

Planning For Medical Decisions

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“Every human being of adult years and sound mind has a right to determine what shall be done with his own body.” Justice Cardozo

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The single fastest-growing demographic group in the US is those 85 and above. As the baby boomers and their parents reach their elder years, issues of medical decision making are becoming imperative. But it is not just the aging elderly who need to plan for incapacity. The conflicts in the Florida family of Terri Schiavo (and the recent Supreme Court decision not to get involved in her treatment) are a ready example of why every client should plan for incapacity. Terri Schiavo had a heart attack at age 26 which rendered her totally incapacitated. For 15 years, her family incurred huge emotional and financial costs to maintain her life. For the last several years, large legal fees have been paid (and the Florida legislature and Congress has spent considerable time) to try and conclude what choices she would have made.

BACKGROUND • The debate over the withdrawal of life support has been a long and costly legal and political conflict. See Peter G. Filene, *In the Arms of Others: A Cultural History of the Right to Die in America*, Chicago: Dee 1998; Alan Meisel and Kathy L. Cerminara, *The Right to Die, The Law of End-of-Life Decision Making*, (Aspen 2003). By the early '60s, medicine had advanced to the stage that permanently unconscious clients could be kept alive even with little brain activity. As a result, debates began to occur about a patient's "right to die." In 1976, the New Jersey Supreme Court decided *In Re Quinlan*, 355 A2d647 (N.J.), *cert denied*, 429 U.S. 922 (1976). The court decided that a heart/lung machine could be withdrawn from Karen Ann Quinlan, but required that intravenous fluids and nourishment must continue, even though Miss Quinlan had no brain activity. Although doctors had expected her to die after being taken off the heart/lung machine, she continued to breathe. She lived almost 10 more years on intravenous fluids and nourishment. Also in 1976, California became the first state to approve living wills. By 1992 all 50 states had adopted similar legislation.

In *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 289 (1990), the U.S. Supreme Court acknowledged a constitutionally protected right to refuse lifesaving hydration and nutrition. The Supreme Court largely deferred to states to determine how this constitutional right would be exercised, particularly when the decision is made by surrogates or there was no written declaration. Missouri applied a “clear and convincing” evidence standard to determine whether such a refusal had been made by Nancy Cruzan. Although this evidence standard would necessitate a written medical directive in most cases, the Missouri courts found that Nancy Cruzan had made sufficient verbal declarations to permit withdrawal of nourishment. Eight years after the accident which rendered her permanently unconscious and without significant brain activity, Nancy Cruzan died.

In 1991 Congress passed The Patient Self-Determination Act, Public Law 101-508; 42 U.S.C. §1395cc(a), which requires health care providers (e.g., hospitals, nursing homes, hospice programs, home health care agencies and HMOs) receiving Medicaid and Medicare payments to ascertain the intent of patients about advance directives for health care and provide patients educational materials about their rights under state law.

In 1994 an Oregon referendum resulted in the adoption of a new statute, The Oregon Death with Dignity Act, Oregon Statutes section 127.800 et. seq., which permitted physician assisted suicide in certain circumstances. The implementation of the act was enjoined by the District Court in *Lee v. State of Oregon*, 819 F. Supp 1429 (D Or 1995). The injunction was lifted by the Ninth Circuit Court of Appeals. *Lee v. Oregon*, 107 F3d 1382 (9th Cir. 1997). The plaintiff’s appeal to the U.S. Supreme Court was denied.

In *Compassion in Dying v. State of Washington*, 79 F3d 790 (9th Cir. 1996), the Ninth Circuit Court of Appeals overturned a Washington statute which made physician assisted suicide a criminal act. The Ninth Circuit found a due process constitutional right to physician assisted suicides. One month later, in *Quill v. Vacco*, 80 F3d 716 (2nd Cir 1996), the Second Circuit Court of Appeals struck down a New York statute which prohibited physician assisted suicide. The Second Circuit ruled that the law violated the equal protection provisions of the U.S. Constitution.

