Legislating Advance Directives for the Terminally Ill: The Living Will and Durable Power of Attorney

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Just as I choose a ship to sail in or a house to live in, so I choose a death for my passage from life . . . Nowhere should we indulge the soul more than in dying . . . A man's life should satisfy other people as well, his death only himself, and whatever sort he likes best.1

I. INTRODUCTION

The scientific revolution, which began with the launching of

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1. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatment 22 (1983) (quoting Seneca, Suicide, in The Stoic Philos-
Sputnik in 1957, has progressed to its next, inevitable stage. Not only has the process of living been taken over by computers, microprocessors, and technology, but the process of dying has also been transformed. In 1949, 50 percent of all deaths occurred in hospitals and nursing homes; by 1980, that figure increased to approximately 80 percent. The practice of medicine has evolved into "an industry bigger than defense and is growing faster than computers." What was once the domain of private physicians and charitable hospitals is now the province of what has become a mass of large profit-making corporations.

The causes of death have also changed. Influenza, pneumonia, gastritis and tuberculosis were the leading causes of death in 1900. All attacked their victims relatively early in life. By 1980, heart disease, cancer, and cardiovascular diseases had become the primary threats to life. Not only do these diseases attack later in life, they are also progressive in the sense that their victims often struggle for several months—or years—before succumbing. When death finally occurs, it is usually an institutional one. Frequently, the dying patient's last glimpse of life is a blur of sterile white nurses' and physicians' garb, beset by reflections from I.V. containers amid the tubes that artificially connect the patient to a world of which he is no longer a part.

In an effort to return control over the final stage of life to the terminally ill individual, a national movement with diverse supporters has gained strength and momentum. What began in 1938 as a special interest group, the Euthanasia Society of America, has evolved into a national movement, representing a variety of religious faiths and political points of view. In Ohio alone, twenty-five special interest groups are supporting legislative proposals which advocate a right to die.

Religious organizations have, for the most part, supported this movement. The Lutheran and Catholic churches actively support the right of a terminally ill patient to take pain killers which may

ophy of Seneca 506 (W. Norton & M. Hadas trans. 1958) [hereinafter cited as President's Commission Report].
2. Id. at 17-18.
3. The Big Business of Medicine, Newsweek, Oct. 31, 1983, at 62 [hereinafter cited as Big Business].
4. Id.
5. President's Commission Report, supra note 1, at 16.
6. Concern For Dying, Information Pamphlet (1983) (on file with the author) [hereinafter cited as Concern For Dying].
not only remove pain, but also shorten life.8 A 1980 Vatican declaration sanctions the Living Will as the right of a competent adult.9 The Jewish community takes a slightly different approach. While traditional Judaism sanctifies life above all else, artificial delay in the dying process is not required. The Central Conference of American Rabbis supports the Euthanasia Council, as evidenced by its statement that, under special circumstances of suffering and helplessness, “you may allow death to come.”10

The common law has long recognized and protected the concepts of human autonomy and self-determination. Implicit in this position is the patient’s right to refuse life-prolonging intrusions. Cardozo originally articulated the idea in a 1914 battery case, stating: “Every human being of adult years and sound mind has the right to determine what shall be done with his own body. . . .”11 In the past ten years, a growing number of courts have reaffirmed this right in the context of informed consent suits based on negligence principles.12 Recently, in cases dealing with medical, legal,
and ethical issues, state courts have also begun to safeguard the "right to decide."13

While such decisions give legal power to patient self-determination, they require a dying patient to initiate court proceedings to prevent or terminate intervention when consent has not been given.14 Consequently, of the thousands of such decisions made daily, only a handful of cases have been litigated thus far. These opinions raise two major issues: Who should decide, and what decisions are appropriate? First, there may be, and often is, a conflict between the patient, family, and physicians about the appropriate method of treatment. The common law makes it very clear that the patient is in charge of the decisionmaking process.15 If the patient is incompetent, someone acting on his behalf may make treatment decisions.16 Case law, however, continues to be very unclear as to a dividing line between competence and incompetence.17

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13. See, e.g., Satz v. Perlmutter, 379 So. 2d 359 (Fla. 1980) (competent adult has a constitutional right to discontinue extraordinary life-sustaining treatment upon family's consent); In re Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981) (guardian of adult incompetent is entitled to consent to termination of patient's respirator where patient, before becoming incompetent, expressed a desire not to have his life prolonged by artificial means).


addition, it is uncertain as to who the appropriate decisionmaker should be once incompetence is determined.18

The other major obstacle centers on the issue of the appropriateness of the decision. It has become abundantly clear in the past ten years that neither physicians nor philosophers agree on what constitutes an “extraordinary” or “useless” treatment, or an “invasive technique.”20 Likewise, physicians trained in the Hippocratic tradition are often far more comfortable with medical intervention than are their patients.21

Given the lack of moral and legal certainty about such matters, it is not surprising that courts have drawn the line in different places.22 The result is that a dying patient, even if he initiates legal action, has no assurance that he will be able to make his wishes known or that his wishes will be honored. Fearing not only civil24
but also criminal liability, physicians are often reluctant to obey even the most precisely expressed wishes of a patient.

