to 7195 (West Supp. 1987); COLO. REV. STAT. §§ 15-18-101 to 15-18-113 (Supp. 1985); CONN. GEN. STAT. ANN. §§ 19a-570 to 19a-575 (West 1987); DEL. CODE ANN. tit. 16, §§ 2501 to 2508 (1983); D.C. CODE ANN. §§ 6-2421 to 6-2430 (Supp. 1987); FLA. STAT. ANN. §§ 765.01 to 765.15 (West 1986); GA. CODE ANN. §§ 31-32-1 to 31-32-12 (1985 & Supp. 1987); HAW. REV. STAT. §§ 327D-1 to 327D-27 (Supp. 1986); IDAHO CODE §§ 39-4501 to 39-4508 (1985); ILL. ANN. STAT. ch. 110½, para. 701 to 710 (Smith-Hurd Supp. 1987); IND. CODE ANN. §§ 16-8-11 to 16-8-22 (Burns Supp. 1987); IOWA CODE ANN. §§ 144A.1 to 144A.11 (West Supp. 1985); KAN. STAT. ANN. §§ 65-28, 101 to 65-28, 109 (1985); LA. REV. STAT. ANN. §§ 40:1299.58.1 to 40:1299.58.10 (West Supp. 1987); ME. REV. STAT. ANN. tit. 22, §§ 2921 to 2931 (Supp. 1987); MD. HEALTH-GEN. CODE ANN. §§ 5-601 to 5-604 (Supp. 1987); MISS. CODE ANN. §§ 41-41-101 to 41-41-121 (Supp. 1986); MO. REV. STAT. §§ 459.010 to 459.055 (Vernon Supp. 1987); MONT. CODE ANN. §§ 50-9-101 to 50-9-104, 50-9-201 to 50-9-206 (1986); NEV. REV. STAT. §§ 449.540 to 449.690 (1985); N.H. REV. STAT. ANN. §§ 137-H:1 to 137-H:16 (Supp. 1986); N.M. STAT. ANN. §§ 24-7-1 to 24-7-10 (1986); N.C. GEN. STAT. §§ 90-320 to 90-323 (1985); OKLA. STAT. ANN. tit. 63, §§ 3101 to 3111 (West Supp. 1987); OR. REV. STAT. §§ 97.050 to 97.090 (1985); S.C. CODE ANN. §§ 44-77-10 to 44-77-160 (Law. Co-op. Supp. 1986); TENN. CODE ANN. §§ 32-11-101 to 32-11-110 (Supp. 1987); TEX. REV. CIV. STAT. ANN. art. 4590h (Vernon Supp. 1987); UTAH CODE ANN. §§ 75-2-1101 to 75-2-1118 (Supp. 1987); VT. STAT. ANN. tit. 18, §§ 5251 to 5262 (Supp. 1986); VA. CODE ANN. §§ 54-325.8:1 to 54-325.8:13 (Supp. 1987); WASH. REV. CODE ANN. §§ 70.122.010 to 70.122.905 (Supp. 1987); W. VA. CODE §§ 16-30-1 to 16-30-10 (1985); WIS. STAT. ANN. §§ 154.01 to 154.15 (West Supp. 1987); WYO. STAT. §§ 33-26-144 to 33-26-152 (Supp. 1985).

14. UNIFORM RIGHTS OF THE TERMINALLY ILL ACT (final version of the Act, with a Prefatory Note and official Comments, was distributed by the National Conference of

York legislation concerning "Orders Not to Resuscitate"¹⁵ will all be examined.

Finally, this Article will urge that the legislature accede to the judicial pleas of recent Florida and New York cases¹⁶ to establish a comprehensive bill that formulates clear standards for resolving requests to withhold or withdraw life-sustaining treatment. It will also urge that such a statute be designed to ensure the integrity of the medical profession while simultaneously protecting the right of each individual to self-determination.

II. Background

To deal with the growing number of older citizens who are living longer, about half the states have implemented "protective services" legislation.¹⁷ For the present day practitioner, an awareness of the capacity of elderly clients to make rational decisions and to implement personal choices is essential to arriving at any judgment of the client's best interests. When that capacity diminishes significantly, the state's inherent *parens patriae* power may be invoked to authorize the government to intervene in a person's life to "promote the ethical principle of benevolence: to protect the person from being harmed and to bestow upon the individual positive benefits."¹⁸ The goal of these services is to assist the elderly in maintaining independent living, particularly in light of the 1970's trend toward deinstitutionalization.¹⁹

There are few other areas of representation where an attor-

Commissioners on Uniform State Laws in Jan., 1986) (available from the National Conference at 645 N. Michigan Ave., Suite 510, Chicago, IL 60611). For a discussion of the policy considerations and legislative purpose of the UNIFORM RIGHTS OF THE TERMINALLY ILL ACT, see Marzen, *The Uniform Rights of the Terminally Ill Act: A Critical Analysis*, 1 ISSUES IN LAW AND MEDICINE 441 (1986).

15. N.Y. PUB. HEALTH LAW §§ 2960 to 2978 (McKinney Supp. 1988) (to become effective Apr. 1, 1988).

16. *John F. Kennedy Hosp., Inc. v. Blutworth*, 432 So. 2d 611 (Fla. Dist. Ct. App. 1983), *rev'd*, 452 So. 2d 921 (Fla. 1984); *In re Saunders*, 129 Misc. 2d 45, 492 N.Y.S.2d 510 (Sup. Ct. 1985).

17. Kapp, *Adult Protective Services: The Attorney's Role*, 59 FLA. B.J. 23 (1985). See generally Regan, *Protecting the Elderly: The New Paternalism*, 32 HASTINGS L.J. 1111 (1981).

18. Kapp, *supra* note 17.

19. *Id.*

ney is likely to be confronted by such difficult legal issues that are bound up with intricate questions of ethics and social policy. This field compels the attorney to "reconcile unresolved personal values concerning individual liberty or autonomy versus society's obligations toward the helpless, on the one hand, with the attorney's traditional role as zealous advocate for the wishes of the client in an adversarial system on the other hand."²⁰

In light of the tremendous strides medical technology has made in the last twenty years, the population has become increasingly concerned with decisions about death and dying. In concert with fundamental changes in the causes of death, significant changes in the places where people die have also occurred. Throughout human history, most deaths by natural causes occurred in the home. However, advances in medicine have concurrently shifted the locus of health care to institutional settings.²¹ It has been estimated that in the late 1970's, approximately 80% of all deaths in the United States occurred in hospitals and long-term care institutions such as nursing homes.²²

In addition, for the majority of patients, the eventuality of death is not an unanticipated phenomenon. One study has shown that in 1978, chronic conditions were the cause of 87% of all deaths for persons aged sixty-five and over.²³ What is of major concern, however, is the preservation of the individual's right to privacy and self-determination within these circumstances.

Courts and legislatures have been increasingly involved in attempting to clarify the rights, duties, and liabilities of all parties concerned in this decisionmaking process. To re-examine the way decisions are and should be made concerning an individual's right to obtain or forego life-sustaining treatment, the President's Commission for the Study of Ethical Problems in

20. *Id.* at 25. Cf. Perlin and Sadoff, *Ethical Issues in the Representation of Individuals in the Commitment Process*, 45 LAW & CONTEMP. PROBS. 161 (1982).

21. PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 1 (1983) [hereinafter DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT].

22. *Id.*

23. Somers, *Long-term Care for the Elderly and Disabled: A New Health Priority*, 307 NEW ENG. J. MED. 221, 222 (1982) (quoting Dorothy P. Rice of the National Center for Health Statistics).

Medicine and Biomedical and Behavioral Research conducted research among health care professionals and legal and ethical scholars, in addition to reviewing cases brought in state and federal courts. The members held public hearings before regional groups from January 1980 to December 1982. In 1983, the Commission published its findings and recommendations.²⁴

The Commission recommended that “[s]tate courts and legislatures should consider making provisions for advance directives through which people designate others to make health care decisions on their behalf and/or give instructions about their care.”²⁵ The members saw in these directives a means of preserving self-determination for patients who might lose their decisionmaking capacity. The Commission noted its preference for durable power of attorney statutes.

[D]urable power of attorney acts offer a simple, flexible, and powerful device for making health care decisions on behalf of incapacitated patients The flexibility of the statutes allows directives to be drafted that are sensitive both to the different needs of patients in appointing proxy decisionmakers and to the range of situations in which decisions may have to be made.²⁶

However, the Commission did add that experience with both durable power of attorney and living will documents in the context of medical decisionmaking was limited.²⁷

The Commission members indicated a clear preference for keeping these issues out of an adjudicative forum unless clearly required by state law.²⁸ However, judicial intervention is also foreseeable when the parties involved cannot resolve their disagreements “over matters of substantial import.”²⁹ The Commission concluded that the individual’s right to self-determination is better protected and served when the competent individual is making his own treatment decisions.³⁰

24. DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT, *supra* note 21, at 11.

25. *Id.* at 5.

26. *Id.* at 146-47.

27. *Id.* at 5.

28. *Id.* at 6.

29. *Id.*

30. *Id.* at 2.

III. Advance Directives: Powers of Attorney

In its report, the President's Commission indicated that an "advance directive" allows people to anticipate that they may be unable to participate in future decisions about their own health care.³¹ The report distinguishes between an "instruction directive," specifying the types of care a person wants or does not want to receive, and a "proxy directive," specifying the surrogate whom a person wants to make such decisions if the person is ever unable to do so.³² Living wills (including those authorized by statute) are generally considered "instruction directives."³³ Durable power of attorney statutes are characterized as "proxy directives."³⁴ In some states, the two forms may be combined.³⁵

A. Power of Attorney — Common Law and Statutory

Even under the common law, a competent individual has always had the power by means of a written instrument to authorize another person to act in his stead.³⁶ Through this "power of attorney," the principal designated an agent called the "attorney-in-fact" who could perform any lawful act the principal might do.³⁷ Within this power, two exceptions should be noted: non-delegable acts including personal services contracts where the respective act is of such a nature that the service can only be rendered by a principal, and statutorily mandated personal acts such as voting, executing a will, and making an affidavit.³⁸ The power given to an agent by this means is usually broad and is given to one whom the principal trusts, such as a spouse, adult child, brother or sister, close friend, or associate.³⁹

31. *Id.* at 136.

32. *Id.*

33. *Id.* at 139.

34. *Id.*

35. See, e.g., ARIZ. REV. STAT. ANN. §§ 36-3201 to 36-3202 (1985); DEL. CODE ANN. tit. 16, §§ 2501 to 2509 (1983); IDAHO CODE §§ 39-4501 to 39-4508 (Supp. 1987); LA. REV. STAT. ANN. §§ 40:1299.58.1 to 40:1299.58.10 (West Supp. 1987).

36. 2A C.J.S. Agency § 144 (1972).

37. *Id.*

38. RESTATEMENT (SECOND) OF AGENCY § 17 (1958).

39. *Id.* See Teitler, *Contingency Planning for Incapacity*, in ADVISING CLIENTS ON DEALING WITH THE INFIRMITIES OF ADVANCED AGE (Comm. on Continuing Legal Educ. of the New York State Bar Ass'n 1986).

A principal can give the attorney-in-fact authorization to perform many acts — to receive and deposit assets, to sign contracts, to buy and sell real or personal property, to sue or be sued, to make gifts, to establish trusts, to spend income or principle from trusts.⁴⁰ The most common form of power of attorney in New York is the statutory short form found in General Obligations Law section 5-1501.⁴¹ It authorizes all of the transactions noted above and provides an additional catch-all category, authorizing the attorney-in-fact to act as an alter-ego of the principal with respect to any and all possible matters and affairs which the principal can do through an agent.⁴²

Alternatively, the authority given to the attorney-in-fact can be cast in narrow terms and can be limited in duration, as is often the case in a single transaction situation, such as an offer on specific property.⁴³ A power of attorney can continue indefinitely, however, if no time limit has been stated. Yet, the power is revoked automatically when a principal is incapacitated.⁴⁴

Particularly in circumstances affecting the elderly, this automatic revocation means that the power of attorney *disappears* at precisely the time an elderly client might need it most — when he or she has become incompetent and lacks the ability to act in his or her own behalf.⁴⁵ The durable power of attorney is a device created with the specific goal of compensating for this defect. Without such a device, the elderly (and others in circumstances of incompetency) who have become incapacitated would be forced to rely on someone petitioning the court for appointment of a guardian or conservator to make decisions in their behalf concerning their property or their person.⁴⁶

40. OFFICE OF HUMAN DEV., U.S. DEP'T OF HEALTH & HUMAN SERVICES, DURABLE POWER OF ATTORNEY: AN IMPORTANT ALTERNATIVE TO GUARDIANSHIP, CONSERVATORSHIP, OR TRUSTEESHIP (1981) [hereinafter DURABLE POWER OF ATTORNEY: AN IMPORTANT ALTERNATIVE].