On June 26, 1997, the U.S. Supreme Court overturned both Circuit Court decisions in *Washington v. Glucksberg*, 521 U.S. 702 (1997), and *Vacco v. Quill*, 521 U.S.793 (1997). The U.S. Supreme Court left it up to the states to determine whether to prohibit physician assisted suicide. The Court could find no constitutional right for terminally ill patients to obtain a physician’s assistance in ending their lives. The battle over physician assisted suicides has continued around the country. In 39 states, it is a criminal act to assist in any suicide.

In April 1998, President Clinton signed into law The Assisted Suicide Funding Restrictions Act of 1997, 42 USC 14401, which prevents the federal governments from reimbursing costs associated with physician assisted suicide. The bill also provided for the funding of programs to reduce the rate of suicide by persons with disabilities or terminal or chronic illnesses.

The legal, medical and moral controversies over euthanasia and the right to die will continue. As attorneys we have a duty to assure that our clients are fully informed about the choices they are entitled to make and the implications of those choices. This article will discuss some of those choices.

The nuances of medical decision making vary widely from state to state. The remainder of this article will discuss some of the general rules governing medical decision making. The article will reference the Uniform Health Care Decisions Act which was adopted by the National Conference of Commissioners on Uniform State Laws in 1993 (the “Act”) (a copy of the act can be found at www.law.upenn.edu/bll/ulc/fnact99/1990s/uhcda93). The Act provides that it applies to both adults and emancipated minors. Act section 2(a).

MAKING MEDICAL DECISIONS • Most people would prefer to decide who will make medical decisions for them and, in some cases, restrict how the decisions can be made. Failing to do so breeds both additional costs and the potential for family turmoil. For example, a 1992 study in the Archives of Internal Medicine reported that having a living will or medical power of attorney saved almost \$65,000 per patient in the final stay in the hospital. *See* C.V. Chambers, J.J. Diamond, R.L. Perkel and L.A. Lasch, *Relationship of Advance Directives to Hospital Charges in a Medicare Population*, Archives of Internal Medicine, March 1994, Volume 154. *See also*, P.A. Singer and F.H. Lowy, *Rationing, Patient Preferences and Cost of Care at the End of Life*, Archives of Internal Medicine, March 1992. The average cost from 1990 through 1992 of persons without medical directives was \$95,305 versus \$30,478 for those who had medical directives. Since 1992 medical care costs have increased at a significant rate.

There are a number of choices in making medical directives, including living wills, durable powers of attorney for healthcare, medical directives, and personal notes.

Living Wills

A living will is a declaration not to provide life-sustaining treatment if there is no significant hope of recovery. It is only operative when its maker can no longer make medical decisions. Although the *Cruzan* decision permits verbal declarations, clients are well advised to sign written documents that are consistent with the state statutes in their state of residence. Failure to sign a proper living will may result in family conflicts over the client’s declared intentions (such as the Schiavo case in Florida) and necessitate litigation to discern what the client wanted.

Basic Language

Every state has adopted legislation allowing individuals to state their intent not to receive advanced medical treatment or life sustaining treatment in certain situations. The Act provides that living wills can be oral or written, as well as a statutory form which is a combined living will and health care power of attorney. The Act’s form provides the following language:

“I do not want my life to be prolonged if (i) I have an incurable and irreversible condition that will result in my death within a relatively short time, (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (iii) the likely risks and burdens of treatment would outweigh the expected benefits.”

The form permits the signer to separately declare whether he or she wants to receive nourishment and hydration. One flaw in some statutory forms is that the form may not contemplate a signer wanting either nourishment or hydration, but not both. Under some states laws, living wills had a limited life or may not have dealt specifically with the withdrawal of nourishment and hydration. Most living wills prepared after the 1993 *Cruzan* decision specifically refer to nutrition and hydration. Therefore, people who have older living wills should discuss with their estate planning advisors whether their living wills are still enforceable and properly cover the providing of nutrition and hydration. Although the prior document may provide evidence of the client’s desires not to be kept artificially alive, the failure to deal specifically with withdrawal of nourishment and hydration could result in the decision to maintain these body resources.

Formalities

Although most statutes specifically provide that the exact format of the statutory form does not have to be followed, the document must be executed with the required formalities to be enforceable under state law. This usually requires the signature of two witnesses and may require other signatures if the signer is in a medical or nursing care facility. A few states require that the document be notarized.

