THE PATIENT SELF-DETERMINATION ACT

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What right has a person to control his or her own destiny while in the care of health professionals? What procedures will ensure implementation of the right, particularly if the patient is incapable of expressing his or her wishes?

To the first question, the answer is, "Theoretically, a great deal." It has been a tenet of Anglo-American law for a long time that an individual is entitled to know what a physician or other health care provider intends to do to effect a cure or ease misery.¹

To the second question, Congress² and the state legislatures³ have enacted statutes intended to guarantee that people are informed of their right of self-determination and have a choice of procedures to exercise it, even if the patient is incapacitated. It is settled that patients have the right to refuse medical treatment, even if such a refusal will result in the death of the patient.⁴ This right is a corollary

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³. See, e.g., Neb. L.B. 671, 92d Leg., 2d Sess. (1992) [hereinafter L.B. 671] (codifying an adult's right to execute a declaration governing the withholding or withdrawal of life-sustaining treatment); Neb. L.B. 696, 92d Leg., 2d Sess. (1992) [hereinafter L.B. 696] (establishing a decisionmaking process allowing a competent adult to designate another person to make health care and medical treatment decisions if the adult becomes incapable of making such decisions).

of the right of informed consent.\(^5\)

If patients possess this pair of guarantees, it is logical to ask how health care providers will inform them of the rights and help in implementing them. Insofar as a person has a right of medical self-determination, Congress has recently enacted a statute designed to allow patients, fully informed about the care intended to be given them, the right to clarify, long before incompetency prevents exercise of the right, what destiny should await them.\(^6\)

The Patient Self-Determination Act\(^7\) does not cover every health care situation. It is a part of the Medicare-Medicaid program and applies only to providers who participate in that broad coverage.\(^8\) As is true of the medical-legal-ethical area of "informed consent" in general, the scope and implementation of the advance medical directive legislation have generated both heated debate and gnawing questions.\(^9\) Some of these questions are:

—Suppose a patient is already incompetent when admitted to hospital care. Who should decide what care is to be given and when care should cease?\(^10\)

—What consequences should befall providers who choose to ignore the specific instructions given by a patient?\(^11\)

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7. See PSDA, supra note 2.


10. Prior to enactment of state legislation dealing with advance directives and proxy authorizations, the courts alone determined the appropriate resolution of such matters. In In re Guardianship of L.W., 482 N.W.2d 60 (Wis. 1992), the court was faced with a situation in which it acknowledged the right of an incompetent in a persistent vegetative state to refuse life-sustaining treatment. Here, there was neither a living will nor a durable power of attorney, and the court ruled that a guardian must decide what is in the patient's best interests. Guardianship of L.W., 482 N.W.2d at 63, 67-68.

11. See, e.g., George J. Annas & Leonard H. Glantz, The Right of Elderly Patients to Refuse Life-Sustaining Treatment, 64 MILBANK Q. 95, 142-44 (1986) (complaining of the failure of the Uniform Rights of the Terminally Ill Act to provide a course of action for a physician to follow when there is disagreement with the wishes of the declarant and an inability to transfer a patient to someone who would honor those wishes). The authors are troubled by the "reasonable medical standards" qualifications, based on a doctor's potential to rely on this provision to "do whatever he or she
—What constitutes a legally binding written directive establishing a patient’s health care decisions?\(^1\)

—What constitutes a legally binding directive reversing a previously executed written directive?\(^2\)

—What exceptions exist to valid written directives?\(^3\)

—What alternative exists to a treatment declaration?\(^4\)

—Who may exercise authority pursuant to such a directive alternative?\(^5\)

This Article will not attempt to address the entire range and complexity of the questions arising from the medical autonomy doctrine. To do so in finite space is as presumptuous as resolving the host of ethical, metaphysical, and jurisprudential issues related to eschatology.\(^7\) Rather, it is hoped that this Article will accomplish two tasks. First, it will undertake the rather mundane task of explaining in sufficient detail, so that the practitioner can make use of the ex-wants regardless of the patient’s stated view in the declaration.” \(^{14}\) See Chapman, 42 Ark. L. Rev. at 370-71.

12. Nebraska’s law provides that a declaration directing a physician to withhold or withdraw life-sustaining treatment “may, but need not, be in the form provided in this subsection.” L.B. 671, supra note 3, § 4. Specifications are mandated for some particulars, such as who may be witnesses, but not for all. \(^{15}\) Id.

13. \(^{15}\) Id. § 6. Section 6 of L.B. 671 states that a “declarant may revoke a declaration at any time and in any manner without regard to the declarant’s mental or physical condition.” \(^{13}\) Id. This apparently means that someone who is able to communicate but is hopelessly mentally ill may revoke a declaration.

14. \(^{13}\) Id. § 12(5). The Nebraska statute provides: “The act shall not affect the right of a patient to make decisions regarding use of life-sustaining treatment so long as the patient is able to do so or impair or supersede a right or responsibility that a person has to effect the withholding or withdrawal of medical care.” \(^{14}\) Id. Read together with the previously discussed § 6, a mentally ill patient is empowered to revoke orally any specific declaration.

15. Does the state have a proxy or durable power of attorney statute as well as a living will law? Suppose a patient has executed both. Which process is to be given effect? Suppose a patient has both but is mentally ill. What directive should providers follow (including oral revocation) if any?\(^{16}\)

16. Assume the existence of a durable power of attorney for health care, giving an attorney in fact for health care the authority to make medical decisions for an incompetent principal. Does it give an attorney in fact for health care decisions the authority to balance the interests of a state against those of the patient? \(^{14}\) See McKay v. Bergstedt, 801 P.2d 617, 629-31 (Nev. 1990) (reasoning that it is not just enough to say who makes medical decisions, or even how they are made). Because the underlying legal principle involves the balancing of a state’s interest with those of the patient, who makes this decision? \(^{14}\) See In re Farrell, 529 A.2d 404 (N.J. 1987).

planation, the evolution of the right of medical autonomy, the federal act, and the state statutes passed by the 1992 Nebraska Legislature to implement and complement the right. Second, it will explore some particularly nettlesome policy problems which plague the area of patient self-determination to see whether the Patient Self-Determination Act and cognate state laws solve them, and, if they do not, to recommend specific change for future legislative sessions.

American courts, faced with questions of whether patients may participate in decisions relating to the cessation of medical care and treatment, have often resolved the questions with reference to the traditional doctrine of informed consent.\(^8\) Health care providers have a duty to inform patients of their prognosis, the proposed treatment, any alternatives to such treatment, and the consequences of failing to agree to the proposed treatment.\(^9\) Patients, on the other hand, have both a right to receive this information and to refuse to consent to treatment.\(^10\)

Certainly, by the 1970s, when a health care provider failed to give a patient adequate information so that he or she could make intelligent, informed decisions regarding treatment alternatives, that failure became actionable itself in many jurisdictions, wholly apart from any actual malpractice of which a provider may be guilty.\(^21\)

The patients' dual right to information and decisionmaking arises from their right as human beings to medical self-determination.\(^22\) The legal principle has been articulated in the notion that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body."\(^23\) The source of the principle is said to be, variously, the common-law right of bodily integrity,\(^24\)

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21. E.g., Truman v. Thomas, 611 P.2d 902, 903, 909 (Cal. 1980); Cornfeldt v. Tongen, 282 N.W.2d 684, 699 (Minn. 1977), modified, 295 N.W.2d 638 (Minn. 1980).

22. See, e.g., Hondroulis v. Schumacher, 546 So. 2d 466, 473 (La. 1989) (holding that the constitutional right to privacy provided for a patient's right to choose whether or not to reject or obtain medical treatment); Cathy M. Smith, Comment, Hondroulis v. Schumacher: The Uniform Consent Law Revisited, 35 LOY. L. REV. 1474, 1477 (1990).

23. Schloendorff, 105 N.E. at 93. This decision reasons that true consent to what happens to one's self is the informed exercise of a choice and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each. Id. See Kelley & Jones, supra, note 1, at 311-12.

the constitutional right of privacy, or the right to free exercise of religion.

It should be noted that a patient does not enjoy an absolute right to refuse treatment. The right to refuse medical treatment may find itself balanced against a state's interest in preserving human life. Critical factors in the balancing include the prognosis of the patient and the invasiveness of the treatment proposed.