In partial response to these problems, the constitutional right to privacy has been used to justify the termination of life-supports for the unconscious, critically ill patient. As early as 1928, Brandeis spoke of the "right to be let alone—the most comprehensive of rights and the right most valued by civilized men." This theme was also articulated later in Supreme Court cases involving unwarranted state limitations on abortion, parental authority and family integrity, and the decisions "to marry, . . . procreate, and . . . use contraceptives." The Court has not yet extended the right of privacy to encompass a "right to die," but it could one day view such a right as consistent with the fourteenth amendment grant of liberty. State courts have already recognized a constitutional

814-15 (1980). The fear of civil liability is usually a fear of a malpractice suit, based on the theory that a reasonably prudent doctor, under similar circumstances, would not fail to prolong life.

In order to establish such a conclusion, the plaintiff (usually a relative in a wrongful death action) must offer the testimony of a physician practicing the same specialty somewhere in the United States. See, e.g., Shilkret v. Annapolis Emergency Hosp. Ass'n, 276 Md. 187, 349 A.2d 245 (1975).

Although the requirement of expert testimony was initially intended as a safeguard against unfounded suits, the recent use of a national rather than local standard of care has greatly expanded the opportunity to prove wrongdoing. Thus, physician-specialists often feel victimized by the possibility of second guessing after the fact by any other specialist in the country.

When confronted with a possible clash between the malpractice standard of care and patient autonomy protected by the doctrine of informed consent, or right of privacy, most courts evade the issue by claiming that professional custom recognizes the rights of dying patients. See Satz v. Perlmutter, 362 So. 2d 160 (Fla. Dist. Ct. App. 1978), aff'd, 379 So. 2d 359 (Fla. 1980); Barber v. Superior Court, 137 Cal. App. 3d 1006, —, 195 Cal. Rptr. 484, 491-92 (1983).


29. Id. at 434 nn. 14-16 (Marshall, J., dissenting) (citing Zablocki v. Redhail, 434 U.S. 374 (1978) (statute denying persons with child support obligations the right to marry absent a showing that such obligations have been met violates the equal protection clause of the fourteenth amendment); Eisenstadt v. Baird, 405 U.S. 438 (1972) (statute prohibiting the distribution of contraceptives is a per se ban on contraception and, therefore, is unconstitutional under Griswold v. Connecticut, 381 U.S. 479 (1965))); Skinner v. Oklahoma, 316 U.S. 535 (1942) (statute authorizing the sterilization of "habitual criminals" violates the equal protection clause).

30. Roe v. Wade, 410 U.S. 113, 152-53 (1973). In Roe, the court noted that although
foundation which could support the right to privacy for the terminally ill. These courts have also indicated that, in the absence of legislative direction, the judiciary should ensure the patient's right to die with as much dignity as possible.

Other factors accent the inadequacy of common law and constitutional principles when applied to medical decisionmaking involving incompetent, terminally ill patients. For example, the cost of caring for the terminally ill patient places an enormous financial burden on the patient's family and health care insurer. Currently, health care costs are increasing at an annual rate of 11 percent with no sign of decreasing. Over half of all health care dollars are spent in the declining years of life. In addition, the cost of legal procedures, such as guardianships or lawsuits to protect patient or staff legal rights, is rapidly becoming a problem. The New York court has noted that, because the health care provider's only protection is the common law doctrine of informed consent, the court's as well as the provider's resources might be excessively

the Constitution does not explicitly guarantee a right of privacy, the Court has consistently recognized that such a right does in fact exist under the Constitution.

Initially, however, the Court could not agree on the source of privacy rights. See Griswold v. Connecticut, 381 U.S. 479 (1965) (Justice Douglas concluded that explicit constitutional amendments created "zones of privacy" or "penumbras," while Justices Goldberg, White and Harlan stated that the concept of liberty contained in the Fourteenth Amendment embraced the right of privacy). Finally, in Roe, Justice Blackmun, writing for the majority, concluded that "[the] right of privacy [is] founded in the Fourteenth Amendment's concept of personal liberty." 410 U.S. 113, 153 (1973).