Durable Power Of Attorney For Healthcare

A living will is simply a declaration not to use life-sustaining measures. A health care power of attorney (also called a medical power of attorney) is designed to give someone the power to make medical decisions upon incapacity, including the withdrawal of life support. The document may also name substitute surrogates and guardians. Although living wills and powers of attorney both deal with life-sustaining issues, it is generally worthwhile to have both, or to have a single document that addresses both life sustaining measures and decision making.

In General

Most states have adopted statutes which provide a statutory form for medical powers of attorney. The Act contains the statutory form of a durable power of attorney for healthcare. Section 4 of the Act provides that the exact language of the statutory form does not have to be followed for the document to be enforceable. It likewise provides that the language can be combined with any other form of a power of attorney, such as a general power of attorney governing property decisions. To be enforceable, the document must be executed in compliance the statutory formalities (e.g., in front of two witnesses who are at least 18 years of age and who are unrelated to the person signing the living will).

Priority

Act section 6(a) provides that the person holding a healthcare power of attorney has priority decision making over any guardian who may have been appointed. Some state statutes also provide that the healthcare power of attorney can even extend beyond the principal's death if "necessary to permit anatomical gifts, autopsy or disposition of remains." *See, e.g.*, O.C.G.A. Section 31-36-6(b).

Effect Of Marriage

Although the Act does not deal with the effect of marriage upon the appointment of a power holder, some states provide that unless the power of attorney expressly provides otherwise, a subsequent marriage acts as an automatic revocation of the designation of any person to serve as power holder other than the principal's spouse. *See, e.g.*, O.C.G.A. Section 31-36-6(b). The Act does provide, however, that if a marriage is dissolved or annulled or a legal separation occurs, the dissolution revokes the principal's former spouse as the principal's agent to make healthcare decisions. *See* Act section 3(d). Thus, it is important to name one or more successors to a spouse (i.e., in case a divorce occurs).

Protection For The Agent Or Guardian

Act Section 9(a) provides that a healthcare provider or other person who acts in good faith in reliance upon the direction of the decision of the person named in the power of attorney is protected and released from liability. The statute also limits the liability of agents who act in good faith. *See*, Act section 9(b).

Multiple Agents?

Can more than one person be named as power holder? The Act does not recognize multiple power holders. Act section 1(2) provides that the power is delegated to an agent who is "an individual." If dual agents are appointed, is the intent that they must act unanimously, or that each has independent authority to act? To avoid such conflicts, it is generally advisable to appoint one power holder at a time. It is also generally advisable to name one or more successors behind the originally appointed power holder (for example, both the agent and principal are involved in the same accident).

Medical Directives

Many clients are concerned about how the holder of a power of attorney will exercise his or her discretionary authority. If the client is concerned about specific decisions the agent may make, review using a more detailed "medical directive." Copies of the directive can be obtained at www.Medicaldirective.org.

Personal Notes

It is also important for clients to leave information for family members on the types of decisions they want to be made if they become incapacitated. For example, "I want to be kept at

home as long as possible.” Clients may want to consider executing “ethical will” in which they discuss their thoughts on receiving life sustaining treatment and other philosophical perspectives. Barry K. Baines, *The Ethical Will: Reviving a Biblical Tradition and Applying it to Retirement Planning*, Journal of Retirement Planning, June 1999. This article provides practical advice in writing an ethical will. *See also*, Kathleen M. Rehl, *Help Your Clients Preserve Values, Tell Stories and Share the “Voice of Their Hearts” Through Ethical Wills*, J. Prac.Est.Plan., July 2003; Josephine Turner, *Estate Planning: Ethical Wills*, found at http://edis.ifas.ufl.edu/BODY_FY536; Robert Flashman, Melissa Flashman, Libby Noble and Sam Quick, *Ethical Wills: Passing on Treasures of the Heart*, found at www.ces.ncsu.edu/depts/fcs/pub/1998/wills.html

LETTING THE STATE DIRECT THE PROCESS • If a client fails to leave directions on how he or she want decisions to be made, the decisions may be made in accordance with applicable state statutes. Among the processes are temporary healthcare placement and guardian over the person.