41. N.Y. GEN. OBLIG. LAW § 5-1501 (McKinney 1978 & Supp. 1987).

42. N.Y. GEN. OBLIG. LAW § 5-1502I(14) (McKinney 1978).

43. DURABLE POWER OF ATTORNEY: AN IMPORTANT ALTERNATIVE, *supra* note 40, at 2.

44. *Id.*

45. *Id.*

46. *Id.*

B. *Durable Power of Attorney*

Virginia was the first state to enact durable power of attorney legislation, in 1950.⁴⁷ However, little attention was paid to the idea until the 1957 National Conference of Commissioners on Uniform State Laws appointed a special committee on the Civil Rights of Persons of Questionable Competency.⁴⁸ The impetus for this investigation was a growing concern for the needs of an aging population that was (and is) rapidly increasing in number. In particular, the special committee directed its attention to persons

unable to care for their property or personal affairs effectively because of injury, old age, senility, disease, blindness, physical disability, or mental illness falling short of insanity, and with respect to whom the laws of most states made no adequate provision for assistance in caring for their property or personal affairs, or for protecting their property or personal rights.⁴⁹

The National Council on Aging, under the provisions of the Older Americans Act,⁵⁰ and the American Bar Foundation had been actively studying this problem for several years prior to the Uniform Commissioners' special committee appointment.⁵¹ After extensive review of the findings and recommendations of all interested constituencies, the National Conference of Commissioners on Uniform State Law promulgated the Model Special Power of Attorney for Small Property Interest Act in 1964.⁵² The model act was designed to assist persons with smaller income and property interests, who

in anticipation or because of physical handicap or infirmity resulting from injury, old age, senility, blindness, disease, or other

47. VA. CODE ANN. § 11-9.1 (1985).

48. NATIONAL CONFERENCE OF COMMISSIONERS ON UNIFORM STATE LAWS, HANDBOOK AND PROCEEDINGS OF THE ANNUAL CONFERENCE MEETING, 273 (1964).

49. *Id.*

50. 42 U.S.C.A. § 3011 (West 1973).

51. A. KARLSSON, APPOINTING AN AGENT FOR MEDICAL CARE DECISIONS UNDER DURABLE POWER OF ATTORNEY STATUTES 4 (1980) (unpublished manuscript available from Concern-For Dying, 250 West 57th Street, New York, N.Y. 10107) (citing the report of the Conference of Commissioners on Uniform State Laws, 1964).

52. MODEL SPECIAL POWER OF ATTORNEY FOR SMALL PROPERTY INTERESTS ACT, reprinted in NATIONAL CONFERENCE OF COMMISSIONERS ON UNIFORM STATE LAWS, HANDBOOK AND PROCEEDINGS OF THE ANNUAL CONFERENCE MEETING — 1964, at 275-81.

related or similar cause, wish to make provision for the care of their personal or property rights or interests, or both when unable adequately to take care of their own affairs.⁵³

The model act, in effect, altered the common law rules in its authorization of specific powers of attorney that would survive a principal's incapacity.

The Virginia Code of 1950 served as a basis for the durable power of attorney provisions adopted by the Commissioners and was incorporated as sections 5-501 and 5-502 of the Uniform Probate Code.⁵⁴ These sections of the Uniform Probate Code were amended by the Commissioners in 1979 after several states had reported their experiences with durable power of attorney statutes. The review and amending process resulted in the promulgation within that same year of a Uniform Durable Power of Attorney Act.⁵⁵ As of this writing, virtually every state and the District of Columbia has implemented some form of a durable power of attorney statute.⁵⁶ The formulation of the Uniform Du-

53. NATIONAL CONFERENCE HANDBOOK, *supra* note 48, at 274.

54. UNIF. PROBATE CODE §§ 5-501 to 5-505 (West 1983 & Supp. 1987).

55. Karlsson, *supra* note 51, at 7. Part 5 of Article V of the Uniform Probate Code was amended by the National Conference of Commissioners on Uniform State Laws in 1979. Sections 5-501 to 5-505, as enacted in 1979, are identical to sections 1 to 5 of the Uniform Durable Power of Attorney Act, also approved by the National Conference in 1979 as an alternative to Part 5 of Article V of the Uniform Probate Code.

56. ALA. CODE § 26-1-2 (1986); ALASKA STAT. §§ 13.26.325 to 13.26.330 (1985); ARIZ. REV. STAT. ANN. §§ 14-5501 to 14-5502 (1975); ARK. STAT. ANN. §§ 58-501 to 58-511 (1971 & Supp. 1985); CAL. CIV. CODE §§ 2400 to 2407 (West Supp. 1987); COLO. REV. STAT. §§ 15-14-501 to 15-14-502 (Supp. 1982); CONN. GEN. STAT. ANN. § 45-696 (West 1979); DEL. CODE ANN. tit. 12 §§ 4901 to 4905 (1987); D.C. CODE ANN. §§ 21-2081 to 21-2082 (Supp. 1987); FLA. STAT. ANN. § 709.08 (West Supp. 1987); GA. CODE ANN. § 10-6-36 (1982); HAW. REV. STAT. §§ 560:5-501 to 560:5-502 (1985); IDAHO CODE §§ 15-5-501 to 15-5-502 (Supp. 1987); IND. CODE ANN. §§ 30-211-1 to 30-211-7 (Burns Supp. 1987); IOWA CODE ANN. §§ 633.705 to 633.706 (West Supp. 1987); KAN. STAT. ANN. §§ 58-610 to 58-617 (1983); KY. REV. STAT. ANN. § 386.093 (Michie/Bobbs Merrill 1984); ME. REV. STAT. ANN. tit. 18-A, §§ 5-501 to 5-502 (1981 & Supp. 1986); MD. EST. & TRUSTS CODE ANN. §§ 13-601 to 13-602 (1974); MASS. GEN. LAWS ANN., ch. 201B, §§ 1 to 7 (West Supp. 1987); MICH. COMP. LAWS ANN. §§ 700.495 to 700.499 (West 1980); MINN. STAT. ANN. §§ 524.5-501 to 524.5-502 (West 1975 & Supp. 1987); MISS. CODE ANN. § 87-3-15 (1972); MO. REV. STAT. §§ 486.550 to 486.595 (Vernon 1987); MONT. CODE ANN. §§ 72-5-501 to 72-5-502 (1982); NEB. REV. STAT. §§ 30-2662 to 30-2663 (1979); NEV. REV. STAT. §§ 111.450 to 111.470 (Supp. 1985); N.J. REV. STAT. ANN. §§ 46:2B-8 to 46:2B-9 (West Supp. 1987); N.M. STAT. ANN. §§ 45-5-501 to 45-5-502 (1978); N.Y. GEN. OBLIG. LAW § 5-1601 (McKinney 1978); N.C. GEN. STAT. § 47-115.1 (1984); N.D. CENT. CODE §§ 30.1-30-01 to 30.1-30-05 (Supp. 1987); OHIO REV. CODE ANN. §§ 1337.01 to 1337.091 (Anderson 1979 & Supp. 1986); OKLA. STAT. ANN. tit. 58, §§ 1051 to 1062 (West Supp. 1987); OR. REV. STAT. §§ 126.407 to 126.413 (1985); PA.

rable Power of Attorney Act was a revolutionary change that gives individuals the ability to select whom they want to make decisions on their own behalf in the event they become incompetent or incapable of managing their own affairs.⁵⁷ These statutes permit a significant degree of particularity, not only in terms of decisions affecting the management of a person's property, but in some states affecting the making of health care decisions as well.⁵⁸

The Uniform Commissioners provided a report enumerating some of the purposes of the Uniform Durable Power of Attorney Act and provided some guidance as to its uses. They noted that the Act might be a substitute for persons who would otherwise set up a funded revocable trust, and that a durable power could be used as an alternative to court-oriented protective procedures such as conservatorship and guardianship.⁵⁹ However, there has been ongoing controversy concerning the use of durable power of attorney legislation to make health care decisions. Some state statutes authorize such use; others do not.⁶⁰ The courts have continued to look to the statutes and legislatures for guidance in this area.

Only those powers which come within the statutory requirements are *durable*. Although there is no one form required for a valid durable power of attorney, the power must be in writing and must include an express provision that the power survives any subsequent incompetence of the principal.⁶¹ In some states, the provision may state that the power takes effect upon the incompetence of the principal (the so-called "springing powers").⁶²

STAT. ANN. tit. 20, §§ 5601 to 5602 (Purdon 1975 & Supp. 1986); R.I. GEN. LAWS §§ 34-22-6 to 34-22-6.1 (1984); S.C. CODE ANN. §§ 62-5-501 to 62-5-502 (Law. Co-op. 1987); S.D. CODIFIED LAWS ANN. §§ 59-7-2.1 to 59-7-2.4 (1978); TENN. CODE ANN. §§ 66-5-104 to 66-5-105 (1982); TEX. PROB. CODE ANN. § 36A (Vernon 1980); UTAH CODE ANN. §§ 75-5-501 to 75-5-502 (1978); VT. STAT. ANN. tit. 14, §§ 3051 to 3052 (Supp. 1986); VA. CODE ANN. §§ 11-9.1 to 11-9.4 (1985 & Supp. 1987); WASH. REV. CODE ANN. §§ 11.94.010 to 11.94.900 (1987); W. VA. CODE §§ 39-4-1 to 39-4-7 (Supp. 1987); WIS. STAT. ANN. § 243.07 (West 1987).

57. DURABLE POWER OF ATTORNEY: AN IMPORTANT ALTERNATIVE, *supra* note 40, at 3.

58. *See, e.g.*, CAL. HEALTH & SAFETY CODE §§ 7185 to 7195 (West Supp. 1987).

59. DURABLE POWER OF ATTORNEY: AN IMPORTANT ALTERNATIVE, *supra* note 40, at 4. *See also* J. KRAUSKOPF, *supra* note 3, at § 6.10 (1st ed. 1983).

60. DURABLE POWER OF ATTORNEY: AN IMPORTANT ALTERNATIVE, *supra* note 40, at 5.

61. Karlsson, *supra* note 51, at 5-6.

62. *See, e.g.*, ARIZ. REV. STAT. ANN. §§ 14-5501 to 14-5502 (1975); COLO. REV. STAT. §§

Some commentators do not believe that New York recognizes such a springing power.⁶³

The formalities and requirements concerning persons who may act as attorney-in-fact under a durable power differ from state to state. In Connecticut, a durable power must be acknowledged by the principal and two witnesses who must attest to the principal's signature.⁶⁴ South Carolina requires that the durable power be executed with the formality of a will before three witnesses and be recorded as a deed.⁶⁵ In Florida, the class of people who may serve as agents under a durable power is limited to the principal's family members, namely, "spouse, parent, child, whether natural or adopted, brother, sister, niece or nephew"⁶⁶

The California Legislature, in 1979, enacted its first version of a durable power of attorney as an alternative to a conservatorship proceeding or a revocable living trust.⁶⁷ In this enactment, the legislature set a one-year limit on duration of the power once the principal became incapacitated. It thereby intended "to limit the opportunity for unscrupulous parties to gain absolute control over the assets of the incapacitated principal."⁶⁸ Subsequently, in 1981, the California Legislature passed the Uniform Durable Power of Attorney Act, superseding the 1979 Act, and consequently removed the one-year limitation of that Act.⁶⁹

The Michigan statutory provision does not contain any re-

15-14-501 to 15-14-502 (Supp. 1982); DEL. CODE ANN. tit. 12, §§ 4901 to 4902 (1987). However, a springing power requires some mechanism for making the determination of incompetency and for deciding when the power actually takes effect. J. KRAUSKOPF, *supra* note 3, at § 6.15 (1st ed. 1983).

63. Schlesinger, *Use of Powers of Attorneys and Joint Bank Accounts in Planning for the Management of the Property of the Aging or Incapacitated Client*, in *ESTATE PLANNING FOR THE AGING OR INCAPACITATED CLIENT* 112 (D.P. Callahan & P.J. Strauss eds. 1986).

64. CONN. GEN. STAT. ANN. §§ 45-69 and 47-5 (West 1987).

65. S.C. CODE ANN. § 32-13-10 (1986).

66. FLA. STAT. ANN. § 709.08 (West Supp. 1987).

67. CAL. CIV. CODE § 2307.1 (repealed 1981) (current version at CAL. CIV. CODE § 2400 (West Supp. 1987)).

68. Comment, *Review of Selected 1979 California Legislation; Administration of Estates*, 11 PAC. L.J. 271, 303 (1980).

69. Dickman, *Court Enforcement of a Durable Power of Attorney*, 17 U.S.F. L. REV. 611, 616-17 (1983).

striction on the subject matter suitable for delegation under a durable power of attorney.⁷⁰ Although the rules as to what can or cannot be delegated are not well developed, the formal requirements for execution are clear. The durable power must be in writing and contain the words, "[t]his power of attorney shall not be affected by the disability of the principal . . ."⁷¹ The statute "recommends" attestation by two competent witnesses and further states that the instrument should contain a jurat or authentication and be sealed by a notary public.⁷²

Given the provisions of many state durable power of attorney statutes, several commentators have stated that these laws provide a legal device which might be used to appoint an agent to make medical care decisions in the future on an individual's behalf in the event of incompetency.⁷³ In Michigan, one member of the Bar Commission studying this issue noted:

Based on the precedents of other jurisdictions, it seems likely that a properly drafted Durable Power of Attorney can be used to authorize an attorney-in-fact not only to assist in the management of the principal's assets, but also to provide for the care, custody, and control of the incompetent, and can even be utilized to authorize an attorney-in-fact to refuse to consent to various kinds of medical treatment. In addition, it would be highly desirable to have the principal make his/her wishes concerning medical treatment known in a clear and unambiguous way. An instructive directive, such as the Living Will, which specifies the type of care a person wants or does not want to receive, would be a very advantageous adjunct to the Durable Power of Attorney.⁷⁴

New York provides that a power of attorney may survive the possible mental or physical disability of the maker in the future.⁷⁵ However, even though a durable power of attorney extends to the attorney-in-fact the right to make decisions concerning financial and personal affairs, there remains a very large question about health care decisions. Even with the combined

70. MICH. COMP. LAWS ANN. § 700.495 (West 1980).

71. *Id.*

72. MICH. COMP. LAWS ANN. § 565.631 (West 1967).

73. A. KARLSSON, *supra* note 51, at 6; Bos, *The Durable Power of Attorney*, 64 MICH. B.J. 694-95 (1985).

74. Bos, *supra* note 73, at 695.

75. N.Y. GEN. OBLIG. LAW § 5-1601 (McKinney 1978).

use of a living will and a durable power of attorney,⁷⁶ the attorney-in-fact must still obtain court approval for terminating the life-sustaining treatment of a principal who has previously indicated such desire.⁷⁷ Such a process is both time-consuming and expensive.