One analyst has described the balancing in terms of the chances for substantial improvement in a patient's condition: if high, a state's interest is stronger; if a patient is hopelessly ill, the interest of a state is relatively weak. But what other factors constitute a state's interest? Many factors have been identified: (1) preservation of human life, (2) protection of the interests of innocent third parties, (3) the prevention of suicide, and (4) the maintenance of the ethical integrity of the medical profession. A fifth interest also has been identified, but rarely discussed in the case law: the interest in encouraging the charitable and humane care of afflicted persons.

Having identified what the respective interests of patient and states are, two questions must be considered in establishing a sound public policy regarding patient self-determination. First, how should society deal with a patient who has become incompetent to articulate a rational choice of medical treatment? Second, who should weigh a state's and patient's interests if a patient is not able to speak for him or herself?

The New Jersey Supreme Court decided a seminal case, In re Quinlan, in 1976 in which it affirmed several elementary principles.
of self-determination as related to the incompetent, and offered a process by which critical questions could be resolved. In Quinlan, the father of a twenty-two-year-old woman in a persistent vegetative state sought authority to exercise power over all his daughter's vital processes. The court affirmed that the right of privacy "is broad enough to encompass a patient's decisions to decline medical treatment under certain circumstances." The court noted that the nature of Karen Quinlan's care and the realistic chances of her recovery were materially different from those of patients in several of the cases where treatments, such as blood transfusions were ordered, constituting a minimal bodily invasion, and where the prospects of recovery and return to functioning life were very good.

A state's interest weakens and the privacy right strengthens when the degree of invasion increases and the prognosis dims, the court explained. The court found that although Karen's father had no right to seek relief on his own behalf, as the father and surrogate of Karen, he could assert, on her behalf, her right of privacy. This was New Jersey's variation of the doctrine of substituted judgment.

By the early 1980s, several pieces of the solution to the puzzle relating to medical decisionmaking were formed. In In re Storar, the New York Court of Appeals, for example, affirmed the doctrine that a hospital or medical facility must respect the right of medical self-determination even after a patient becomes incompetent if the patient while still competent had stated that he or she did not desire certain procedures to be used under specified circumstances. The New York court announced that there had to be clear and convincing evidence that a patient had made a firm and settled commitment, while competent, to decline medical assistance.
Within three years of the New York decision, the Minnesota Supreme Court stated in *In re Conservatorship of Torres* that the jurisdictions that had considered the issues had "uniformly upheld the right of an incompetent to refuse life sustaining treatment and the authority of their trial courts to order the removal of an incompetent's life supports at the request of the incompetent's guardian or conservator." The Minnesota court added that the right to refuse treatment also includes the right to order the disconnection of extraordinary life-support systems.

Cases such as these were of necessity limited to their facts. They did not always recognize, much less answer, questions such as "who weighs the state's interest against those of a patient? Is it the attending physician? A Surrogate? A court?" It is not just enough to say who makes the decision to withdraw life-sustaining treatment and how it will be done, but also who resolves the balancing between the state and the individual.

As these cases were decided, it was apparent that although certain core principles were agreed upon, others were not. Thus, in

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45. 357 N.W.2d 332 (Minn. 1984).
46. *In re Conservatorship of Torres*, 357 N.W.2d 332, 339 (Minn. 1984).
48. An examination of the pre-Cruzan decisions reveals that various appellate courts had approached the issues with varying analytical frameworks, and the outcomes were fact-dependent. Some courts elected to take positions inconsistent with their own earlier decisions. Consistency was not guaranteed by Quinlan, however, which can be contrasted with *In re Conroy*, 486 A.2d 1209, 1225 (N.J. 1985) (holding that a patient's self-determination right usually outweighs any state interests). The court in *Conroy* reasoned that an incompetent should not lose the right merely because of inability to sense a violation of it. Without evidence of the desires of the incompetent, a surrogate may invoke a patient's right in certain circumstances under the objective test, and use a subjective test when there is clear and convincing evidence that the incompetent would have exercised it. *Conroy*, 486 A.2d at 1229. See L. Jay Gilberg, Note, Cruzan and Its Impact on Patient Self-Determination, 30 J. FAM. L. 111, 116 (1991).
49. *Farrell*, 529 A.2d at 408, 411.
1985, the National Conference of Commissioners on Uniform State Laws took a first step toward statutory consistency and approved the Uniform Rights of the Terminally Ill Act.\textsuperscript{52}

This legislative model was very narrow in scope. It merely provided for the execution of a declaration instructing physicians to withdraw or withhold life-sustaining treatment if a patient was in a terminal condition and could not participate lucidly in medical decisionmaking.\textsuperscript{53} The Uniform Act did not address questions such as the treatment of those who had not executed a declaration, the problem of minors, or the circumstances for validation of a proxy.\textsuperscript{54} Missouri, one of the first states to adopt the Uniform Act,\textsuperscript{55} also was the state in which the most important case arose.

**SELF-DETERMINATION AND INFORMATION: CRUZAN**

The previous discussion demonstrates that the state of the law is such that a person may refuse medical treatment even if it means the person will not survive. When an individual becomes incompetent, or is incompetent at the outset of medical treatment, it is not possible to express one’s wishes on this subject to health care providers. The state of technology is such that many people are sustained long past the time when they might wish to die.\textsuperscript{56} When a person is terminally ill, incompetent, or in a persistent vegetative state, what action should a health care provider undertake, and what treatment should it withhold or withdraw?

These questions were addressed in *Cruzan v. Director, Missouri Department of Health*.\textsuperscript{57} In this important case, the United States Supreme Court sustained the ability of the State of Missouri to require members of an incapacitated person’s family to prove by clear and convincing evidence that the person would wish to order the withdrawal of life-sustaining treatment. The closeness of the vote in *Cruzan* — a five to four decision\textsuperscript{58} — resulted in the states having lit-


\textsuperscript{53} See URTIA, supra note 52, 9B U.L.A. at 609.

\textsuperscript{54} Id.


\textsuperscript{56} Fred H. Cate & Barbara A. Gill, The Patient Self-Determination Act: Implementation Issues and Opportunities, Annenberg Washington Program 2-3 (undated) [hereinafter Cate & Gill].

\textsuperscript{57} 110 S. Ct. 2841 (1990).

\textsuperscript{58} Cruzan v. Director, Mo. Dep't of Health, 110 S. Ct. 2841, 2844 (1990) [hereinafter Cruzan I]. The vote on the majority side consisted of Chief Justice Rehnquist and Justices Antonin Scalia, Sandra Day O'Connor, Byron White, and Anthony Kennedy.
ittle clear direction in knowing whether they were required to acknowledge any asserted right to refuse treatment to sustain life.\(^\text{59}\)

In the Missouri court, it had been held that a health care provider must give life-sustaining treatment with two significant exceptions: (1) when the person was a mentally competent adult refusing treatment based upon adequate information, and (2) when a close family member or legal guardian could demonstrate by clear and convincing evidence that the patient would have turned down life-sustaining treatment under the facts of the case.\(^\text{60}\)

Chief Justice William Rehnquist, the author of the plurality opinion, wrote that the "clear and convincing evidence" rule violated no legal principle grounded in the Fourteenth Amendment.\(^\text{61}\) He conceded that the Constitution, and particularly the liberty interest rooted in the Fourth and Fourteenth Amendments, contains a right to refuse medical treatment, if the person so refusing is mentally competent.\(^\text{62}\)

But the right could be limited to the individual or to a guardian. The standard of proof was heightened because the interest at stake was so significant.\(^\text{63}\) A state is free to refuse to make an independent judgment about the quality of life just as it is free to ignore decisions by family members that a patient's interests would be served by terminating life-sustaining treatment.\(^\text{64}\)

The four dissenting Justices, as well as Justice O'Connor, who concurred, indicated that a fundamental right exists for a competent person to refuse either lifesaving nutrition or medical treatment.\(^\text{65}\)

\(^{59}\) Id. at 2852-53. The Court in *Cruzan* did not expressly give the right to refuse treatment to incompetents. At least one separate opinion — the concurrence of Justice O'Connor — can be taken to mean that incompetents who have taken steps while competent to give durable powers of attorney for health care, or have expressed themselves clearly (as in a living will), have rights. *Id.* at 2857 (O'Connor, J., concurring).