Temporary Healthcare Placement

Many states provide a process by which certain designated persons have the authority to approve the placement of an individual in a healthcare facility. The act requires a certification that the physician believes the adult cannot consent for himself or herself and that it would be in the person’s best interest to transfer to or be admitted to an alternative facility, including, but not limited to:

- Nursing facilities;
- Personal care homes;
- Rehabilitation facilities; and
- Home and community-based programs.

Guardian Over The Person

If a client does not sign a medial power of attorney or living will, it may be necessary to have a guardian appointed to make medical decisions. Guardians may not have the same authority the client has to require remove intravenous nourishment and hydration. Virtually every decision requires court approval. As the Terri Schiavo fights demonstrated, the decision process can create tremendous emotional and legal costs.

ANATOMICAL GIFTS • In many cases, anatomical gifts can provide great benefits to others and be a source of comfort to survivors. Power holders under medical powers of attorney generally have the authority to make anatomical gifts. If a client wants parts of his or her body be made available, consider attaching such a statement to the medical power of attorney. In many states, residents can make anatomical gifts by making such a declaration on their driver's licenses.

Anatomical Gift Statutes

Most states also have an Anatomical Gift statute. See the Uniform Anatomical Gift Act. State statutes generally provide a priority list of persons who have the right to make anatomical gifts of parts of a deceased relative's body. It provides that if persons having the same priority of decision making disagree, that the gift cannot be made. However, if a person with a higher priority makes the decision, persons down the list cannot stop the gift. For example, a person having a medical power of attorney has priority over a spouse who has priority over children.

THE ETHICS AND MORALS SURROUNDING MEDICAL DIRECTIVES • The issues surrounding medical incapacity and the withdrawal of life support involve more than legal and medical decision making. There are ethical, moral and religious issues which must also be addressed by both the person signing a medical directive and those who will be called upon to implement the document. As lawyers we should help the client address the personal questions which may occur in both executing and implementing these documents.

CONCLUSION • Planning for medical decisions involves more than planning for incapacity. To increase the likelihood that the medical decision-making plans will be honored and carried out, they have to be part of an overall estate plan. Clients should have documents in place to assure that decisions with regard to property, business, and income are handled by the people they have selected, and in the way that they want. The better and more comprehensive the planning, the more likely it is that the client's wishes will be carried out.

APPENDIX

Resources

Books On Medical Decision Making

- *Living Wills Made E-Z: Includes Power of Attorney for Healthcare* (Made Ez Products, 2001)
- Kessler, David, *The Needs of the Dying* (Quill 2000)
- Kuhl, David, *What Dying People Want* (Public Affairs 2003)
- Lieberman, Alan D., *Advance Medical Directives* (West 2004)

- Meisel, Alan and Cerminara, Kathy L., *The Right To Die* (Aspen Publishers 2003).
- William Molloy, *Let Me Decide: The Health and Personal Care Directive That Speaks for You When You Can't* (Biblio Distribution 2003)

Websites On Aging And Critical Care Issues

- www.critical-conditions.org
- www.abanet.org/aging/toolkit/
- www.ama-assn.org/public/booklets/livgwill.htm
- www.help4srs.com
- www.mag.org/content
- www.nolo.com
- www.Medicaldirective.org
- www.caregiver.org

Internet Resources For The Elderly

- www.aoa.gov. The federal government's Agency on Aging
- www.eldercare.gov - a website of the Agency on Aging
- www.medicare.gov - the national website for Medicare
- www.cms.gov - The government's center for both Medicare and Medicaid advice
- www.socialsecurity.gov - the Social Security website
- www.aarp.org - American Association of Retired Persons website
- www.caremanager.org - a helpful website on care giver resources
- www.nia.nih.gov - providing information on gerontology

Articles Discussing the Moral, Ethical and Religious Issues of Medical Directives

- Rabbi Yitchok Breitowitz, *The Right to Die: A Halachic Approach*, found at www.us-israel.org/jsource/Judaism/right_to_die.html
- A Discussion of the topic and how different cultures deal with the issue can be found at www.ethics.acusd.edu/applied/euthanasia/