Generally, in New York, a power of attorney will not be an available alternative for one who is already incompetent and whose only option in such a case would be a committee or conservatorship. "The advent of the durable power solves a major shortcoming of powers that previously existed because a durable power survives incapacity and provides an informal and inexpensive alternative to committee or conservatorship."⁷⁸ In New York, a power, to be durable, must be in writing and must contain the words: "This power of attorney shall not be affected by the subsequent disability or incompetence of the principal"⁷⁹ The signature of the principal must be acknowledged by a notary public.⁸⁰

Although the courts have not specifically ruled on this question, legal practitioners appear split on the interpretation of the durable power of attorney statutes to include the power to consent to medical treatment. For example, in South Carolina, two attorneys noted:

The durable power can contain provisions relating not only to asset management, but also to the care, custody, and control of the incompetent A power of attorney dealing with the custody of the person should cover such matters as the establishment of the incompetent's place of residence, including the specific location, city, county, and state, and it may also include establishing that residence at a nursing or convalescent home. The power can also permit the attorney in fact to retain and dismiss a variety of professional help (medical, legal, accounting) and to consent to those kinds of medical or surgical treatment and procedures for which consent is required.⁸¹

76. *Supra* note 35 and accompanying text.

77. Kramer, *The Professional's Role in Helping the Client and the Family Deal with Death*, 58 N.Y. St. B.J. no. 2 at 26 (1986).

78. Schlesinger, *Personal Planning for the Elderly Client*, 59 N.Y. St. B.J. no. 1 at 16 (1987).

79. N.Y. GEN. OBLIG. LAW § 5-1601 (McKinney 1978).

80. N.Y. GEN. OBLIG. LAW § 5-1501 (McKinney 1978 & Supp. 1987).

81. Moses & Pope, *Estate Planning, Disability, and the Durable Power of Attor-*

It is also worth noting that in the early days of the durable power of attorney statutes, the American Bar Association conducted an informal poll of physicians, hospitals, and medical care providers and found that "they would accept . . . [durable powers of attorney] . . . not only as to personal care, but as to their contractual relationship with" the patient.⁸²

However, in 1984, the New York State Attorney General issued a formal opinion⁸³ which held that in New York, durable powers of attorney may not "generally" be used for health care decisions. The opinion notes in part:

[W]e believe that a durable power of attorney cannot with prudence be used to delegate *generally* to an agent the authority to make health care decisions on behalf of an incompetent principal However, it is our opinion that a durable and properly limited power of attorney may be used to delegate specifically to an agent the responsibility to communicate the principal's decision to decline medical treatment under defined circumstances.⁸⁴

In addition, a member of the Trusts and Estates section of the New York Bar recently conducted an informal telephone survey of several New York City hospitals and found that the administrative policies at these institutions demonstrate an unwillingness to honor durable power of attorney documents for health care decisions and that enforcement will require a court order.⁸⁵

To cope with these difficult circumstances, California adopted a durable power of attorney for health care,⁸⁶ effective January 1, 1984. The statutory power is valid for seven years after execution. No cases have yet been brought under this legislation.⁸⁷

The durable power of attorney does possess certain advantages, particularly in comparison to guardianship. It allows the

ney, 30 S.C.L. REV. 511, 528 (1979).

82. *Legal Problems of the Aged and Infirm — the Durable Power of Attorney — Planned Protective Services and the Living Will*, 13 REAL PROP. PROB. & TR. J. 1, 4 (1978).

83. 1984 Op. N.Y. Att'y Gen. 16.

84. *Id.*

85. Schlesinger, *supra* note 78, at 19.

86. CAL. CIVIL CODE §§ 2430 to 2444 (West Supp. 1987).

87. *Bouvia v. Superior Court* (Glenchur), 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986) (hearing denied) was brought under other statutory provisions.

client more autonomy since the client is free to terminate the power at any time, as long as he has capacity.⁸⁸ The client can also decide, while still having capacity, who will have responsibility over his affairs.⁸⁹ The durable power is less expensive to execute than guardianship proceedings.⁹⁰ Guardianship also requires automatic supervision of the client and the client's affairs usually by a guardian — virtually eliminating any sense of individual autonomy.⁹¹ The real question, then, is whether the durable power of attorney is a strong enough instrument to allow such medical planning as the discontinuance of life-support and life-sustaining measures. This issue will be assessed once the correlative issue, living wills, has been discussed.

IV. Advance Directives: Living Wills

A. *History and Legislative Intent*

Living wills are signed documents in which a person requests that his life not be unnecessarily prolonged if he becomes terminally ill.⁹² This advance directive has medical, legal, and ethical dimensions. Its existence depends upon certain ethical principles regarding human rights, including the right to a quality of life that goes beyond mere physical duration.

Initially, living wills were developed as documents without any binding legal effects; they were ordinarily considered "instruction directives."⁹³ The primary thrust behind the introduction of natural death act legislation was the desire to give legal recognition to living wills. These documents enable individuals to indicate their preference not to be given heroic or extraordinary treatments.

The living will has two important functions. First, by clearly indicating the patient's preferences regarding certain medical

88. McKay, *New Types of Protective Services*, 8 GENERATIONS No. 8 at 11 (1984).

89. J. KRAUSKOPF, *supra* note 3, at § 6.13 (1st ed. 1983).

90. *Id.* at § 6.1.

91. UNIF. PROBATE CODE § 5-303, 8 U.L.A. 463 (1982). See generally Alexander, *Pre-mature Probate: A Different Perspective on Guardianship for the Elderly*, 31 STAN. L. REV. 1003 (1979).

92. CONCERN FOR DYING, THE LIVING WILL AND OTHER ADVANCE DIRECTIVES, A LEGAL GUIDE TO MEDICAL TREATMENT DECISIONS 5 (1986) [hereinafter THE LIVING WILL AND OTHER ADVANCE DIRECTIVES].

93. DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT, *supra* note 21, at 139.

procedures or measures, the will guides treatment decisions made by the family and health care providers. This ensures respect for patient autonomy even when the patient is no longer competent. Second, the will provides documentation of the patient's instructions regarding withholding or withdrawing of certain life-prolonging or life-sustaining technology. This protects health care providers and institutions that follow the patient's directives.⁹⁴

As of this writing, thirty-eight states and the District of Columbia have passed legislation detailing the legal rights of individuals who execute living wills.⁹⁵ In the absence of specific living will legislation, proponents of these documents and a number of courts find a legal basis for them in the common law.⁹⁶ These fundamental legal rights include the common law right to self-determination and the constitutional right to privacy.⁹⁷

One of the best known commentators concerning the law as it affects the elderly, Robert Brown, has noted that although natural death directives and living wills are similar in purpose and content, there is a significant difference between the two.⁹⁸ In some states where living wills are not legally binding, natural death directives have been expressly authorized by legislatures⁹⁹ and are therefore binding upon patients, doctors, and hospitals in those states. However, no natural death act now in force deals with all the possible issues to be raised when living wills are used without any particular statutory sanction.¹⁰⁰ On the other hand, where living will legislation is binding, penalties are imposed on physicians and health care providers who refuse to act in accordance with stated living will provisions (such as transfer-

94. THE LIVING WILL AND OTHER ADVANCE DIRECTIVES, *supra* note 92, at 5.

95. For a list of statutes, see *supra* note 13.

96. See, e.g., *Union Pac. Ry. v. Botsford*, 141 U.S. 250, 251 (1891) (refusing to compel a personal injury plaintiff to undergo pretrial medical examination); *Schloendorff v. Society of New York Hosp.*, 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914) (recognizing the individual's strong interest in being free from nonconsensual invasions of his bodily integrity).

97. Comment, *Natural Death Legislation in Illinois — The Illinois Living Will Act*, 1984 So. ILL. U.L.J. 465, 468 (1984). See *Doe v. Bolton*, 410 U.S. 179, 213 (1973) (Douglas, J., concurring) (the term "liberty" as used in the fourteenth amendment includes "the freedom to care for one's health and person").

98. R. BROWN, *supra* note 10, at 339.

99. DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT, *supra* note 21, at 141.

100. *Id.*

ring the patient to a doctor who will comply with the patient's directives).¹⁰¹

Rather than defining the exact scope of a patient's rights (a topic outside the limitations of this Article), the purpose here is to indicate the status of current common law and statutory efforts to protect a patient's rights. Within that framework, it is necessary to address these rights when a patient is competent, as well as to discuss the problems which arise in attempting to sustain those rights when the individual becomes incapacitated.

The law is well established that competent adult patients have the right to determine medical treatment given to them. The doctrine of informed consent means that a physician may not treat a patient until he has disclosed and explained the risks and material facts concerning the treatment and thereafter has secured his patient's consent.¹⁰² This right to decide on one's own medical treatment is based on the common law right of bodily self-determination¹⁰³ and the constitutional right of privacy which encompasses the right to refuse medical treatment.¹⁰⁴

In 1914, Justice Cardozo took the argument one step further in *Schloendorff v. Society of New York Hospital*:

Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault, for which he is liable in damages.¹⁰⁵

No fundamental right is absolute, and the state in fact retains certain bedrock interests in medical decisionmaking.¹⁰⁶

101. *Id.*

102. R. BROWN, *supra* note 10, at 329.

103. See, e.g., *Schloendorff v. New York Hosp.*, 211 N.Y. 125, 130, 105 N.E. 92, 93 (1914); *In re Storar*, 52 N.Y.2d 363, 376, 420 N.E.2d 64, 70, 438 N.Y.S.2d 266, 272, *cert. denied*, 454 U.S. 858 (1981).

104. See, e.g., *Severns v. Wilmington Medical Center, Inc.*, 421 A.2d 1334 (Del. 1980); *In re Severns*, 425 A.2d 156 (Del. Ch. 1980); *Satz v. Perlmutter*, 362 So. 2d 160 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980); *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976); *In re Colyer*, 99 Wash. 2d 114, 660 P.2d 738 (1983); *Doe v. Bolton*, 410 U.S. 179, 213 (1973).

105. *Schloendorff*, 211 N.Y. at 129-30, 105 N.E. at 93.

106. For a discussion of the state's fundamental interests in medical decisions and the individual's right to refuse treatment, see Note, *In re Conroy: A Limited Right to Withhold or Withdraw Artificial Nourishment*, 6 PACE L. REV. 219, 224 n.23 (1986) (dis-

The state's interest in preserving life is considered the most significant.¹⁰⁷ However, no state interest has ever been held by an appellate court to outweigh a competent patient's right to refuse treatment — unless such refusal would endanger the life of an innocent third party. With the exception of Arkansas and Idaho, the states that have passed living will/natural death acts have incorporated provisions excluding pregnant women from exercising the right to forego treatment during the pregnancy.¹⁰⁸

Clearly, the Karen Ann Quinlan case¹⁰⁹ served as the strongest impetus for this type of legislation under the aegis of the constitutional right to privacy. In commenting on this case and the initial opposition to living will-type legislation, Lawrence Tribe has noted:

There may nonetheless be grounds to suspect that those seeking to secure their own rights to execute "living wills" are at a disadvantage in the political process, in part because the issue is one to which most people will be indifferent (or which they will deliberately avoid) until they are hardly in a position to be politically active, and in part because highly organized opposition groups may regard the issue as inseparable from such questions as abortion.¹¹⁰

The organized opposition of which Tribe speaks has since dramatically diminished, primarily as a result of rulings that followed the *Quinlan* case in other jurisdictions. Some of these rulings ironically caused major opponents of living will legislation from organized religious groups to recant their positions.¹¹¹ However, the positions taken by organized churches are becoming more narrowly defined as the term "living will" is further distinguished from other advance directives, such as the do-not-resuscitate orders. These will be discussed below in the context

cussing *Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977)).

107. See *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 741, 370 N.E.2d 417, 425 (1977).

108. See, e.g., MO. ANN. STAT. § 459.025 (Supp. 1987); N.H. REV. STAT. ANN. § 137-H:14(1) (Supp. 1986); UTAH CODE ANN. § 75-2-1109 (Supp. 1987).