\(^{60}\) *Cruzan v. Harmon*, 760 S.W.2d 408, 425 (Mo. 1988), *aff'd sub nom.*, *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841 (1990) [hereinafter *Cruzan I*].


\(^{62}\) *Cruzan I*, 110 S. Ct. at 2851.

\(^{63}\) *Id.* at 2853.

\(^{64}\) *Id.* at 2854.

\(^{65}\) *Id.* at 2865 (Brennan, J., dissenting); *id.* at 2856 (O'Connor, J., concurring). As one author has noted, "By defining the 'right to die' as [fundamental], Justice Brennan would extend that right to incompetents, for they also are entitled to due process and the equal protection of their rights." Elizabeth D. McLean, Note, *Living Will Statutes in Light of Cruzan v. Director, Missouri Department of Health: Ensuring That a Patient's Wishes Will Prevail*, 40 EMORY L.J. 1305, 1314 (1991).
The case contains no majority opinion on the question, however, of whether there is a constitutionally rooted right to die.

Left unanswered in the wake of *Cruzan* are several important questions which may or may not be resolved now that the Patient Self-Determination Act  has become law. State law, after all, must clearly indicate the right of the patient to both information from a provider and the right to refuse such treatment. But even assuming that each state has enacted such clarifying legislation explaining when a person may refuse treatment, what type of instrument is necessary to effect a patient's right, and under what circumstances must health care providers obey valid directives, several intriguing questions remain.

In the first place, “right to die” decisions can involve “active” or “passive” interventions when a patient is in failing health. In the former, the issue is whether death may be brought about by means other than natural ones. In the latter, the patient is allowed to die from the underlying condition. The law, it seems, has strongly opposed active intervention which may constitute suicide, assisted suicide, or even homicide. In the case of passive measures, on the other hand, treatment orders such as “do not resuscitate” directives have become common in hospitals.

One authority claims that discussions between physicians and patients concerning the desirability of resuscitative efforts can have as many as four consequences:

First, both may agree that the hospital should attempt to resuscitate the patient. Second, both may agree that the hospital should not try to resuscitate the patient. Third, the patient may desire a DNR order which the doctor opposes. Finally, the patient may request resuscitation which the doctor thinks is inappropriate.

Each of these scenarios, Professor Carol Mooney asserts, may call into play the fundamental interests of patient autonomy and preser-
Secondly, although the decision in *Cruzan* acknowledges that there are circumstances in which an individual has the right to refuse medical treatment, including refusal of hydration and nutrition, the case is of absolutely no help in distinguishing between a patient's rights relating to nutrition and hydration on the one hand and other forms of treatment.

While refusing to be attached to a respirator or heart-lung machine is clearly within a patient's right to refuse treatment, it is not clear that the same can be said for a diabetic who refuses to take insulin, an individual who declines the provision of antibiotics, or an accident victim who refuses attempts to stem arterial bleeding. Even more disturbing is the possibility that an individual can attempt a suicide and leave a suicide note invoking a constitutional right to resist medical treatment. Perhaps at least a part of the problem arises from the Court's inconsistent use of terminology, leading one to conclude that there might be "a difference between a healthy patient and a dying or incompetent one." Surely, some comprehensive legislative solution would begin to unravel the puzzle left after this unsettling set of opinions.

THE PATIENT SELF-DETERMINATION ACT

The congressional origin of the Patient Self-Determination Act ("Act") was the introduction in the United States Senate in October, 1989, of a bill by Senators John Danforth, R-Mo., and Daniel Patrick Moynihan, D-N.Y.

This bill "reflected a bipartisan effort to assure that patients are given information about the extent to which (the rights to make health care decisions even if unconscious or incapacitated) already exist under applicable state law." This legislation was signed into law on November 5, 1990, and took effect December 1, 1991.

Any health care facilities — hospitals, nursing homes, or hospices, for example — which receive Medicare or Medicaid payments must give their patients written information concerning their rights

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72. *Id.*
74. *Id.* Thomas noted that although the petitioners in *Cruzan* had urged a right to resist "life-sustaining treatment," the Court established the right as one to resist life-saving nutrition and hydration. *Id.* at 14 n.54.
75. PSDA, *supra* note 2.
77. Cate & Gill, *supra* note 56, at 7.
78. *Id.*
under the law of the state in which they are located. This package of information includes material about the right to accept or refuse medical or surgical treatment. Specifically, the information must describe:

(i) an individual’s rights under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives and (ii) the written policies of the provider or organization respecting the implementation of such rights.

The information is to be given to hospital patients at the time of their admission as inpatients, by nursing facilities at the time of an individual’s admission as a resident, by a home health agency in advance of a person’s coming under the care of the agency, by a hospice at the time of initial receipt of such care, and by a Health Maintenance Organization (“HMO”) at the time of enrollment of a person. In addition, the care facility must prepare an “advance directive” which is a written document detailing what kinds of treatment the patient may want. As will be fully set out later in this Article, advance directives for purposes of complying with the Act are of three common forms: living wills, which declare what kind of life-sustaining treatment an individual would want if terminally ill and not capable of engaging in medical decisionmaking, durable powers of attorney for health care purposes, which name an agent who is empowered to make decisions if the executor of the document is unable to make them, and medical directives, which combine and refine elements of the first two forms.

Each medical care facility receiving Medicare or Medicaid treatment is required under the Act to inform patients about its internal policies relating to life-sustaining treatments. The facility must ask the patient whether he or she has executed an advance directive. The information must be included in the medical records retained by the facility.

80. Id.
81. Id. §§ 1395cc(f)(2), 1396a(w)(2).
82. Id. §§ 1395cc(f)(3), 1396a(w)(4).
85. PSDA, supra note 2, 42 U.S.C. §§ 1395cc(f)(1), 1396a(w)(1); see AMI St. Joseph Hospital, Advance Directives, Omaha, Nebraska (1991) (Hospital Policy Documents on Advance Directives on file at the Creighton Law Review).
The facility also is required to conduct educational campaigns both for members of its professional staff and for the public at large. The Act does provide, however, that it is not intended to "prohibit the application of a State law which allows for an objection on the basis of conscience for any health care provider or any agent of such provider which as a matter of conscience cannot implement an advance directive." States are required under the Act to develop a written description of the law of the state (whether statutory or as recognized by the courts of the state) concerning advance directives that would be distributed by providers.

Finally, the Secretary of the United States Department of Health and Human Services is required to develop a national campaign to inform the public of the option to execute advance directives and of a patient's right to participate and direct health care decisions. This section of the law mandates that the Secretary approve or develop "nationwide informational materials that would be distributed by [the] providers . . . to inform the public and the medical and legal profession of each person's right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the existence of advance directives."

The Secretary is further ordered to work with the states in preparing materials on applicable state law, to mail information to Social Security recipients, and to add a description of the new law to the Medicare handbook. It is clear that the Act did not create a comprehensive package of advance directive health care rights. The existence and shape of such rights depends on the law of each state.

UNDERSTANDING STATE LAW ON ADVANCE DIRECTIVES

The critical center of the Act is the requirement that program participants inform patients of their rights to formulate their own health care decisions consistent with state law. Broadly speaking, advance directives for health care assume one of three recognized forms: Living Will, Health Care Power of Attorney, and Medical Directive. In some cases, hybrid variations are permitted under local law. Not every state recognizes every form. It would be rare if

87. Id. §§ 1395cc(f)(1)(E), 1396a(w)(1)(E).
88. Id. § 1396a(w)(3).
89. Id. § 1396(a)(58).
90. PSDA, supra note 2, § 4751(d).
91. Id. § 4751(d)(2).
92. Id. §§ 4751(d)(3)-(4).
95. In Nebraska, for example, only the Living Will and Durable Power of Attor-
any state addressed every contingency which may arise during medical treatment. The forms generally recognized are living will, durable power of attorney for health care, and medical directive combining and refining the elements of the first two.