109. *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976).

110. L. TRIBE, *AMERICAN CONSTITUTIONAL LAW* § 15-11, at 937 (1978) (footnote omitted).

111. See Paris & McCormick, *Living Will Legislation Reconsidered*, AMERICA, Sept. 5, 1981, at 86-87.

of more recent acts and decisions.¹¹²

The right of an individual to refuse to be touched or treated in any manner protects an individual from coercive acts. The growing number of United States Supreme Court decisions delineating an individual's right of privacy has provided a basis for court decisions not to intervene in the termination of life-sustaining treatment or not to prevent such termination.¹¹³ The Supreme Court has consistently recognized the existence of a right of privacy (though not an express right), deriving that right from several sources, including the "penumbra" of the first, fourth, fifth, ninth, and fourteenth amendments.¹¹⁴

Each state with living will legislation generally provides a definition of key terms used in its natural death laws.¹¹⁵ In virtually every opening statement of legislative intent, each state has recognized that adult persons have the fundamental right to control decisions relating to their own medical care, including the right to make a written directive or declaration instructing their physicians to withhold or withdraw life-sustaining procedures in the event of a *terminal* condition.¹¹⁶ Generally, life-sustaining procedures or mechanisms are defined to include any medical treatment, procedure, or intervention which uses mechanical or other artificial means to sustain, restore, or supplant a spontaneous vital function.¹¹⁷

The provisions of each of the thirty-nine laws in existence at this writing establish that a legal document is being executed. The declarant states that he or she is of sound mind and that the declaration is being made voluntarily.¹¹⁸ Procedurally, many states require the elements of execution identical to those for

112. See *infra* text accompanying notes 195-198, 278, 295-296.

113. See generally Martyn & Jacobs, *Legislating Advance Directives for the Terminally Ill: The Living Will and Durable Power of Attorney*, 63 NEB. L. REV. 779 (1984); Comment, *Right to Die: Procedure for the Exercise of the Terminally Ill Incompetent Patient's Right to Refuse Treatment*, 23 WASHBURN L.J. 719 (1984).

114. *Griswold v. Connecticut*, 381 U.S. 479, 484 (1965); *Roe v. Wade*, 410 U.S. 113 (1973); *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976).

115. See Note, *Natural Death Legislation in Illinois*, *supra* note 97, at 465 n.2.

116. See, e.g., CAL. HEALTH & SAFETY CODE § 7186 (West Supp. 1987); DEL. CODE ANN. tit. 16, § 2502 (1983); VA. CODE ANN. § 54-325.8:1 (Supp. 1987).

117. See, e.g., CAL. HEALTH & SAFETY CODE § 7187(c) (West Supp. 1987); DEL. CODE ANN. tit. 16 § 2501(d) (1983); VA. CODE ANN. § 54-325.8:2 (Supp. 1987).

118. See, e.g., D.C. CODE ANN. § 6-2422 (Supp. 1987); GA. CODE ANN. § 31-32-3 (Supp. 1987); IDAHO CODE § 39-4504 (Supp. 1987).

testamentary documents: the living will must be signed and witnessed.¹¹⁹ In only two states is an oral declaration, properly witnessed, acceptable.¹²⁰ All of the states require at least two adult witnesses (three in South Carolina) and in the majority of states, these witnesses may not be any individual who has an interest in the declarant's estate, anyone related by blood or marriage to the declarant, or anyone who may have a claim against the estate.¹²¹ Although it is impossible to list all of the legislative differences, a brief review of several variables in living will legislation can provide a perspective of the consequences at issue.

In a number of states, only one attending physician is required to diagnose a patient's condition as terminal.¹²² In Maryland,¹²³ two physicians must make the certification; in Mississippi,¹²⁴ the diagnosis of a terminal condition by the attending physician must be verified by two other physicians. The majority of states require the declarant to be a competent adult.¹²⁵ One of the few universal provisions is that living wills are revocable.¹²⁶

In Virginia¹²⁷ and Louisiana,¹²⁸ the statutes outline a nonjudicial procedure authorizing another person to make a declaration on behalf of an incompetent patient who has not made a previous declaration. Louisiana permits a spouse, parent, sibling, adult child of the patient, or a judicially appointed surrogate to make a declaration on a patient's behalf if he is comatose or unable to communicate.¹²⁹ Two physicians must further certify

119. See, e.g., ARIZ. REV. STAT. ANN. § 36-3202(A) (1986); IND. CODE ANN. § 16-8-11(b)(3), (5) (Burns Supp. 1987); OKLA. STAT. ANN. tit. 63, § 3103(A) (West Supp. 1987); TEX. STAT. ANN. art. 4590h(3)(a) (Supp. 1987).

120. LA. REV. STAT. ANN. § 40:1299.58.2(2) (West Supp. 1987); VA. CODE ANN. § 54-325.8:3 (Supp. 1987).

121. See, e.g., ALA. CODE § 22-8A-4(a) (1984); DEL. CODE ANN. tit. 16, § 2503(b)(1) to (3) (1983).

122. See, e.g., ILL. ANN. STAT. ch. 110½, para. 701 to 710 (Smith-Hurd Supp. 1987).

123. MD. HEALTH-GEN. CODE ANN. § 5-602(c) (Supp. 1987).

124. MISS. CODE ANN. §§ 41-41-101 to 41-41-121 (Supp. 1986).

125. See, e.g., GA. CODE ANN. § 31-32-3 (Supp. 1987); IOWA CODE ANN. § 144A.3 (West Supp. 1987); ME. REV. STAT. ANN. tit. 22, § 2922 (Supp. 1987).

126. See Kite, *The Right to Die a Natural Death and the Living Will*, 13 TEX. TECH. L. REV. 99 (1982).

127. VA. CODE ANN. § 54-325.8:6 (Supp. 1987).

128. LA. REV. STAT. ANN. § 40:1299.58.5 (West Supp. 1987).

129. *Id.* § 40:1299.58.5(A)(2).

that the patient has a terminal and irreversible condition.¹³⁰ In California¹³¹ and Georgia,¹³² the declaration expires after a stated period and must be reexecuted.

About one-third of the states make legal provisions for fines and imprisonment or other sanctions in the case of physicians who do not adhere to the patient's rights as set forth in its living will legislation.¹³³ One of the newer provisions concerning the elderly in nursing homes or long term care facilities mandates the co-signing of a declaration by the institutional ombudsman as well as two other qualified witnesses.¹³⁴ One major drawback in this legislation is that only two states, Maine¹³⁵ and Maryland,¹³⁶ specifically recognize living will documents executed out of state. In all other states, if an individual becomes comatose or incompetent in a state other than the one in which the living will was executed, the sister state has no obligation to give force and effect to the declaration.

Unlike the California statute which has been characterized as representing "a form of unwarranted paternalism,"¹³⁷ the Louisiana Natural Death Act permits a person to prepare a declaration at any time.¹³⁸ The directive is valid and does not require a waiting period.¹³⁹ Louisiana followed the lead of Delaware¹⁴⁰ by providing for the appointment of a surrogate decisionmaker if the declarant becomes incompetent.¹⁴¹ This aspect of living will legislation is perhaps more critical than any other component in dealing with the elderly.

Louisiana's natural death act, while relying on the Model Medical Treatment Decision Act, avoids many of the pitfalls of

130. *Id.* § 40:1299.58.3(C)(1).

131. CAL. HEALTH & SAFETY CODE § 7189.5 (West Supp. 1987).

132. GA. CODE ANN. § 31-32-6 (1985).

133. *See, e.g.*, IND. CODE ANN. §§ 16-8-11 to 16-8-22 (Burns Supp. 1987); ME. REV. STAT. ANN. tit. 22, § 2928 (Supp. 1987); TENN. CODE ANN. § 32-11-108 (Supp. 1987).

134. *See, e.g.*, CAL. CIVIL CODE § 2432(f) (West Supp. 1987); D.C. CODE ANN. § 6-2423 (Supp. 1987); DEL. CODE ANN. tit. 16, § 2506(c) (1983).

135. ME. REV. STAT. ANN. tit. 22, § 2930 (Supp. 1987).

136. MD. HEALTH-GEN. CODE ANN. § 5-612(b) (Supp. 1987).

137. Vitiello, *Louisiana's Natural Death Act and Dilemmas in Medical Ethics*, 46 LA. L. REV. 259, 272 (1985).

138. LA. REV. STAT. ANN. § 40:1299.58.3(A) (West Supp. 1987).

139. *Id.*

140. DEL. CODE ANN. tit. 16, § 2502(b) (1983).

141. LA. REV. STAT. ANN. § 40:1299.58.3(c) (West Supp. 1987).

the earlier acts . . . Louisiana recognizes the right of self-determination when an individual is not faced with a diagnosis of terminal illness. In place of a waiting period, the Louisiana act makes the revocation of an advance directive extremely easy. The Act also gives express recognition of the right of a competent adult to make an oral declaration when so incapacitated that he cannot prepare a written document. The required formalities limit the possibility that a patient will refuse painful treatment in a moment of stress.¹⁴²

The major weakness in this type of legislation is the fact that natural death acts are not drafted to encompass every potentially complicated situation. Courts will, of necessity, continue their struggle to strike a balance between a right to refuse medical treatment and ethical prohibitions against euthanasia.

When statutory language becomes narrowly restrictive, it is virtually inapplicable. The Executive Director of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical Research noted early on that "[t]he intent of these statutes is simple . . . [to] mak[e] Living Wills legally binding documents. Yet the resulting statutes are, in my view, so cumbersome and restrictive as to be useless at best, and possibly very mischievous."¹⁴³ As outlined in the provisions noted above, Louisiana's natural death act is perhaps the most comprehensive legislation yet passed in this area.

B. *Problems of Incompetency*

In the context of foregoing life-sustaining treatment for incompetent patients, most courts that have addressed the issue have explicitly stated that patients do not lose their constitutional or common law rights by virtue of incompetency.¹⁴⁴ Al-

142. Vitiello, *supra* note 137, at 275.

143. Capron, *Borrowed Lessons: The Role of Ethical Dimensions in Framing Law on Life-Sustaining Treatment*, ARIZ. STAT. L.J. 647, 652 (1985).

144. See, e.g., *Canterbury v. Spence*, 464 F.2d 772, 789 n.92 (D.C. Cir. 1972), *cert. denied*, 409 U.S. 1064 (1972) (asserting that "absent an emergency, the physician must obtain the necessary authority from a relative" before treating an incapacitated patient); *Karp v. Cooley*, 349 F. Supp. 827, 835 (S.D. Tex. 1972), *aff'd*, 493 F.2d 408 (5th Cir. 1974), *reh'g denied*, 496 F.2d 878 (5th Cir. 1974), *cert. denied*, 419 U.S. 845 (1974) (physician's conveying of information to patient's wife does not obviate his duty to seek informed consent of the patient-husband); *Superintendent of Belchertown v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977) (recognizing strong interest of a person in being

though the right of privacy has not been expanded to read the "right to die," the right to refuse medical treatment has been extended to incompetent patients in many states,¹⁴⁵ but that right must be exercised by a representative on the incompetent's behalf.

In two states,¹⁴⁶ the living will/natural death acts have established a list of relatives who have the power to give substituted consent. Unfortunately, in the majority of states, there are no statutes stipulating who can give consent for an incapacitated patient.

The President's Commission, along with many courts, has recognized that family members are usually appropriate surrogate decisionmakers. The Commission observed that "[i]n [its] view, the cumbersomeness and costs of legal guardianship strongly militate against its use and ought to be taken into account by lawmakers before they require that decisions about life-sustaining treatment be made by judicially appointed guardians."¹⁴⁷ The Commission also suggested that courts are ill-equipped to assume the role of substitute decisionmaker.¹⁴⁸

The courts have leaned upon common law doctrine to establish standards for cases dealing with incompetent patients. The two standards that have traditionally been used to guide decisionmaking for incompetent patients are the best interests standard and the substituted judgment standard.¹⁴⁹ The best inter-

free from nonconsensual invasion of bodily integrity as a basis for the interest of the individual in refusing medical treatment); *Severns v. Wilmington Medical Center, Inc.*, 421 A.2d 1334, 1347 (Del. 1980) (based upon the constitutional right of privacy, husband could assert any constitutional right to which wife was entitled concerning termination of life support systems); *In re Colyer*, 99 Wash. 2d 114, 121, 660 P.2d 738, 743 (1983) (overruled on other grounds); *In re Hamlin*, 102 Wash. 2d 810, 689 P.2d 1372 (recognizing common-law right to be free from bodily invasion as alternative basis for the right to refuse life-sustaining treatment); *In re Conroy*, 98 N.J. 321, 348, 486 A.2d 1209, 1223 (1985) (noting that the right to decline medical treatment is embraced within the common-law right of a person to control his own body).

145. See, e.g., *Severns*, 421 A.2d at 1347; *Leach v. Akron Gen. Medical Center*, 68 Ohio Misc. 1, 12, 426 N.E.2d 809, 816 (1980); *In re Storar*, 52 N.Y.2d at 376-79, 420 N.E.2d at 70-72, 438 N.Y.S.2d at 272-74.