The typical state statute treating these forms includes such elements as who may execute a directive, what form the directive must take in that jurisdiction, portability of directives, requirements for witnessing, circumstances under which it will be enforced, circumstances under which providers may decline to honor the directive, and revocation.96

LIVING WILLS

Living wills are devices which allow individuals to express their medical treatment preferences formally.97 The typical state statute defines the range of clinical circumstances under which the instrument may be invoked.98 The important starting point, therefore, for assessing the breadth and usefulness of a living will, is an examination of the definition sections of a statute. Such sections will define the circumstances under which a “terminally ill,”99 “incompetent”100 patient, facing “imminent death,”101 may have treatment suspended. The statute will define the duties of specific providers, including their right to exercise independent medical judgment to refuse to carry out the wishes of the principal.102

DURABLE POWERS OF ATTORNEY FOR HEALTH CARE

The common-law power of attorney is a document by which a principal gives authority to another to act on his or her behalf.103 Because, powers of attorney under common law were extinguished when the principal became incapacitated, states have enacted statutes authorizing general durable powers of attorney.104 These instru-

98. See, e.g., Neb. L.B. 671, supra note 3, §§ 5, 7 & 8 (adopting the Rights of the Terminally Ill Act).
99. Id. § 3 (11).
100. Id. § 3 (6).
101. Id. § 3 (11).
102. Id. §§ 9, 10.
104. Stiegel et al., 25 CLEARINGHOUSE REV. at 690.
ments remain valid even when the principal is incapacitated.\textsuperscript{105}

States also have drafted statutes on durable powers of attorney for health care which allow a principal to name another person to act on the principal's behalf in the making of health care decisions should the principal become incapacitated.\textsuperscript{106} The statutes authorizing these instruments, like the living will laws, typically define the parties who may execute them, the circumstances under which they become effective, the persons who qualify as attorneys in fact, the powers of providers to exercise independent judgment notwithstanding the directions of the attorney in fact or the instrument, and the process by which the instrument may be revoked.\textsuperscript{107} The instrument may be more, or less, specific with relation to specific clinical situations, depending on the scope of the authorizing statute and the desires of the principal. The decisionmaker is not permitted to make medical determinations, for example, which are forbidden to the patient, nor to engage in conduct forbidden by local law.\textsuperscript{108}

**MEDICAL DIRECTIVES**

A third form of advance authorization, called a "medical directive," has been designed.\textsuperscript{109} This permits a principal to "specify both the clinical situations and the medical treatments to be administered, withdrawn or withheld."\textsuperscript{110} Thus, a principal gets the advantages of both the living will and the durable power of attorney for health care. It has been observed that although these directives may be comprehensive, they also may be confusing to patients seeking to use them.\textsuperscript{111} The more specific they are, however, the more likely it is that health care providers will honor their specifications. It should be apparent that although the living will and the proxy appointment are relatively simply executed, the medical directive may require medical advice to select a treatment alternative.\textsuperscript{112}

The process of policymaking is ongoing. Legislators must understand that their challenge is to draft comprehensive, sound processes consistent with the advances in modern science.\textsuperscript{113}

\textsuperscript{105} Id.
\textsuperscript{106} See L.B. 696, supra note 3, § 1(1).
\textsuperscript{107} Id. § 2 (definitions); id. § 17 (limiting to powers of attorney in fact); id. § 20 (revocation).
\textsuperscript{108} Id. § 17(1)(a).
\textsuperscript{110} Gieszl & Velasco, 24 ARIZ. ST. L. REV. at 736.
\textsuperscript{111} Id.
\textsuperscript{112} Id. at 737 (chart). See Gilbert, 30 J. FAM. L. at 131-32.
\textsuperscript{113} See Cate & Gill, supra note 56, at 22-25 (discussing the many unresolved challenges to lawmakers, attorneys, and health care providers).
NEBRASKA'S LEGISLATION

During the 1992 session, the Nebraska Legislature enacted two pieces of legislation which would serve as the state implementation of the Patient Self-Determination Act. One was a living will law called the Rights of the Terminally Ill Act. ("Act") The other was a durable power of attorney law.

NEBRASKA'S LIVING WILL LEGISLATION

The Rights of the Terminally Ill Act is based largely on the Uniform Rights of the Terminally Ill Act, approved in 1985 by the National Conference of Commissioners on Uniform State Laws. At the time of this writing, at least ten states had enacted living will legislation based on significant portions of the uniform act.

Legislative Intent

The legislative intent of the Nebraska Act is found in section 2(1), which provides that the Legislature adopted the Act to provide a means for Nebraskans to exercise their common-law right and constitutionally protected interest in directing their own medical treatment. The exercise of this right includes the discretion "to withdraw or withhold life-sustaining" medical procedures. Furthermore, the Act gives a patient or a "patient's next of kin" the right to bring a civil cause of action if the directives of the patient are unjustifiably violated.

However, the Legislature made clear that the right to self-deter-
mination is not absolute, and specified that the right is subject to conflicting state interests in "preventing homicide and suicide, protecting dependent third parties, and maintaining the integrity of the medical profession."

Thus, the Nebraska law, like the Uniform Act on which it was patterned, distinguishes the removal or refusal of treatment is merely life prolonging from an affirmative act quickening occurrence of death.

Terms Defined in the Nebraska Living Will Act

The Nebraska Act defines key terms used in the statute. Although the Act is based on the Uniform Act, some of the key

122. Id.
123. Compare id. § 12(7) (stating that the Act does not alter existing laws concerning homicide, suicide or assisted suicide) with URTIA, supra note 52, 9B U.L.A. at 609 (providing that the URITA "is limited to treatment that is merely life prolonging, and to patients whose terminal condition in incurable and/or irreversible, whose death will soon occur, and who are unable to participate in treatment decisions").
124. See L.B. 871, supra note 3, § 3, at 2-4. The text of § 3 provides:

(1) Adult shall mean any person who is nineteen years of age or older or who is or has been married;
(2) Attending physician shall mean the physician who has primary responsibility for the treatment and care of the patient;
(3) Declaration shall mean a writing executed in accordance with the requirements of subsection (1) of section 4 of this act;
(4) Health care provider shall mean a person who is licensed, certified, or otherwise authorized by the law of this state to administer health care in the ordinary course of business or practice of a profession;
(5) Life-sustaining treatment shall mean any medical procedure or intervention that, when administered to a qualified patient, will serve only to prolong the process of dying or maintain the qualified patient in a persistent vegetative state;
(6) Persistent vegetative state shall mean a medical condition that, to a reasonable degree of medical certainty as determined in accordance with currently accepted medical standards, is characterized by a total and irreversible loss of consciousness and capacity for cognitive interaction with the environment and no reasonable hope of improvement;
(7) Person shall mean an individual, corporation, business trust, estate, trust, partnership, association, joint venture, government, governmental subdivision or agency, or any other legal or commercial entity;
(8) Physician shall mean an individual licensed to practice medicine in this state;
(9) Qualified patient shall mean an adult who has executed a declaration and who has been determined by the attending physician to be in a terminal condition or a persistent vegetative state;
(10) State shall mean a state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, or a territory or insular possession subject to the jurisdiction of the United States; and
(11) Terminal condition shall mean an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of the attending physician, result in death within a relatively short time.