146. ARK. STAT. ANN. § 82-3803 (Supp. 1987); LA. REV. STAT. ANN. § 40:1299.58.5 (A)(2) (West Supp. 1987).

147. DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT, *supra* note 21, at 131.

148. *Id.* at 126-32.

149. *Id.* at 132-36.

ests standard is an objective test which seeks to determine what would be most beneficial to the patient "according to societally shared criteria."¹⁵⁰ More commonly used is the substituted judgment standard, where the decisionmaker attempts to reach the decision the patient would reach if he or she were able to decide.¹⁵¹ The goal is to preserve the right of self-determination to the extent possible, considering that the patient is incapable of making a contemporaneous decision.¹⁵² While cases have grown in number, this is still an unsettled area of law. In reviewing some of these cases, this Article now focuses on those in which the interests of elderly patients have been at stake.

In *Lane v. Candura*,¹⁵³ the Massachusetts appeals court held that the irrationality of a patient's decision not to submit to surgical amputation of her leg — a decision which would result in her death — did not justify the conclusion that the patient's capacity to make a decision was impaired to the point of legal incompetence. Mrs. Candura was a seventy-seven-year-old widow, a diabetic suffering from gangrene in the right foot and lower leg. She had been depressed since losing her husband two years earlier and had already undergone two smaller amputations for a toe and part of her foot. Prior to the medical circumstances of the case, she had stated her belief that the operation would not cure her and she did not wish to live as an invalid in a nursing home.¹⁵⁴ The court noted that her competence was not questioned until she changed her original decision and withdrew her consent to the amputation.¹⁵⁵ Noting that Mrs. Candura had no obligation to agree with her doctors, but only to make an informed decision, the appeals court upheld her right to refuse the operation, knowing full well the consequences.¹⁵⁶

The Ohio County Court of Common Pleas held in *Leach v. Akron General Medical Center*¹⁵⁷ that the constitutional right

150. See Simpson, *Living Wills: A Matter of Life and Death*, 125 TRUSTS & ESTATES 10, 12.

151. DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT, *supra* note 21, at 132.

152. *Id.* at 132-33.

153. 6 Mass. App. Ct. 377, 376 N.E.2d 1232 (1978).

154. *Id.* at 381, 376 N.E.2d at 1234.

155. *Id.* at 383, 376 N.E.2d at 1235.

156. *Id.* at 385, 376 N.E.2d at 1236.

157. 68 Ohio Misc. 1, 426 N.E.2d 809 (1980).

to privacy guarantees the right of a terminally ill and permanently semicomatose person to decide his or her own treatment and that an order authorizing discontinuation of a respirator sustaining the life of a seventy-seven-year-old patient was appropriate in recognition of those rights.¹⁵⁸

Neither the Ohio Supreme Court nor the Ohio General Assembly has yet spoken on the topic of life-support systems or the right of a terminally ill patient to determine his own choice of treatment or refusal of treatment, although legislation has been introduced into the Ohio Assembly and various groups have urged its adoption.¹⁵⁹ Mrs. Leach was suffering from Lou Gehrig's disease (amyotrophic lateral sclerosis) and had been hospitalized, during which time she experienced cardiac arrest. Although physicians revived her, her condition warranted placement on a life-support system. After she had lapsed into a chronic vegetative state, her husband sought and received appointment as her guardian. He then brought an action to discontinue his wife's life-support system.¹⁶⁰

The weakness in *Leach*, as one reviewer has noted, is that it is a trial court decision and therefore is not binding precedent on any court in Ohio.¹⁶¹ In addition, the case addresses only the rights of a limited class of patients who are either terminally ill, comatose, or maintained on life-support systems.¹⁶² The question of patient treatment options before life-supports are applied is still unresolved.

The Supreme Court of Washington has held that where family members were available, some member of the family may become the surrogate decisionmaker for the incompetent patient — without prior court appointment as guardian.¹⁶³ Where no family members exist, a court-appointed guardian would be necessary.¹⁶⁴ The court adopted the view that life-sustaining treatment could be withdrawn where a court or guardian found

158. *Id.*

159. Note, *Toward an Ohio Natural Death Act: The Need for Living Will Legislation*, 46 OHIO ST. L.J. 1019, 1032 (1985).

160. *Leach*, 68 Ohio Misc. at 2-3, 426 N.E.2d at 810-11.

161. Note, *supra* note 159, at 1021.

162. *Id.*

163. *In re Colyer*, 99 Wash. 2d 114, 660 P.2d 738 (1983).

164. *In re Hamlin*, 102 Wash. 2d 810, 689 P.2d 1372 (1984).

that the patient would choose to have treatment discontinued if competent, and at least three physicians concurred in the opinion that the patient's condition was incurable and that there was no reasonable medical probability of a return to a cognitive, sapient state.¹⁶⁵ In other nonfamily situations, no judicial approval would be needed, provided a hospital prognosis committee unanimsously concurred in a decision to withdraw such treatment.¹⁶⁶

There are only a few cases in which the validity and enforceability of living wills have actually been litigated. One recent case, *In re Saunders*, will be discussed in another section.¹⁶⁷ However, in *John F. Kennedy Memorial Hospital v. Bludworth*,¹⁶⁸ the Supreme Court of Florida in 1984 held that an incompetent's duly executed five-year-old living will could be persuasive evidence of his wishes and should be given great weight by those who held the decisionmaking reins.¹⁶⁹ The court authorized the termination of life-support systems and held that the right to forego such treatment could be exercised by a family member or a guardian appointed by the court.¹⁷⁰ The court further explained that incompetent persons being sustained through the use of extraordinary artificial means have the same right to refuse to be held on the threshold of death as terminally ill competent patients.¹⁷¹

In *In re Hier*,¹⁷² a Massachusetts appeals court authorized drug therapy for an incompetent patient. However, the court would not authorize a highly intrusive surgical procedure needed to provide adequate nutrition.¹⁷³ Mary Hier was ninety-two years old and had a long history of severe mental illness that had kept her in a psychiatric hospital for fifty-seven years. The court ruled that a temporary guardian should be appointed with power to authorize the drug therapy. The guardian would not have authority, however, to consent to surgical procedures re-

165. *In re Colyer*, 99 Wash. 2d at 136-37, 660 P.2d at 750-51.

166. *In re Hamlin*, 102 Wash. 2d at 819-21, 689 P.2d at 1378.

167. 129 Misc. 2d 45, 492 N.Y.S.2d 510 (Sup. Ct. 1985). See *infra* notes 214-221.

168. 432 So. 2d 611 (Fla. Dist. Ct. App. 1983), *rev'd*, 452 So. 2d 921 (Fla. 1984).

169. *Id.* at 620.

170. *Id.*

171. *Id.* at 614-15.

172. 18 Mass. App. Ct. 200, 464 N.E.2d 959, *review denied*, 392 Mass. 1102, 465 N.E.2d 261 (1984).

173. *Id.* at 208, 464 N.E.2d at 964.

quired for her to receive adequate nutrition.¹⁷⁴ Applying a substituted judgment analysis,¹⁷⁵ the court found that the patient's circumstances indicated she would not consent to surgical treatment if she were competent.¹⁷⁶

Mrs. Hier had been receiving nutrition by means of a feeding tube surgically implanted into her stomach through her abdominal wall, but she had repeatedly pulled out the tube.¹⁷⁷ She had refused to consent to reinsertion of the tube which would have necessitated a highly intrusive procedure, one which the court concluded would be "onerous and burdensome."¹⁷⁸ In addition, the court found no third parties whose interests required protection, nor did it find any state interest in the preservation of life which was strong enough to overcome the patient's wishes, indicating that the treatment would only extend her suffering.¹⁷⁹

A New Jersey case which has generated a great deal of attention may indicate another direction evolving law may take.¹⁸⁰ In *In re Conroy*,¹⁸¹ one of the key points the court considered was the type of treatment sought to be withdrawn — in this case, nourishment through a nasogastric tube.

Mrs. Conroy was eighty-four years old, incompetent, and suffering from heart disease, hypertension, diabetes, and a gangrenous leg. The doctors expected her death to occur within a year. Her nephew, who had previously been appointed her guardian, sought the removal of the feeding tube. The trial court granted the nephew's petition and permitted the removal of the feeding tube.¹⁸² However, the intermediate appellate court reversed, on the grounds that the right to terminate treatment in New Jersey was limited to brain-dead or terminal patients, not someone in Mrs. Conroy's condition.¹⁸³ The New Jersey Su-

174. *Id.* at 201, 464 N.E.2d at 960.

175. See *supra* text accompanying notes 149-151.

176. 18 Mass. App. Ct. at 203, 464 N.E.2d at 961.

177. *Id.* at 201, 464 N.E.2d at 960.

178. *Id.* at 208, 464 N.E.2d at 964.

179. *Id.* at 210, 464 N.E.2d at 965.

180. Simpson, *supra* note 150, at 14.

181. 98 N.J. 321, 486 A.2d 1209 (1985).

182. *In re Conroy*, 188 N.J. Super. 523, 532, 457 A.2d 1232, 1237 (Super. Ct. Ch. Div. 1983).

183. *In re Conroy*, 190 N.J. Super. 453, 476, 464 A.2d 303, 315 (Super. Ct. App. Div.

preme Court reversed, ruling that the feeding tube could be removed.¹⁸⁴ In one of the tests specifically stated, the court noted that a living will should embody a patient's desire for withdrawal or withholding of a life-sustaining treatment.¹⁸⁵ This approach is most significant in the fact that New Jersey is one of the twelve remaining states without living will legislation.

The *Conroy* decision has been interpreted by some to be limited to nursing home residents who are elderly and incompetent, and who have a limited life expectancy.¹⁸⁶ Very specific procedures must be followed and certain tests met. As one commentator has noted:

The *Conroy* court spoke to cases of nursing home residents whose mental and physical functioning is severely and permanently impaired, and whose life expectancy is relatively short. Medical decisions must inevitably be made by some agent on behalf of such incompetent residents. The social isolation of such persons, their impairments, and the limited presence of medical staff all prompted the court to erect significant procedural, as well as substantive, hurdles to decisions to withdraw life-preserving treatment.¹⁸⁷

A few lower courts have issued opinions on the enforceability of living wills. In one Arizona case, the court ordered a hospital and its employees to stop providing medical treatment against a patient's will and against the instructions of the patient's daughter.¹⁸⁸ The patient had executed a living will while competent and the court upheld its provisions.¹⁸⁹

1983).

184. *In re Conroy*, 98 N.J. at 388, 486 A.2d at 1244.

185. *Id.* at 361, 486 A.2d at 1229.

186. See Comment, *Natural Death: An Alternative in New Jersey*, 73 GEO. L.J. 1331, 1332 (1985); Note, *In re Conroy: A Limited Right to Withhold or Withdraw Artificial Nourishment*, 6 PACE L. REV. 219, 220 (1986).

187. Cantor, Conroy, *Best Interests, and the Handling of Dying Patients*, 37 RUTGERS L. REV. 543, 554 (1985).

188. *Lurie v. Samaritan Health Serv.*, No. C510198 (Maricopa County Superior Ct., Ariz., 1984).

189. *Id.*

C. *Current Case Law in New York*

New York currently has no living will or natural death statute. In addition, New York has not yet recognized the substituted judgment standard which was recommended by the President's Commission and which is presently followed by all other courts that have addressed the issue.¹⁹⁰

However, since *Schloendorff*,¹⁹¹ New York has recognized the common-law right to decline life-saving medical treatment by imposing civil liability on those who provide medical treatment without consent. In a more recent case, prior to all of the living will statutes in other states, the New York court upheld this common-law right in considering the plight of an eighty-year-old woman whose two sons wanted her physicians to amputate her gangrenous leg because they believed she would die otherwise.¹⁹² The mother did not want the surgery, and her third son, who was a physician, opposed the operation as well because he did not consider the mother's condition terminal.¹⁹³ The court declined to authorize the operation based upon its respect for the mother's wishes and its own conclusion that the operation was not necessary to save her life.¹⁹⁴

In 1977, the New York State Assembly attempted to pass a living will bill. However, a powerful lobbying effort against the bill was launched by Right-to-Life groups and several Roman Catholic organizations.¹⁹⁵ The bill would have permitted an individual to make a "living will," directing that life-sustaining procedures be discontinued if use of such measures would cause loss of patient dignity and unnecessary pain and suffering, while providing nothing medically necessary or beneficial to the patient.¹⁹⁶ The bill was resoundingly defeated, and its sponsors accused lobbyists of a misinformation campaign that portrayed the bill as a measure to legalize euthanasia.¹⁹⁷ However, after courts across the country ruled in some similar cases, two representa-

190. See *supra* text accompanying notes 147-151.

191. *Schloendorff v. New York Hosp.*, 211 N.Y. 125, 105 N.E. 92 (1914).

192. *In re Nemser*, 51 Misc. 2d 616, 273 N.Y.S.2d 624 (Sup. Ct. 1966).

193. *Id.* at 617, 273 N.Y.S.2d at 625.

194. *Id.* at 623-25, 273 N.Y.S.2d at 630-32.

195. N.Y. Times, May 5, 1977, at B26, col. 1.

196. *Id.*

197. *Id.*

tive Catholic theologians reversed their positions:

Our experience of recent rulings by the Florida (Satz v. Perlmutter), Delaware (Severns v. Wilmington Medical Center) and New York (Eichner v. Dillon) Supreme Courts on the need for legislative direction on these questions, and the fact that an overwhelming number of physicians, attorneys and legislators continue to believe an individual's statement has no legitimacy without a statutory enactment, force us to revise our previous opposition to this legislation.

. . . .

With the legislative recognition of the dignity and natural moral rights of the person and the carefully drawn provisions to protect those without living wills and to prohibit any form of active euthanasia, we find no substantial reason for continued opposition to living will legislation. Indeed, we believe that the probability of continued court involvement in this area makes it prudent to support well-delineated legislation rather than to leave the determination of patients' rights to the vagaries of conflicting court rulings.¹⁹⁸

In blood transfusion cases where competent adults have refused treatment based on religious beliefs, the New York courts have continued to uphold the right of refusal.¹⁹⁹ Subsequently, in *In re Lydia E. Hall Hospital*,²⁰⁰ a forty-one-year-old competent patient made a decision to refuse further hemodialysis in what can only be considered one of the most devastating cases outlining the multiple life-threatening conditions brought on by juvenile diabetes, from which this patient suffered for thirty-five years. The patient had discussed his decision to withdraw from treatment repeatedly with members of his family and with priests within the months leading up to his becoming comatose. The court denied the hospital's petition to continue dialysis, noting that competent adults have the right of self-determination and cannot be subjected to medical treatment without their consent.²⁰¹

198. Paris & McCormick, *supra* note 111, at 86-87.

199. *See, e.g.*, Erikson v. Dilgard, 44 Misc. 2d 27, 252 N.Y.S.2d 705 (Sup. Ct. 1962); *In re Melideo*, 88 Misc. 2d 974, 390 N.Y.S.2d 523 (Sup. Ct. 1976).

200. 116 Misc. 2d 477, 455 N.Y.S.2d 706 (Sup. Ct. 1982).

201. *Id.* at 488, 455 N.Y.S.2d at 712-13.

In a landmark New York case, *In re Storar*,²⁰² the court of appeals refused to accept a right of privacy argument as a basis for permitting the withdrawal of life-prolonging treatment. *Storar* consolidated two appellate division cases, *In re Storar* and *In re Eichner*,²⁰³ and imposed a clear and convincing evidence standard based upon a common-law right of bodily self-determination. Addressing *Eichner*,²⁰⁴ the court of appeals did approve the removal of a respirator from eighty-three-year-old Brother Fox, who had been diagnosed as being in a permanent vegetative state after surgery. Brother Fox had publicly expressed the view prior to his surgery, and particularly in light of the circumstances of the *Quinlan* case, that he did not want to be maintained on a life-support system when there was no hope of recovery.²⁰⁵ The court determined that, based on the clear and convincing proof of Brother Fox's feelings on the matter, the priest was entitled, through his guardian, Father Eichner, to the relief sought.²⁰⁶

This same clear and convincing evidence standard was applied by the court of appeals in addressing the companion case, *In re Storar*.²⁰⁷ However, the court reversed the appellate division decision, which had allowed a mother to deprive her incompetent child of life-saving blood transfusions.²⁰⁸ Moreover, the court explicitly rejected both the best interests and substituted judgment standards,²⁰⁹ finding there were no prior statements available for the court's review since *Storar* had been incompetent his entire life. The court refused any further exploration of the substituted judgment rationale and ordered continuation of the disputed treatment based on the state's *parens patriae* power.²¹⁰

In a recent New York case concerning a woman quadriplegic

202. 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981).

203. The two appellate cases were *In re Storar*, 78 A.D.2d 1013, 434 N.Y.S.2d 46 (4th Dep't 1980) and *In re Eichner*, 73 A.D.2d 431, 426 N.Y.S.2d 517 (2d Dep't 1980).

204. *In re Storar*, 52 N.Y.2d at 369-70, 420 N.E.2d at 66-67, 438 N.Y.S.2d at 268-69.
205. *Id.* at 371-72, 420 N.E.2d at 68, 438 N.Y.S.2d at 270.

206. *Id.* at 376-80, 420 N.E.2d at 70-72, 438 N.Y.S.2d at 272-74.

207. *Id.* at 380, 420 N.E.2d at 72, 438 N.Y.S.2d at 274.

208. *Id.* at 375, 420 N.E.2d at 70, 438 N.Y.S.2d at 272.

209. *See supra* text accompanying notes 149-151.

210. *In re Storar*, 52 N.Y.2d at 380-81, 420 N.E.2d at 72-73, 438 N.Y.S.2d at 274-75.

who was not hospitalized but who characterized her state as a "living hell,"²¹¹ the supreme court in Schenectady County held that it could not grant a patient's request for an order allowing her to refuse future medical treatment and nourishment in the absence of an actual and real controversy.²¹² In that case, the court ended its opinion by requesting that the legislature create some type of special proceeding whereby a person could obtain an order along the lines sought there by the petitioner.²¹³

Perhaps the most important case in terms of future legislative action is *In re Saunders*,²¹⁴ heard by the supreme court in Nassau County in 1985. Selma Saunders, age seventy, petitioned the New York court to determine the validity and effectiveness of a living will which she had executed while living in Pennsylvania. This case is one of the very rare instances in which a specific living will document has been brought into court for adjudication.

Saunders was suffering from emphysema and lung cancer and was confined to her daughter's home in New York.²¹⁵ Her condition was described as being "progressive and without current known medical cure."²¹⁶

In April, 1984, Mrs. Saunders had prepared and executed a living will providing in pertinent part:

"If, due to injury or illness, . . . I become incompetent, and my condition becomes such that . . . I am in an irreversible coma . . . or . . . I have been continuously unconscious for a period of one (1) week . . . or . . . my condition is terminal and hopeless and death is imminent; then, as of that time, I withdraw my actual and implied consent to and substitute this REFUSAL of, all further treatment of me by artificial means and devices."²¹⁷

The State of New York, which had been named as defendant, asserted that there was no justiciable controversy.²¹⁸ However, the court found that "the underlying issue is of public im-

211. *A.B. v. C.*, 124 Misc. 2d 672, 673, 477 N.Y.S.2d 281, 282 (Sup. Ct. 1984).

212. *Id.* at 674, 477 N.Y.S.2d at 283.

213. *Id.* at 676, 477 N.Y.S.2d at 284.

214. 129 Misc. 2d 45, 492 N.Y.S.2d 510 (Sup. Ct. 1985).

215. *Id.* at 46, 492 N.Y.S.2d at 511.

216. *Id.*

217. *Id.* at 47, 492 N.Y.S.2d at 512.

218. *Id.* at 48, 492 N.Y.S.2d at 512.

portance and is of a recurring nature of a type that is likely to escape any appropriate court review or determination, because it reaches the court at a time when it is really too late for the court to afford any meaningful relief."²¹⁹ Although New York did not have living will/natural death legislation to enforce in this case, the court held that such a document is in the nature of an informed medical consent statement which offers sufficiently "clear and convincing evidence" of a patient's rational and knowing decision to decline specified medical treatment, and that no further judicial intervention would be needed for a physician, health care professional, or institution to act in accord with the patient's expressed preferences.²²⁰ The court noted particularly a judicial responsibility to create guideposts, in the absence of legislation, that will help protect people's interests in determining the course of their own lives. In a plea to the legislature, Justice McCaffrey stated:

It would, of course, be best if the Legislature formulated clear standards for resolving requests to terminate life-sustaining treatment for incompetent patients. As the elected law-making representatives of the People, the Legislature is better suited and equipped than any other single institution to reflect the social value at stake, and it has the resources to collect, compile and analyze the data and opinions and formulate general guidelines that may be applicable to a broad range of situations.²²¹

D. *New York's Interim Experimental Procedure*

The New York courts have continued to grapple with the area of health care decisionmaking. In the case of a once competent patient who is now incompetent, the court of appeals has given the legal and medical professions a clearer standard based on *Eichner*:²²² that each individual's common-law right to decide upon the course of his or her treatment is paramount to the physician's determination of the course of treatment, provided that there is clear and convincing evidence available of that per-

219. *Id.* at 48, 492 N.Y.S.2d at 513.

220. *Id.* at 54-55, 492 N.Y.S.2d at 517.

221. *Id.* at 51-52, 492 N.Y.S.2d at 515.

222. *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981).

son's wishes during a period when he was competent.

However, the courts have not resolved the issues which prevail in cases where the individual has never been competent and is now terminally ill. The court of appeals has not recognized a "substituted judgment" standard, even by court appointed guardians, as the *Storar* decision clearly demonstrates.²²³ To deal with the growing number of incompetent individuals in similar circumstances, the New York State Assembly passed interim legislation, Article 80 of the Mental Hygiene Law.²²⁴ This statute became effective April 1, 1986, and will automatically be deemed repealed on July 1, 1988.²²⁵ Article 80 mandates that the Commission on Quality Care for the Mentally Disabled conduct an independent evaluation and assemble a report regarding the effectiveness of this act, and that its findings be submitted to the Governor and legislature no later than January 31, 1988.²²⁶

The statute provides for the establishment of surrogate decisionmaking committees to be selected by the Commission.²²⁷ These committees are utilized to ensure that health care decisions are based on the "best interests" of the patient and reflect as nearly as possible the patient's own personal beliefs and values.²²⁸ In outlining the statutory purpose, the

legislature further finds and declares that the public interest will be served by the implementation, on a demonstration basis in two limited geographic areas of the state, of a non-judicial surrogate decision-making process, which would determine patient capacity to consent to or refuse medical treatment and assess whether the proposed treatment promotes the patient's best interests, consistent with the patient's values and preferences.²²⁹

There are several drawbacks to this legislation. First, the "experiment" applies only to patients in *state* mental hygiene facilities who lack capacity to consent to or refuse treatment.²³⁰

223. *Id.* at 363, 420 N.E.2d at 64, 438 N.Y.S.2d at 266.

224. N.Y. MENTAL HYG. LAW §§ 80.01 to 80.13 (McKinney Supp. 1988).

225. *Id.* at § 80.01 (note on Effective Date; Expiration; Implementation).

226. *Id.* at § 80.01 (note on Independent Evaluation; Report to Governor and Legislature).

227. *Id.* at § 80.05.

228. *Id.* at § 80.01.

229. *Id.*

230. *Id.* at § 80.03(b).

Secondly, "medical treatment" as defined in the statute specifically does not include the withdrawal or discontinuance of medical treatment which is sustaining life functions.²³¹ This provision clearly limits the statute's scope and leaves open the whole question of protecting a patient's right to self-determination in such circumstances. In addition, the bureaucracy necessitated in the name of protecting the "best interests" of each patient would appear to defeat the statutory purpose, because most terminally ill incompetents will have died or been irretrievably placed on life-support systems by the time the surrogate decisionmaking committees have made the required determination — particularly since these committees must consist of at least twelve persons in two geographic areas of the state.²³² These committees are to operate through panels of four committee members and an elaborate set of procedures for even the initial decision of whether or not a patient is in need of surrogate decisionmaking.²³³ Thus far, no cases have been brought under the provisions of Article 80.

Although, in 1985, the New York representative to the National Conference of Commissioners on Uniform State Laws voted affirmatively to approve the Uniform Rights of the Terminally Ill Act,²³⁴ New York still has not adopted the model act. In addition to promoting statutory uniformity in living will laws, the Act was also designed to provide for "cross-jurisdictional enforcement" of such laws.²³⁵ Unfortunately, the Act fails to address critical policy concerns regarding treatment given to persons who have not or cannot make their treatment preferences known — including those who have not made a declaration, such as a living will, nor those who have always been mentally disabled.²³⁶ It also does not address the issue of proxy treatment decisions. Consequently, in New York, the Attorney General's opinion cited earlier²³⁷ is still the guidepost: although it is not possible to delegate the authority to another to *make* health care

231. *Id.* at § 80.03(a).

232. *Id.* at § 80.05(a).

233. *Id.* at § 80.07(a) to (g).

234. *See supra* note 14 and accompanying text.

235. Marzen, *supra* note 14, at 443.

236. *Id.* at 444.

237. *See supra* notes 83-84 and accompanying text.

decisions, a power of attorney is a viable instrument to *communicate* a health care decision made by a principal. This alternative is less than satisfactory as the cases indicate. New York is critically in need of an effective and comprehensive statutory resolution to the issue of living wills and proxy health care decisionmaking for the elderly and the terminally ill.

V. New York's Legislative Agenda

Perhaps some rationale for New York's failure to make use of the durable power of attorney for health care decisions is fear, from a public policy standpoint, of the very considerable power a durable power of attorney puts into the hands of the attorney-in-fact. The attorney-in-fact literally has unrestrained use of those powers which can be implemented to the detriment as well as to the benefit of the principal. The New York State Assembly is trying to come to grips with the issue of whether medical decisionmaking is a delegable act, and, if so, whether present statutes in any way preclude the use of the durable power of attorney in this area.