Id.
terms have been changed to reflect the intent given the statute by the Nebraska Legislature.125 The terms defined by the Nebraska Act include “declaration,” “life-sustaining treatment,” “persistent vegetative state,” “qualified patient,” and “terminal condition.”126

The Definition of “Declaration”

The term “declaration” is defined in the Nebraska Act as an actual physical writing, in the manner set forth in section 4(1) of the Act.127 Section 4(2) provides a model form for the declaration, but it is not mandatory that the statutory language be followed.128 Thus, a declaration will not be deemed ineffective merely because an individual puts the declaration in his or her own words. This provision is consistent with the Uniform Act which also provides that a declaration “may, but need not, be” in the form provided.129

The Nebraska Act also sets forth specific elements that must be present for an individual to have the capacity to execute a declaration to withhold or withdraw life-sustaining treatment.130 The Act specifically requires that the declarant (1) be an adult, (2) be of sound mind, and (3) sign the declaration or, at their direction, have another individual sign it in the presence of two adult witnesses or a notary public.131 When a health care provider is furnished with the declaration, or a copy of it, the declaration is to be made part of a patient’s medical record.132 If the provider is unwilling to comply with the declaration, the provider is to promptly advise the declarant.133

The Definition of “Qualified Patient”

The Nebraska Act provides that a “qualified patient may make decisions regarding life-sustaining treatment so long as the patient is

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125. Compare id. with URTIA, supra note 52, 9B U.L.A. at 611-12 (defining terms in the Uniform Rights of the Terminally Ill Act).
126. L.B. 671, supra note 3, § 3. Section 3 also defines the terms “adult,” “attending physician,” “health care provider,” “person,” “physician,” and “state.” Id. These terms are commonly recognized statutory terms that are highly unlikely to raise interpretation issues.
127. Id. For the text of section 3, see supra note 119.
128. See L.B. 671, supra note 3, § 4(2).
129. URTIA, supra note 52, § 2 official comment, 9B U.L.A. at 614 (stating that the sample declaration form is not mandatory, and rejecting a more detailed declaration due to the concern that a simpler form would be held ineffective).
130. L.B. 671, supra note 3, § 4(1).
131. Id. Section 4(1) also puts limits on individuals who qualify as witnesses. Id. Section 4(1) states: “No more than one witness to a declaration shall be an administrator or employee of a health care provider who is caring for or treating the declarant, and no witness shall be an employee of a life or health insurance provider for the declarant.” Id. These restrictions do not apply to a notary public witness. Id.
132. L.B. 671, supra note 3, § 4(3).
133. Id.
able to do so."134 For the purposes of the Nebraska Act, a qualified patient must meet at least three requirements. First, the patient must be an adult under Nebraska law; second, the patient must have executed the declaration; third, the attending physician must have determined that the patient is in a “terminal condition or persistent vegetative state.”135 However, section 8(3) of the Nebraska Act limits the circumstances in which a pregnant declarant may be considered a “qualified patient.”136 The Act expressly states that if there is a probability of the fetus continuing to develop to the point of live birth with continued use of life-sustaining treatment, life-sustaining treatment will not be withheld or withdrawn.137

The Definition of “Life-Sustaining Treatment”

The definition of “life-sustaining treatment” in the Nebraska Act provides: “Life sustaining treatment shall mean any medical procedure or intervention that, when administered to a qualified patient, will serve only to prolong the process of dying or maintain the qualified patient in a persistent vegetative state.”138 This language appears broad enough to include anything ordered by a physician. Furthermore, the “prolong the process of dying” language appears to indicate that death would occur whether or not the treatment is utilized.

The Definition of “Terminal Condition”

The definition of “terminal condition” is essentially an affirmative statement.139 Under the Nebraska Act, “terminal condition” is limited to when a patient’s condition is incurable or irreversible, and when death is imminent.140 Conversely, a medical condition that is not incurable or irreversible, or when death is not imminent, is not a “terminal condition” as defined by the Nebraska Act.

The Definition of “Persistent Vegetative State”

The inclusion of a definition for “persistent vegetative state” broadens the scope of the Nebraska Act beyond that of the Uniform Act after which the Nebraska Act was patterned.141 The definition in the Nebraska Act allows life-sustaining treatment to be discontin-
ued, through a declaration, even if an individual is not near death.\textsuperscript{142} The Nebraska Act defines a persistent vegetative state as a medical condition in which there is (1) "total and irreversible loss of consciousness and capacity for cognitive interaction with the environment," (2) "no reasonable hope of improvement," and (3) a reasonable degree of medical certainty to support the first two determinations.\textsuperscript{143}

\textbf{When Does the Living Will Become Operative?}

Section 5 of the Nebraska Act details four prerequisites under which the declaration shall become operative.\textsuperscript{144} One requirement for the declaration to become operative is "that the declaration must be communicated" to the attending physician.\textsuperscript{145} The physician is then required to place a copy of the declaration in the patient's medical record.\textsuperscript{146} The Act, however, is silent as to the method of communication that will satisfy the requirement that the physician be notified.\textsuperscript{147}

Once this first requirement has been met, the attending physician then must determine that the patient is in either a "terminal condition or persistent vegetative state" and unable to make treatment decisions for himself or herself.\textsuperscript{148} Finally, the Act requires that the attending physician notify a member of the patient's family of his or her condition, and of the intent to invoke the declaration.\textsuperscript{149} When these requirements have been met, the declaration becomes operative.\textsuperscript{150}

The Act does not mandate that a physician withhold or withdraw life-sustaining treatment once the declaration becomes operative.\textsuperscript{151} However, the Act does require that a physician and other health care providers either comply with the declaration or promptly take every reasonable step to transfer the patient to a "provider who is willing to do so."\textsuperscript{152}

\textsuperscript{142} L.B. 671, supra note 3, § 3(6).
\textsuperscript{143} Id.
\textsuperscript{144} Id. § 5.
\textsuperscript{145} Id. § 5(1).
\textsuperscript{146} Id. § 4(3).
\textsuperscript{147} Id. § 5(1) (requiring only that the declaration be communicated to the attending physician).
\textsuperscript{148} Id. § 5(2)-(3).
\textsuperscript{149} Id. § 5(4).
\textsuperscript{150} Id. § 5.
\textsuperscript{151} Id. §§ 4(3), 8(3), 9, 12(3), (6), (7) & 16.
\textsuperscript{152} Id. § 9.
Revocation of a Declaration

The Act provides that a declaration may be revoked "at any time and in any manner" regardless of a declarant's physical or mental condition.\(^\text{153}\) The revocation becomes operative when it is communicated to the health care provider.\(^\text{154}\) This communication may be made by either the declarant or a witness to the revocation.\(^\text{155}\) And, as with the declaration, a health care provider must make the revocation a part of the patient's medical record.\(^\text{156}\)

Immunities and Liabilities

Section 10 of the Act allows health care providers to carry out a living will declaration without fear of liability.\(^\text{157}\) Section 10 immunizes health care providers under certain circumstances from civil, criminal, and disciplinary action.\(^\text{158}\) For example, health care providers are immune from civil or criminal liability or discipline if they give effect to a declaration absent the knowledge that the declaration has been revoked.\(^\text{159}\) Providers also are given such immunity when their actions conform to reasonable medical standards.\(^\text{160}\)

Just as the Act provides for certain immunities, it also provides for certain liabilities.\(^\text{161}\) Section 12 of the Act declares specific forms of physician or other health care provider conduct as a Class 1 misdemeanor.\(^\text{162}\) For example, the following forms of conduct are declared Class 1 misdemeanors: (1) the willful failure to transfer a patient in accordance with the Act; (2) the willful failure to record the terms of a declaration or a diagnosis of a terminal condition or persistent vegetative state on a patient's medical record; (3) the willful cancellation, obliteration, concealment, or defacement of another's declaration without a declarant's consent; (4) the falsification or forgery of another's declaration; (5) the falsification or forgery of another's revocation of a declaration; and (6) willfully concealing or withholding personal knowledge of a revocation made in accordance with the Act.\(^\text{163}\)

\(^{153}\) Id. § 6(1).
\(^{154}\) Id.
\(^{155}\) Id.
\(^{156}\) Id. § 6(2).
\(^{157}\) Id. § 10.
\(^{158}\) Id. § 10(1).
\(^{159}\) Id.
\(^{160}\) Id. § 10(2).
\(^{161}\) Id. § 11.
\(^{162}\) Id. § 11(1).
\(^{163}\) Id. § 11.
What Effect Does a Declaration Have on Insurance?

The drafters of the Nebraska Living Will Act expressly directed that the “making of a declaration pursuant to” the Act would neither affect the sale, purchase, or issuance of a life insurance policy or annuity, nor would it legally impair existing insurance or annuity policies. Furthermore, the Act prohibits health care or insurance companies from increasing or decreasing rates for self-determination declarants, and it demands that no person shall require any other individual to execute a declaration as a condition to obtaining insurance.

Conclusion

The Nebraska Rights of the Terminally Ill Act is a first step toward implementing the rights of patients in the area of medical self-determination. Although the Act contains definitions that are not wholly consistent with those in the “durable power of attorney for health care” statute, it demonstrates a willingness of the State’s lawmakers to acknowledge patient rights and comply with the new federal law.