Presently, however, these questions have only come to the fore in the limited context of "orders not to resuscitate." Despite the enactment of Article 29-B of the New York Public Health Law,²³⁸ many of the crucial issues involving health care decisionmaking, particularly for the elderly, continue to fall outside the narrow scope of such "DNR orders."²³⁹

A. Article 29-B

Article 29-B was enacted on August 7, 1987, and will become effective on April 1, 1988.²⁴⁰ The legislation was one of the initial recommendations of the Governor's Task Force on Life and the Law, and was announced as "An Act to amend the public health law, in relation to cardiopulmonary resuscitation."²⁴¹

Section 2960 outlines the appropriateness of an attending physician issuing an order not to attempt cardiopulmonary re-

238. N.Y. PUB. HEALTH LAW §§ 2960 to 2978 (McKinney Supp. 1988) (to become effective on Apr. 1, 1988).

239. DNR stands for "do not resuscitate."

240. N.Y. PUB. HEALTH LAW §§ 2960 to 2978 (McKinney Supp. 1988).

241. *Memorandum* to N.Y.S. 413, 210th Sess. (1987).

suscitation (“CPR”) of a patient, in certain circumstances, where the appropriate consent has been obtained.²⁴² In addition, the findings note that the “legislature further finds that there is a need to clarify and establish the rights and obligations of patients, their families, and health care providers regarding cardiopulmonary resuscitation and the issuance of orders not to resuscitate.”²⁴³ Section 2962 establishes the lawfulness of a DNR order issued by a physician when he has obtained the consent of the patient, surrogate, parent, or guardian.²⁴⁴ It further specifies the information which the physician must provide, such as diagnosis and prognosis, and risks and benefits of CPR for the patient, in order to ensure that the consent to a DNR order is truly informed.²⁴⁵

At least one physician designated by the hospital concerned must concur in the attending physician’s determination that the patient lacks capacity to consent to a DNR order, and such a determination by both doctors must be recorded in the patient’s medical chart.²⁴⁶ This provision is not unlike many of the living will/natural death acts that require affirmation by two physicians that a patient is terminally ill. Section 2964, however, enables a competent adult to make a valid, express decision orally to reject CPR, so long as that declaration is made in the presence of at least two witnesses who are eighteen years of age or older, and one of whom is a physician affiliated with a hospital in which the patient is being treated.²⁴⁷ As an alternative, prior to hospitalization, an individual may execute a written declaration rejecting CPR, so long as the document is dated and signed, and subscribed to by at least two witnesses who are eighteen years or older.²⁴⁸

Section 2964 also gives the attending physician discretionary authorization to forego discussion of CPR procedures with a competent patient and to issue a DNR order if the physician had determined, to a reasonable degree of medical certainty,

242. N.Y. PUB. HEALTH LAW § 2960 (McKinney Supp. 1988).

243. *Id.*

244. *Id.* at § 2962(2), (3).

245. *Id.* at § 2962(3).

246. *Id.* at § 2963(3).

247. *Id.* at § 2964(2)(a).

248. *Id.* at § 2964(2)(b).

that the patient would suffer immediate and severe injury from a discussion of CPR.²⁴⁹ When the physician is informed of a patient's oral or written declaration rejecting CPR, he must record this information on the patient's medical chart and issue the order, or promptly make his objections known to the patient and arrange for the transfer of the patient to the care of another physician, or refer the issue to the dispute mediation system mandated by this legislation.²⁵⁰

In the situation where the physician, for the patient's welfare, does not discuss CPR and does not obtain prior consent for a DNR order, he must comply with certain regulations in order to issue the DNR order: 1) obtaining concurrence of a second physician; 2) ascertaining the wishes of the patient concerning CPR to the extent possible; 3) stating on the patient's chart the reasons for not consulting the patient; and 4) obtaining the consent of a surrogate.²⁵¹ The subsequent provisions delineate who may serve as a surrogate, from one appointed by the patient, to a wife, adult child, and on down to a close friend.²⁵² The surrogate acts on the basis of the adult patient's known wishes, or if unknown, on the basis of the patient's "best interests."²⁵³

Section 2968 clearly stipulates that consent to a DNR order shall not constitute consent to withhold or withdraw medical treatment other than cardiopulmonary resuscitation.²⁵⁴ Section 2969 further provides for the automatic right of the patient to revoke consent to a DNR order at any time,²⁵⁵ a provision typical of many living will/natural death acts. One of the seemingly impractical sections requires a physician to review a DNR order at least every three days for a patient in a general hospital.²⁵⁶ With the overwhelming increase in the number of geriatric patients (the highest proportional population increase in the past ten years has come in the over seventy-five age cohort²⁵⁷), this

249. *Id.* at § 2964(3)(a).

250. *Id.* at § 2964(2)(c)(ii).

251. *Id.* at § 2964(3)(a)(i), (iv).

252. *Id.* at § 2965(4)(a)(i)-(vii).

253. *Id.* at § 2965(5)(a).

254. *Id.* at § 2968.

255. *Id.* at § 2969(1).

256. *Id.* at § 2970(1)(a).

257. J. KRAUSKOPF, *supra* note 3, at § 1.7 (1st ed. 1983).

provision seems unenforceable, even in the most ideal circumstances, given the added monitoring responsibility it places on an already overburdened hospital staff.

The remainder of Article 29-B addresses issues of terminally ill minors and the establishment of dispute mediation systems in hospitals. Where a dispute is not settled after seventy-two hours, the proposed statute authorizes the patient, doctor, or surrogate to seek judicial relief.²⁵⁸ Physicians, nurses, and hospital employees are immune from civil and criminal liability for carrying out a DNR order in good faith,²⁵⁹ as are surrogates or guardians who consent or decline to consent to a DNR order.²⁶⁰

Although this law is a step in the right direction in its attempt to bring into harmony often conflicting societal interests relating to health care, and specifically to DNR decisions, it leaves many legal issues unanswered. The New York State Bar Association has initially raised some of the most important issues left open by the enactment of Article 29-B.

B. Response to Article 29-B — Trusts and Estates Law Section

When Article 29-B was proposed, the New York State Bar Association (the "Association"), through the Trust and Estates Law Section and the Committee on Mental and Physical Disability, urged the Assembly not to enact the law. The Association noted:

While we recognize that Legislation to establish policy on withholding and withdrawing life-sustaining treatment is an imperative necessity, we nevertheless oppose the Task Force's DNR Bill *firstly*, because its piecemeal approach frustrates the objective of establishing such policy on a uniform basis and *secondly*, because even within the limited scope of its stated purpose to clarify rights and duties regarding cardiopulmonary resuscitation, the Bill fails to accomplish this objective.²⁶¹

258. N.Y. PUB. HEALTH LAW § 2973(3) (McKinney Supp. 1988).

259. *Id.* at § 2974(1).

260. *Id.* at § 2974(3).

261. Letter from New York State Bar Association to New York State Assembly Committee on Health and Senate Committee on Health (Jan. 19, 1987) (discussing problems of N.Y.S. 413 regarding the issuance of Do Not Resuscitate Orders) [hereinaf-

The Association further criticized the fragmented approach proposed by the Task Force and alternatively recommended a policy which would recognize "that the same principles apply to withholding and withdrawing all manner of life-sustaining treatment."²⁶² In citing the need for two separate policies (one to assure that decisions by competent adults are given effect and a second to fill the "decisionmaking vacuum"²⁶³ in which persons under a legal disability find themselves), the Association recommended a single form of consent or instructions that would be applicable to all forms of treatment declined by (or on behalf of) a patient — thereby avoiding separate procedural mechanisms for consent in every type of treatment situation.²⁶⁴

In promoting patient autonomy, the Association was most critical of the law's provisions concerning dispute mediation procedures. During the seventy-two hour waiting period, the common-law right of a competent adult to determine the course of his/her own medical treatment is suspended.²⁶⁵ Further, during that period, if a cardiac arrest situation arises, CPR procedures are mandated.²⁶⁶ If the individual is placed on a respirator during that time, no authority exists to withdraw what may have clearly been unwanted treatment, without judicial intervention.²⁶⁷ The Association stated that there is "good reason to believe that this restriction would be found by the courts to violate constitutionally protected rights of patients."²⁶⁸ Additionally, the Minority Report of the Governor's Task Force clearly noted that this legislation is founded on the presumption that "'all patients, in the event of cardiac or respiratory arrest consent to the provision of CPR.'"²⁶⁹ Yet, there were no cases and no statutes in New York that established such a presumption. The response of the Association concluded that adopting such a premise would clearly result in the administration of medically futile

ter Bar Association Letter].

262. *Id.* at 2.

263. *Id.*

264. *Id.* at 2-3.

265. *Id.* at 5.

266. *Id.*

267. *Id.*

268. *Id.* at 6.

269. *Id.* at 7.

CPR procedures where they have not been used previously.²⁷⁰ Such actions acutely affect the rights of the elderly infirm.

The New York State Bar Association and the Association of the Bar of the City of New York jointly submitted draft health care decisionmaking legislation as an alternative to Article 29-B. Their proposal would have provided a broader statutory framework for such decisionmaking by *competent* adults.²⁷¹ This draft legislation called for a two-part approach to the problem — one implementing advance directives to take effect when an individual becomes terminally ill, and the other initiating a proxy health care decisionmaking process through the use of a special power of attorney.²⁷²

Ironically, the bar associations had been willing to leave open the question of decisionmaking by life-long incompetents, and have deferred instead to the eventual report assessing the impact of Article 80 of the Mental Hygiene Law.²⁷³ They expect to file recommendations for establishing a uniform policy in this area once sufficient information has been yielded by the Mental and Physical Disabilities Committee.²⁷⁴

The Association had recommended that Article 29-B be abandoned, and that in its place, the legislature adopt living wills as a vehicle to preserve individual autonomy *in conjunction with* special health care decision proxies. It is clear that the Association has been recommending the delegation of authority with respect to health care decisions through the use of a separate instrument, rather than by incorporating such a delegation in the statutory short form durable power of attorney. However, the draft legislative alternative realizes that many individuals and their counsel will wish to include both living wills and health care decision proxies in the same instrument and expressly authorizes such inclusion.²⁷⁵ Most of the recommenda-

270. *Id.* at 8.

271. Memorandum in Support of Health Care Decisions Legislation at 1 (Apr. 30, 1986) (submitted to the New York State Legislature by the New York State Bar Association and the Association of the Bar of the City of New York) (available from the New York State Bar Association) [hereinafter Bar Association Memorandum].

272. *Id.*

273. Bar Association Letter, *supra* note 261, at 3-4. See also *supra* notes 224-233 and accompanying text.

274. Bar Association Letter, *supra* note 261, at 4.

275. Bar Association Memorandum, *supra* note 271, at 6-7.

tions made by the Association are drawn from the Uniform Rights of Terminally Ill Act. It is only in this context that the Association foresees the common law right to self-determination being preserved.

C. *The Goodhue Proposal*

In March, 1987, New York State Senator Mary Goodhue introduced a bill to make living wills legally binding instruments in New York State.²⁷⁶ However, the bill was withdrawn in June 1987 in response to two factors: 1) lack of sufficient time remaining in the legislative session to win support for the bill²⁷⁷ and 2) substantial opposition from several senators as well as the New York State Catholic Conference, the lobbying group for the Roman Catholic Church.²⁷⁸ The primary objection to the bill derived from its provision that an advance directive may, at the discretion of the declarant, expressly provide for the withholding of nutrition and hydration.²⁷⁹ It is clear that within the medical and political arenas, there is broader consensus about DNR orders than about withdrawing life support systems.²⁸⁰

The Goodhue Bill contained many provisions similar to the Louisiana Natural Death Act.²⁸¹ For example, an eligible declarant who is making a living will must be eighteen years of age or older and must be competent at the time the directive is executed.²⁸² In addition, two physicians must have personally examined the patient and certified in writing that he is in a terminal condition.²⁸³ One of these must be the attending

276. N.Y.S. 4525-A, 201 Sess. (1987).

277. The Daily Argus (Gannett Westchester Newspapers), June 18, 1987, at A21, col. 5.

278. Letter from Rev. Kenneth J. Doyle, Director of Government Relations for the New York State Catholic Conference, to the Honorable Members of the New York State Senate (June 1, 1987) (discussing the Catholic Conference's opposition to the Goodhue Bill, N.Y.S. 4525-A).

279. N.Y.S. 4525-A, 201 Sess. (1987).

280. Miller, *Making Life-and-Death Decisions*, Newsday, June 30, 1987, at 62, col. 1. (Tracey E. Miller is executive director of the New York State Task Force on Life and Law.).

281. See *supra* note 128-129 and accompanying text.

282. N.Y.S. 4525-A, at § 4601(3).

283. *Id.*

physician.²⁸⁴

All of the usual formalities for executing a testamentary disposition in New York are incorporated into this living will bill.²⁸⁵ Further, the subscribing witnesses may not be a spouse, blood relative, attending physician or his employee, an employee of any health facility in which the declarant is a patient, or anyone with a claim against the declarant's estate.²⁸⁶ The Goodhue Bill also included a provision that is new to many sister state acts: if the declarant is a patient in a nursing home, he or she must have a patient advocate or ombudsman designated by the Office on Aging as one of the two subscribing witnesses.²⁸⁷ The majority of remaining provisions are common to other living will statutes, including those which outline the declarant's responsibility to notify the attending physician of the declaration's existence,²⁸⁸ a disclaimer of pregnancy,²⁸⁹ revocation procedures,²⁹⁰ immunity from criminal or civil liability for physicians and health care professionals acting pursuant to a living will directive,²⁹¹ and the imposition of penalties.²⁹²

One of the uncommon provisions is the recognition of living will directives executed in other states.²⁹³ By far, the most controversial section deals with the declarant's ability to direct that artificial life-sustaining procedures be withheld or withdrawn, *including* procedures to accomplish the purpose of nutrition and hydration.²⁹⁴ Those opposing the Goodhue Bill have focused particularly on this provision, characterizing it as one that would jeopardize the lives of certain individuals.²⁹⁵ The New York State Catholic Conference has stated:

Our Conference does not believe that every possible medical treatment must be used to prolong life, particularly when the

284. *Id.* at § 4602(1)(b).