NEBRASKA’S DURABLE POWER OF ATTORNEY STATUTE

Legislative Intent

The 1992 Nebraska Legislature enacted a second piece of legislation which relates to the Patient Self-Determination Act: L.B. 696, the Power of Attorney for Health Care Act. (“Power of Attorney Act”) The legislative intent of this statute is found in L.B. 696, section 1(1) and (2). Section 1 provides, generally, that it is the intent of the Power of Attorney Act to allow “a competent adult to designate another person to make health and medical treatment deci-

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164. Id. § 12(2).
165. Id. § 12(3).
167. L.B. 671, supra note 3, § 3, and L.B. 696, supra note 3, § 2, define such terms as “health care provider” and “life sustaining treatment” differently, for example.
168. See L.B. 671, supra note 3, Summary Analysis (Mar. 6, 1991) (statement of Judiciary Committee Staff).
169. L.B. 696, supra note 3.
170. Id. § 1(1),(2).
sions if the adult becomes incapable of making them. Furthermore, like the Rights of the Terminally Ill Act, this statute does not create any new rights or alter existing rights, but rather allows an adult to "exercise rights he or she already possesses by means of delegation of decisionmaking authority to a designated attorney in fact." The Power of Attorney Act does nothing in relation to the provision or rejection of any specific medical treatment and alters no legislation about homicide, suicide, or assisted suicides.

Terms Defined in Nebraska's Power of Attorney for Health Care Act

Just as in the Rights of the Terminally Ill Act, the Power of Attorney Act carefully defines key terms used in the statute. Logically, because the statutes are closely related, many of the terms defined in the Power of Attorney Act are substantially similar to those defined in the Rights of the Terminally Ill Act. However, there are several terms that should be highlighted.

Definition of "Attorney in Fact"

The Power of Attorney Act uses the term "attorney in fact" consistently with its common usage. An "attorney in fact" is commonly understood to be a person (agent) appointed by another person (principal) to act and make decisions in the appointing principal's place through a written instrument known as a "power of attorney." The Power of Attorney Act defines an "attorney in fact" as an adult who is properly designated to make health care decisions for another person pursuant to a power of attorney for health care.

To meet the "properly designated" requirement, the adult must be appointed pursuant to a power of attorney that meets the requirements set out in section 4, and be appointed without violating the sec-

\[\text{\textsuperscript{171}} \text{ Id. \ $1(1).}\]
\[\text{\textsuperscript{172}} \text{ See id. \ $1(2).}\]
\[\text{\textsuperscript{173}} \text{ See id. \ $1(3).}\]
\[\text{\textsuperscript{174}} \text{ See id. \ $2.}\]
\[\text{\textsuperscript{175}} \text{ Compare id. \ $2 (defining rights of terminally ill persons) with L.B. 671, supra note 3, \ $3 (providing for creation of power of attorney).}\]
\[\text{\textsuperscript{176}} \text{ Compare L.B. 696, supra note 3, \ $2(3) with BLACK'S LAW DICTIONARY 129 (6th ed. 1990) (defining "attorney in fact" as "[a] private attorney authorized by another to act in his place and stead, either for some particular purpose, as to do a particular act, or for the transaction of business in general, not of a legal character"). Black's Law Dictionary also provides that "[t]his authority is conferred by an instrument in writing called a 'letter of attorney,' or more commonly a 'power of attorney.'" Id.}\]
\[\text{\textsuperscript{177}} \text{ L.B. 696, supra note 3, \ $2(3). Note that an "attorney in fact" is not the same thing as an attorney at law, given the former does not need to be a legal practitioner. See BLACK'S LAW DICTIONARY 129 (6th ed. 1990).}\]
\[\text{\textsuperscript{178}} \text{ L.B. 696, supra note 3, \ $2(3).}\]
tion 6 prohibitions against who may serve as an attorney in fact.\textsuperscript{179}

In addition to providing for an attorney in fact, the Power of Attorney Act also provides for a successor attorney in fact.\textsuperscript{180} The successor attorney in fact must naturally meet the same appointment standards as the original attorney in fact.\textsuperscript{181} The successor would serve in the place of the original attorney in fact if for some reason the original attorney in fact was not reasonably available, or unwilling or unable to serve as the attorney in fact.\textsuperscript{182} However, the original attorney in fact shall take over authority and the successor's authority shall cease if the original attorney in fact becomes able, available, and willing to serve as attorney in fact.\textsuperscript{183}

The Definition of “Health Care” and “Health Care Decisions”

The term “health care” has a broad connotation under section 2(4) of the Power of Attorney Act.\textsuperscript{184} It means “any treatment, procedure, or intervention to diagnose, cure, care for, or treat the effects of disease, injury, and degenerative conditions.”\textsuperscript{185} Health care decisions are defined as including the “consent, refusal of consent, or withdraw of consent to health care.”\textsuperscript{186} As can be seen, the statutory health care power not only permits an authorized agent to handle decisions that deal with actual medical treatment, but also permits an authorized agent to handle issues involving the personal care and maintenance of the principal.\textsuperscript{187} Thus, the terms, as used in the Power of Attorney Act, encompass decisions regarding institutional care and nursing homes, as well as the types of personal services that should be provided at home or in an institution.

The Definition of “Incapable” as Used in the Power of Attorney Act

According to section 3(7), a person is deemed incapable once he or she has (1) lost the ability to “understand and appreciate the nature and consequence of health care decisions,” or (2) lost the ability

\begin{footnotesize}
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\item 179. Id. §§ 4, 6. See id. § 5(1). Section 5(1) for those persons who may not qualify as a witness under § 4 of the Power of Attorney Act.
\item 180. Id. § 3(1).
\item 181. Id. § 2(3).
\item 182. Id. § 3(1). Additionally, section 7 provides the methods by which an attorney in fact may withdraw. Id. § 7.
\item 183. Id. § 3(1).
\item 184. Id. § 2(4).
\item 185. Id.
\item 186. Id. § 2(5). Section 2(5) also states that health care decisions do not include “(a) withdrawal or withholding of routine care necessary to maintain patient comfort; (b) withdrawal or withholding of the usual and typical provision of nutrition and hydration; (c) withdrawal or withholding of life-sustaining procedures or of artificially administered nutrition or hydration, except as provided for by this act.” Id.
\item 187. See supra notes 179, 181 and accompanying text.
\end{itemize}
\end{footnotesize}
to communicate "in any manner an informed health care decision." Understanding the "nature and consequence of health care decisions" includes understanding available health care alternatives in addition to understanding the risks and benefits of a particular form of health care under consideration.\(^{189}\)

Incapacity determinations are made in writing by the attending physician (and consulting physician, if there is one).\(^{190}\) Section 12 requires the written determination to include the "cause and nature of the principal's incapacity."\(^{191}\) Section 12 also requires that the determination be placed in the principal's medical record kept by the attending physician (and, when applicable, with the records of the consulting physician, and health care facility where the principal is a patient).\(^{192}\) Finally, after the incapacity determination has been made, the attending physician is required to promptly notify (1) the principal, if she is able to comprehend such notice; (2) the attorney in fact; and (3) the health care provider.\(^{193}\)

If a dispute regarding a principal's incapacity arises, a petition, asking for a judicial determination of the principal's ability to make health care decisions, may be filed in the county where the principal resides or is located.\(^{194}\) Upon such a petition being filed, a court is required to "appoint a guardian ad litem to represent the principal" and conduct a capacity determination hearing.\(^{195}\) The court then has seven days to make its determination.\(^{196}\) A court determination that the principal is incapable will activate the "authority, rights, and responsibilities of the principal's attorney in fact."\(^{197}\)

The Form of the Health Care Power of Attorney

The form of the statutory health care power of attorney and the meaning of the general grant of powers contained in the form are set out in section 8(1) and paragraphs (a) through (d) of that section.\(^{198}\) Although the Power of Attorney Act requires a health care power of attorney to substantially comply with the form set out in section 8, it also permits a power of attorney instrument "drafted under the Uniform Durable Power of Attorney Act or in any other form" if it fully

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188. L.B. 696, supra note 3, § 3(7).
189. Id.
190. Id. § 12(1).
191. Id.
192. Id.
193. Id. § 13.
194. Id. § 15.
195. Id.
196. Id.
197. Id.
198. Id. § 8(1).
complies with section 4 of the Nebraska Power of Attorney Act. Furthermore, the Act specifically notes that a validly executed power of attorney for health care under another state’s laws will be upheld as valid in Nebraska. As with a living will, the power of attorney for health care should be included in a principal’s medical record kept by the attending physician.

The Scope of an Attorney in Fact’s Authority

As stated earlier, either a medical or judicial determination that a principal is incapable of making health care decisions will activate the powers and authority of the attorney in fact. Guidance concerning the extent of the attorney in fact’s authority is found in section 17, the heart of the statute. The first part of this section grants the attorney in fact power to make health care decisions on a principal’s behalf. The second part of the section deems this power to be superior to any other person’s power (excluding the principal’s own power) to act on the principal’s behalf. However, it is important to keep in mind that an attorney in fact only has authority to make health care decisions if and when the principal is incapable of doing so. In addition to having the power to make health care decisions for the incapable principal, the attorney in fact has the same right as the principal to receive information about proposed health care and medical and clinical records. The attorney in fact also has the right to disclose such medical and clinical records.

The legislatively conferred ability of a competent adult to plan for the day of decisionmaking incapacity is not unlimited. Sections 17 and 18 of the Power of Attorney Act impose several limitations and restrictions on a attorney in fact’s powers. An attorney in fact may not (1) “consent to any act or omission” that the principal could not lawfully consent to; (2) make decisions limiting the health care of a pregnant woman if such decisions would result in the unborn child’s death — given it is probable that a child would be born alive

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199. Id. 8(1) (requiring substantial compliance); id. § 8(2) (permitting other forms of compliance).
200. Id. § 8(4).
201. Id. § 9.
202. See id. § 17.
203. Id. § 17(1).
204. Id. § 17(2).
205. Id.
206. Id. § 17(4). These rights can be limited by the power of attorney. See id.
207. Id. Note that the Act specifically provides “that the right to access of such records shall not be a waiver of any evidentiary privilege.” Id.
208. Id. § 17(1).
209. Id. §§ 17(1), 18.
210. Id. § 17(1).
with continued health care;\(^\text{211}\) (3) refuse or withdraw the continued provision of comfort care;\(^\text{212}\) and, (4) except as provided in the Power of Attorney Act, refuse or withdraw "artificially administered nutrition and hydration."\(^\text{213}\) In addition to these restrictions, an attorney in fact, who is making health care decisions pursuant to a health care power of attorney, has the duty of consulting with medical personnel in making such decisions.\(^\text{214}\)

It is important to note that the Power of Attorney Act does not require a health care provider to accept the decision of the attorney in fact if that decision is one that would not have been honored if made by the principal.\(^\text{215}\) A health care provider is justified in rejecting a health care decision if the rejection is based on a provider's previously established policy, which is grounded in sincerely held religious, ethical, or moral beliefs, and if the provider, when reasonably possible, has informed the attorney in fact or principal of such policy.\(^\text{216}\) If this creates an unresolvable problem, a provider must promptly step in and arrange for the principal to be transferred if the attorney in fact is unwilling or unable to do so.\(^\text{217}\)

The Revocation of a Power of Attorney for Health Care

A valid power of attorney continues in effect for the life of the principal, until the attorney in fact and any successor withdraws, or until the instrument is revoked.\(^\text{218}\) Section 20 of the Power of Attor-

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\(^{211}\) Id.  
\(^{212}\) Id. at 18(3).  
\(^{213}\) Id. § 18(2). The Power of Attorney Act provides that an attorney in fact does have authority to refuse or withdraw a "life sustaining procedure or artificial hydration or nutrition" when (a) the principal is suffering from a terminal condition or is in a persistent vegetative state and (b) the power of attorney for health care explicitly grants such authority to the attorney in fact or the intent of the principal to have life-sustaining procedures or artificially administered nutrition or hydration withheld or withdrawn under such circumstances is established by clear and convincing evidence. 

\(^{214}\) Id. § 18(1). This duty requires: In exercising authority under the power of attorney for health care, an attorney in fact shall have a duty to consult with medical personnel, including the attending physician, and thereupon to make health care decisions (a) in accordance with the principal's wishes as expressed in the power of attorney for health care or as otherwise made known to the attorney in fact or (b) if the principal's wishes are not reasonably known and cannot with reasonable diligence be ascertained, in accordance with the principal's best interests, with due regard for the principal's religious and moral beliefs if known.

\(^{215}\) Id. § 27(1).  
\(^{216}\) Id.  
\(^{217}\) Id.  
\(^{218}\) Id. § 10.
ney Act states the rules for revocation.\textsuperscript{219} The general rule in section 20(1) gives a principal the right to revoke the power of attorney “at any time . . . and in any manner” so long as he or she is competent to do so.\textsuperscript{220} Subsections (4) and (6) of section 20 specifically state that a revocation can be properly made by including the desire to do so in a divorce decree entered into pursuant to Nebraska Revised Statutes sections 42-347 to 42-380, or executing a new valid power of attorney which automatically replaces any previously existing ones.\textsuperscript{221} Like the living will revocation, the power of attorney revocation becomes operative when it is communicated to a health care provider and must be included in a principal’s medical record.\textsuperscript{222}

**Immunities and Liabilities**

Section 23 of the Power of Attorney Act is an extremely important section. This section provides a special set of rules regarding the immunities of an attorney in fact and the health care provider acting under this statute.\textsuperscript{223} Under section 23(1), an attorney in fact is immune from any civil or criminal liability or professional disciplinary action when the attorney in fact acts “in good faith pursuant to a power of attorney for health care.”\textsuperscript{224}

Similarly, section 23 also shields health care providers from liability in a criminal, civil, or professional disciplinary action.\textsuperscript{225} Specifically, health care providers are granted immunity from “acting or declining to act in reliance upon the decision made by the person whom” a provider thinks in good faith to be the attorney in fact for health care decisions.\textsuperscript{226} However, the Power of Attorney Act in no way limits liability that health care providers are subject to as the result of negligence associated with “the medical diagnosis, treatment, or care of the principal.”\textsuperscript{227}

**CRITIQUE AND RECOMMENDATIONS**

Since the decision in *Cruzan v. Director, Missouri Department of Health*...
Health and the attendant realization that most Americans were not, at that time, in control of their fate should they become incompetent and terminally ill, two important legislative steps have been taken to assert an individual’s autonomy over health care decisions, especially at the end of life. Neither of these events has answered the entire array of questions poseable in the area of health care directives. They have, however, broken the proverbial roadblock in the path of recognition of the full range of protectable liberty interests associated with health care.

No legislative scheme, especially when it is dependent on action by both the nation and the respective state legislatures and may involve judicial intervention for full implementation, can be expected to solve the host of problems in this field without considerable refining over time. To take the next steps toward implementing the legal protections of individuals, however, one first must identify and correct the principal shortcomings of the current legislation.

The Patient Self-Determination Act ("PSDA") acknowledged what the common law and constitutional law guarantee — that the patient generally possesses the legal authority to refuse medical treatment, even if such refusal will result in death. The PSDA creates no new rights. It encourages patients to clarify their wishes before the onset of incompetency. It does not ensure — it cannot ensure — that patients will take advantage of any information given to them by providers, nor does it guarantee that states will adopt anything approximating a uniform, consistent, broad system for information insemination and advance directive declarations. The law is deferential to the states, leaving them to design any sanctioned directive.