285. *Id.* at § 4602(2).

286. *Id.*

287. *Id.* at § 4603.

288. *Id.* at § 4602(3).

289. *Id.* at § 4602(4)(c).

290. *Id.* at § 4604(1).

291. *Id.* at § 4609.

292. *Id.* at § 4610(1)-(3).

293. *Id.* at § 4614.

294. *Id.* at § 4602(5).

295. Letter of Rev. Kenneth J. Doyle, *supra* note 278, at para. 3.

treatment itself is excessively burdensome and offers little hope of benefit. However, nutrition and hydration in most cases do not constitute *medical treatment* — instead they normally represent minimal means of *ordinary human care* which one individual owes to another.

Nutrition meets a basic need of all human beings, a need which is not specifically medical. Moreover, to remove nutrition and hydration is to bring about death directly. When *medical treatment* is removed — as in the celebrated *Karen Quinlan* case — a patient may or may not die. But when nutrition and hydration are removed, that removal causes death surely and soon.²⁹⁶

The Goodhue Bill was also set aside in an attempt to allow the Governor's Task Force on Life and Law to gather and report its findings, which have centered upon an evaluation of the ethical and legal issues inherent in living will legislation and the termination of life support systems. The Task Force made its recommendation public in September of 1987.²⁹⁷ Competent adults should be allowed to designate a proxy for health care decisions, whether such decisions are routine or "life and death."²⁹⁸ Health care providers who honor such decisions would be immune from both civil and criminal liability, while failure to honor them could result in civil penalties.²⁹⁹ Physicians declining to comply with the decisions must refer the patient to other physicians or hospitals.³⁰⁰ The proposed legislation will be introduced in the New York State Assembly in January 1988 by Richard N. Gottfried of Manhattan, the chairman of the Assembly Health Committee, and the bill is not expected to receive significant opposition.³⁰¹

Ironically, while the Goodhue proposal was before the New York State Legislature, a case involving the withdrawal of nutrition and hydration was presented in the appellate division, second department,³⁰² appealing a judgment of the New York Su-

296. *Id.* at para. 4, 5.

297. Sullivan, *New York Panel Urges Widening Patients' Rights*, N.Y. Times, Sept. 30, 1987, at A1, col. 1.

298. *Id.* at B3, col. 2.

299. *Id.*

300. *Id.*

301. *Id.* at B3, col. 3.

302. *In re Delio*, 129 A.D.2d 1, 516 N.Y.S.2d 677 (2d Dep't 1987).

preme Court, Westchester County.³⁰³ In *In re Delio*, the wife of a thirty-three year old patient who was in a chronic vegetative state with no hope of recovery petitioned to terminate the patient's care. The hospital in which the patient was confined opposed the application on the grounds that discontinuation of nutrition and hydration was contrary to the hospital's ethical and moral standards.³⁰⁴ The supreme court denied the petition,³⁰⁵ and the wife appealed. The appellate division held that the wife, as conservator of the patient, was entitled to act in accordance with prior clearly expressed wishes of the patient and to have the use of feeding and hydration tubes discontinued;³⁰⁶ the appellate division thereby granted the petition.

Although Daniel Delio was only thirty-three, his condition was not unlike that of many elderly patients. During the course of a routine surgical procedure, Delio suffered cardiac arrest with resulting severe and irreversible brain damage.³⁰⁷ Although he was able to breathe spontaneously and did not require the assistance of a respirator, he could not chew food or voluntarily swallow.³⁰⁸ Nutrition and hydration were therefore provided to him by means of two artificial devices surgically inserted in his stomach and small intestines.³⁰⁹

When the lower court denied Julianne Delio's application to withdraw the surgically inserted feeding tubes, it noted that "placing a judicial imprimatur on a decision to terminate the care in this case, in the absence of clear legislative or judicial guidance, is fraught with danger."³¹⁰ The appellate division chose to apply the same clear and convincing standard that the court of appeals had utilized in the *Eichner* and *Storar* decisions.³¹¹ Although Delio had not executed a living will, the appellate division was cognizant of the substantial testimony presented at the hearing in the lower court and stated:

303. *In re Delio*, 134 Misc. 2d 1106, 510 N.Y.S.2d 415 (Sup. Ct. 1986).

304. *In re Delio*, 129 A.D.2d 1, 4, 516 N.Y.S.2d 677, 680 (2d Dep't 1987).

305. *Id.*

306. *Id.* at 26, 516 N.Y.S.2d at 693-94.

307. *Id.* at 3, 516 N.Y.S.2d at 679.

308. *Id.* at 3, 516 N.Y.S.2d at 680.

309. *Id.* at 3-4, 516 N.Y.S.2d at 680.

310. *In re Delio*, 134 Misc. 2d 206, 214-15, 510 N.Y.S.2d 415, 420 (Sup. Ct. 1986).

311. See *supra* text accompanying notes 202-210.

While we are painfully aware of the responsibility which we undertake in reaching a determination in this matter, we are aided in our determination by the clear and convincing evidence presented at the hearing before the trial court that the patient for whom the application to withdraw medical treatment is made would, if competent, have rejected nutrition and hydration by artificial means and, in effect, would have chosen to allow the processes of nature to take their course.³¹²

The hospital's argument centered upon its distinction between a respirator, which it characterized as "'extraordinary medical care' and nutrition, arguing that the common law right of bodily self-determination should be confined to the former."³¹³ Citing the *Conroy*³¹⁴ and *Brophy*³¹⁵ cases, the court rejected the hospital's differentiation between feeding by artificial means and other forms of medical treatment. Although noting certain differences between the two, the court concluded:

We agree with those courts' decisions that the withdrawal or withholding of feeding by artificial means should be evaluated in the same manner as any other medical procedure. In this respect, we view nutrition and hydration by artificial means as being the same as the use of a respirator or other form of life support equipment.³¹⁶

Without the force of law, cases such as Daniel Delio's will continue to be pressed in the courts. One observer in this particular case noted that if Delio had executed a living will that was legally enforceable in New York, the family might have been able to shorten or avoid altogether the initial part of the case — that phase in which the petitioner had to prove that Delio would not have wanted to be kept alive by artificial feeding tubes.³¹⁷

312. *In re Delio*, 129 A.D.2d at 3, 516 N.Y.S.2d at 679.

313. *Id.* at 16, 516 N.Y.S.2d at 687.

314. *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985).

315. *Brophy v. New England Sinai Hosp.*, 398 Mass. 417, 497 N.E.2d 626 (1986).

316. *In re Delio*, 129 A.D.2d at 19, 516 N.Y.S.2d at 689 (citation omitted).

317. Lane, *A Will to Live . . . or to Die*, *The Daily Argus* (Gannett Westchester Newspapers), June 3, 1987, at A12, col. 3.

VI. Practical Implementation for the Practitioner

The primary task for the practitioner in dealing with elderly clients is the need to resolve, on a case-by-case basis, the ongoing tension between autonomy and paternalism. Guardianship and conservatorship are not panaceas for the elderly person who is more likely to be partially rather than totally incapacitated or disabled. As one respected advocate for the aging has noted, "these procedures may be responsible for stripping the elderly person of his last measure of dignity and self-esteem."³¹⁸

A growing concern for the practitioner should be sensitivity and vigilance toward elderly clients in terms of apprising them of alternatives to guardianship and general conservatorship. The attorney's primary role should encompass counseling and actions that will assist the client to retain autonomy and control over person and property. The durable power of attorney has been the single, most rapidly adopted mechanism for achieving these goals.³¹⁹ For the practitioner working with elderly clients, it has been the most practical and least expensive alternative to traditional protective services.

The court, in *Saunders*, recommended the use of a limited durable power of attorney to delegate decisionmaking.³²⁰ However, the court was also quick to note the "catch-22" circumstances brought about by such an instrument. In using this device, the principal is giving over to a third party the power to determine what kind and extent of care is to be provided in life-threatening situations. This is exactly what Mrs. Saunders sought to avoid since the purpose of her living will was to maintain her right to self-determination.³²¹

Despite the fact that the legislature has not yet adopted living will legislation, clients should be encouraged to make a living will declaration. Then, in the event such circumstances arrive and the client is incompetent, the living will can be brought to light as clear and convincing evidence of the client's wishes. The living will should include a durable power of attorney by which an individual can designate some other person as his legal

318. J. KRAUSKOPF, *supra* note 3, at § 6.1 (1st ed. 1983).

319. *Id.*

320. *See supra* notes 214-221 and accompanying text.

321. *In re Saunders*, 129 Misc. 2d 45, 53, 492 N.Y.S.2d 510, 516 (Sup. Ct. 1985).

guardian for questions concerning medical treatment.³²² It should be noted that even if the legislature resurrects the Goodhue proposal, there is no provision in the bill for the appointment of an agent for medical decisionmaking.

Even if New York adopts specific legislation, clients ought to be encouraged to use the living will declaration in order to make specific and personalized directives. For example, when discussing what extraordinary life-sustaining procedures the client would not like to endure, he or she should clearly mention that he does not want to be placed on a respirator or dialysis or to be fed in any other way than by mouth. Incorporating such specific provisions will eliminate potential disputes over what the client actually meant when vague terms have been used.

In addition, trusts and estates specialists have recommended that the durable power of attorney be used as a separate instrument, delegating authority to communicate health care decisions exclusively.³²³ However, the lawyer must emphasize to the client the importance of careful selection of an attorney-in-fact based on the sweeping nature of the powers that are transferred. In the case of the elderly client who often appoints his or her elderly spouse as attorney-in-fact, the client should be advised to appoint a back-up agent to prepare for the possibility of an attorney-in-fact predeceasing the incapacitated spouse principal.

Both the living will and the limited durable power of attorney for these circumstances ought to be notarized and witnessed by disinterested parties (those who are not blood relatives and are not beneficiaries of the person's estate). From there, it is incumbent upon the attorney and client to ensure that both documents become part of that client's medical records in the appropriate physician's office. For the practitioner working with elderly clients, the living will declaration and the durable power of attorney should become part of the normal estate planning discussions between attorney and client — at least until such time as the legislature has acted in this area.

322. A sample living will may be obtained from Concern for Dying, 250 West 57th Street, New York, N.Y. 10107.

323. Note, *supra* note 39.

VII. Conclusion

Using advance directives, whether a living will, durable power of attorney, or specific appointment of an agent for health care decisions (via a limited durable power of attorney) may eliminate the need for conservators and committees. The President's Commission echoed the concern over the cumbersomeness and costs of legal guardianship.³²⁴ It noted that these factors strongly militate against legal guardianship and ought to be taken into account by lawmakers before they require that decisions about life-sustaining treatment be made by judicially appointed guardians.³²⁵ Given the demographics in New York State concerning the number of elderly who may find themselves in these circumstances over the next ten to twenty years, the court system could not withstand the demands that such procedures would place upon it.

In addition to time and money, court proceedings place the family and the patient under enormous emotional stress at an already difficult time by making public what should essentially be a private matter. The *Delio* case is one striking example among many. Although many of the living will statutes were designed to make such documents legally binding, the resulting laws are so restrictive in some instances that their effectiveness is impaired.³²⁶ Although the DNR statute is a breakthrough, its scope is limited to the final circumstances in an individual's life — situations in which that individual very often has little control. Appointing an agent for medical care decisions in the future by means of a durable power of attorney, standing alone, also has an uncertain legal status. Although New York has leaned on the common-law right to self-determination, it is difficult to place great reliance on such common-law rights. After all, if the common law had unequivocally established such rights, there would be no need for the statutes.

Within the legislature, lawmakers have the ability to deliberate and seek input from all segments of the medical and legal communities. As Judge McCaffrey noted in his plea during the *Saunders* case, the legislature is eminently better suited than a

324. DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT, *supra* note 21, at 130.

325. *Id.* at 131.

326. Capron, *supra* note 143.

court to address these issues.³²⁷ The DNR law is not a final answer — it has merely opened the door ever so slightly on a much larger set of issues. It behooves the New York Legislature to review and adopt the alternative legislation proposed by the bar associations advocating the combined use of living will declarations and health care decision proxies — at least until some greater, perfecting piece of legislation is forthcoming. The legislature has an ethical and moral responsibility, particularly to the growing elderly population in New York State, to preserve their right to self-determination before that right is forever lost in the morass of bureaucracy.

327. *In re Saunders*, 129 Misc. 2d 45, 54, 492 N.Y.S.2d 510, 516 (Sup. Ct. 1985).