Insofar as patients engage the health care delivery system in a leisurely and rational fashion, the federal law serves them best, assuming the states have carried out their part of the underlying program and that health care providers cooperate in the enterprise. Insofar as patients do not engage the health care system in leisure

229. See supra notes 2-3 and accompanying text.
232. Id. at 609.
233. Id.
234. PSDA, supra note 2, 42 U.S.C. § 1395cc(f)(1)(A)(i). The statute directs program participants to provide written information regarding "an individual’s rights under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning such medical care." Id.
235. Moran Danis et al., A Prospective Study of Advance Directives for Life-Sustaining Care, 324 New Eng. J. Med. 882, 884 (1991) (reporting that only 75% of pa-
and with rationality — as when they are victims of strokes or incapacitating accidents — the PSDA is virtually worthless\textsuperscript{236} except insofar as it calls for a program of education and directs the government to notify some Americans of their rights under it. As has often been pointed out, even Nancy Cruzan would not be able to take advantage of the new federal law were she encountering the health care system for the first time today.\textsuperscript{237}

There are three failings of the PSDA. First, it provides no protection for patients in states that do not have advance directive laws.\textsuperscript{238} It does provide some incentives for the states to have some form of law on the books and some policy for communicating information to patients regarding their rights.\textsuperscript{239} Second, it does not address situations where there is no advance directive, whether living will, durable power of attorney for health care, or a modern variation of these tools.\textsuperscript{240} A patient who comes to the hospital with no advance directive and is not in a position to execute one is out of luck.

The final failing of the PSDA is that it leaves intact a myriad of restrictions on advance directives found in state law.\textsuperscript{241} It is not a comprehensive national program. A patient in a persistent vegetative state is not necessarily in a terminal condition under the law of some states.\textsuperscript{242} Treatment may not be terminated regardless of the patients’ advance directives were carried out in one study). See Gieszl & Velasco, 24 ARIZ. ST. L.J. at 770-71.

\textsuperscript{236} See PSDA, supra note 2, 42 U.S.C. § 1395cc(f)(2)(A). The statute states that the written information required to be given to a hospital patient, for example, shall be provided “to an adult individual . . . at the time of the individual’s admission as an inpatient.” Id.

\textsuperscript{237} Mulholland, 28 HARV. J. ON LEG. at 628 n.84. See Cruzan v. Director, Mo. Dep’t of Health, 110 S. Ct. 2841, 2852 (1990). Compare Thomas, supra note 8, at 23 (noting that a state requirement of “competent” expressions of a desire to resist medical treatment could be construed so as to prohibit minors or a person incompetent because of disease or mental disability from exercising their right to have medical treatment withheld) and Chapman, 42 ARK. L. REV. at 393 (commenting on other landmark cases, and the need to extend living will legislation to the permanently unconscious) with Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 431-32 (Ohio Ct. App. 1977) (allowing treatment to be refused on behalf of a 67-year-old retarded person on the basis that he would have refused treatment had he been competent and aware of his circumstances).

\textsuperscript{238} L.B. 696 was not to become operative until January 1, 1993, more than a year following the operative date of the PSDA.

\textsuperscript{239} See PSDA, supra note 2.

\textsuperscript{240} Nebraska’s laws, for example, were not enacted until 1992, well over a year following the enactment of the federal law and one-half year after its effective date. See L.B. 671, supra note 3, § 33.


\textsuperscript{242} Gilbert, Note, 30 J. FAM. L. at 126 (citing Kentucky law which defines “terminal condition” as one that is “caused by injury, disease or illness which, to a reasonable
ence of evidence that the patient would choose to refuse treatment.\textsuperscript{243} The federal law’s prophylactic effect, then, is circumscribed by the state law where the patient is being treated.\textsuperscript{244}

These shortcomings could be remedied by enactment of preemptive federal legislation which, by the nature of things, would invade states’ rights.\textsuperscript{245} Thus, whether it is politically possible to enact a sweeping federal law is highly problematic. Attention therefore must be turned to the state scheme of things.

State laws on advance directives apply most typically to people in terminal conditions whose deaths are imminent.\textsuperscript{246} States should reexamine their laws to address the question of whether they would want to devise a plan whereby the exercise of the right of medical self-determination could be triggered for a Nancy Cruzan.\textsuperscript{247} This would require adoption of a “substituted judgment” process for those in her position.\textsuperscript{248} In effect, it would be a fourth form of medical directive, wholly outside the pattern of the three previously discussed.\textsuperscript{249} Even without such a radical addition, the existing pattern should be reevaluated beginning with careful attention to the definition of terms.

The question should be asked, for example, whether the expression “terminal condition” should be defined differently.\textsuperscript{250} The term is said to be a condition in which a patient is incurable and his or her condition is irreversible. The term imminent death\textsuperscript{251} is likewise restrictive, for it often is defined by a term certain, such as “within
degree of medical probability . . . is incurable and irreversible and will result in death within a relatively short time, and where the application of life-prolonging treatment would serve only to artificially prolong the dying process”). \textsuperscript{4}See \textsuperscript{5}KY. REV. STAT. ANN. § 311.624(8) (Baldwin 1992).

\textsuperscript{243} Gilbert, 30 J. FAM. L. at 127.

\textsuperscript{244} Id. As one commentator has noted: “Until the legislatures of those states consider the implications of \textit{Cruzan} and revise their right-to-die statutes accordingly, those laws are virtually useless to a competent person who executes a living will preferring death over an existence in a persistent vegetative state.” \textit{Id.}

\textsuperscript{245} \textit{See} Mulholland, 28 HARV. J. ON LEG. at 629 (arguing for protecting the right to die, and that a sweeping federal law “arguably might intrude upon the states’ rights to regulate the welfare of their citizens. Indeed, these laws might not survive judicial scrutiny”). The author reasons that the Supreme Court, sympathetic towards states’ rights, might overturn Garcia v. San Antonio Metro. Transit Auth., 495 U.S. 528 (1985), which is highly deferential to federal use of the commerce power. Mulholland, 28 HARV. J. ON LEG. at 629 n.88.

\textsuperscript{246} Gilberg, 30 J. FAM. L. at 126.

\textsuperscript{247} Id.

\textsuperscript{248} Id.


\textsuperscript{250} \textit{See L.B. 671, supra note 3, §§ 1(13) & 3(11).}

\textsuperscript{251} \textit{See WIS. STAT. ANN. §§ 154.01(8), 154.03(1)-(2) (West Supp. 1985).}
The imminent death notion is troublesome because it may not cover the cases where an advance directive could be most humane, that is, where a patient is in a persistent vegetative state, and there is no medical certainty as to when death will occur. The definition, on the other hand, may be so vague as to cause health care providers to refrain from implementing any advance directive, lest they face liability or professional discipline.

Should greater efforts be made to encourage each state to adopt a comprehensive advance medical directive, broader in scheme than the Uniform Rights of the Terminally Ill Act and the durable power of attorney for health care? Such a hybrid document has been considered thoughtfully and is available for introduction in state legislatures. It will take considerable alteration of existing state law in those jurisdictions which contemplate "either or" directives at present, and employ different definitions of the same terms depending on the directive involved. States reluctant to adopt the modern hybrid advance directive should, at least, consider whether it is possible for patients to employ both a living will and a durable power of attorney for health care, insofar as these are not inconsistent. A necessary start is as suggested above — uniformity of definitions in existing state law.

The federal legislation contemplates extensive public education on advance directives, but does not formulate a program nor provide funding. As Congress was considering the Patient Self-Determination Act, a Wall Street Journal article reported that only between fifteen and twenty percent of the adults in the nation had any type of written directive. To begin the process of broader public awareness of their rights, an official of the American Bar Association has urged that family lawyers routinely ask their clients whether they have or desire advance directives. Physicians likewise should ask patients while the patients are well if they understand their rights and wish to take steps to implement them. Public health officials

252. See id.
254. See, e.g., L.B. 671, supra note 3, § 10 (absolving helath care providers of civil or criminal liability, or professional discipline for giving effect to a declaration).
255. Emanuel & Emanuel, 261 JAMA at 3292-93.
256. See Chapman, 42 ARK. L. REV. at 391-94.
257. Id.
258. See PSDA, supra note 2, § 4751(d). The PSDA directs that the Secretary of Health and Human Services undertake responsibilities for materials development and education. No penalty, however, is attached to noncompliance. Id.
260. Id.
could undertake extensive planning and implementation of education programs, beginning with programs in the elementary and secondary schools.

In a short period of time, Americans have begun to be aware of a right to control their own medical destiny. States have formulated devices whereby patients can express their wishes before a crisis strikes or the patient is incompetent to direct his or her care. The Supreme Court’s decision in *Cruzan*, the new federal law, and state directive statutes comprise a first, though shaky, step toward full patient self-determination. Much work is yet to be done.