32. Big Business, supra note 3, at 63.

33. Id.

34. In 1978, health care expenditures for those persons 65 and over totaled $50 billion. On a per capita basis, those who were 65 and over spent an annual average of $2000three times more than the annual average of $600 spent by those under 65. WHERE HOUSE CONFERENCE ON AGING, CHARTBOOK ON AGING IN AMERICA 94 (1981).

35. One of the authors recently questioned lawyers in Kansas City about the cost of establishing a guardianship for a family member. It was estimated that $1,000 would be needed to cover legal and court costs in initiating such a proceeding. Id.

taxed by "an increase in the institution of such proceedings, in some instances as an anticipatory defense strategy with respect to possible future claims from malpractice."\textsuperscript{37}

To meet these realities of contemporary law and medicine, state legislatures in fifteen jurisdictions have enacted statutes authorizing the use of the Living Will for health care decisionmaking.\textsuperscript{38} This document, written by a legally competent adult (usually before a terminal illness or disease strikes), constitutes an affirmative directive to medical personnel to withhold artificial life-support systems in certain instances.\textsuperscript{39} The person affirms his right to die peacefully and as painlessly as possible, without futile prolongation of life.

As an advanced directive, the Living Will is only as effective as its specific message. Descriptive terms, such as "terminal illness," "extraordinary measures," or "artificial life-supports," often take on a different meaning after tragedy strikes. Since it will often be impossible for a person who executes a Living Will to anticipate the precise medical and practical circumstances that influence his dying process, the moral and legal ambiguities surrounding these phrases hamper the effectiveness of the Living Will.\textsuperscript{40}

In light of the inherent difficulty in phraseology, the President's Commission for the Study of Ethical Problems in Medicine, in its final report issued in March of 1983, recommended new legislation as an alternative to current and proposed Living Will provisions. In place of the specific advanced directive of the Living Will, the Commission advocated the use of a general durable power of attorney statute which would vest the decisionmaking responsibility in a designated person. Forty-nine jurisdictions\textsuperscript{41} have already enacted legislation that grants a durable power (one not affected by the principal's incapacity) to a specified individual to act for the principal in accordance with the authorization granted to him in the document. Most of this legislation is patterned after the 1979 Uniform Durable Power of Attorney Act\textsuperscript{42} and appears to adopt the

\textsuperscript{37} Id. at 389, 420 N.E.2d at 77-78, 438 N.Y.S.2d at 279-80 (Jones, J., dissenting in part).
\textsuperscript{39} Id. at 139.
\textsuperscript{40} See supra notes 19-21 and accompanying text.
\textsuperscript{41} Only the District of Columbia lacks a general durable power of attorney statute.
\textsuperscript{42} See President's Commission Report, supra note 1, at 391-92.
durable power concept as used in property transactions. Its potential for extending the authority of the attorney-in-fact to include health care decisions has not yet been tested by the courts.\textsuperscript{43}

A few states have specifically added limited health care decisionmaking authority for the attorney-in-fact.\textsuperscript{44} California's statute is the most extensive. Its 1983 Durable Power of Attorney for Health Care Decisions Act\textsuperscript{45} permits competent adult citizens to draft a power of attorney document in which an attorney-in-fact for health care decisions is specifically mandated. In addition, this legislation defines when, and under what conditions, the principal may authorize an attorney-in-fact to act as his proxy. It also limits the agent's decisionmaking power and specifies the extent of the immunity granted health care providers in carrying out the directives of the attorney-in-fact.\textsuperscript{46}

This Article will examine the mechanics of Living Will and durable power of attorney legislation. It will analyze their relative strengths and weaknesses as well as their potential usefulness to the terminally ill patient. Because the California statute represents the latest approach to advance directive decisionmaking, it will be examined in detail. Used exclusive of, or in tandem with, the Living Will, the California durable power of attorney has the potential for becoming a powerful tool for those who struggle to retain control over the circumstances surrounding their inevitable death.

\section*{II. THE LIVING WILL AS A LEGISLATIVE ALTERNATIVE}

The term "Living Will" was first used in 1967 by Dr. Louis Kutner to describe a document drafted by a competent adult as an advance directive to his physicians or family. Usually the document provides that no extraordinary artificial life-support systems may be used to prolong the drafter's life or suffering in the event of a terminal illness or injury which would render him incapable of expressing his wishes.

The Karen Ann Quinlan case\textsuperscript{47} provided the impetus for the

\begin{itemize}
  \item \textsuperscript{43} Note, Appointing an Agent to Make Medical Treatment Choices, 84 Col. L. Rev. 985, 986 n.9 (1984).
  \item \textsuperscript{45} See infra note 86.
  \item \textsuperscript{46} See infra notes 87-123 and accompanying text.
  \item \textsuperscript{47} In re Quinlan, 70 N.J. 10, 355 A.2d 647, cert. denied, 429 U.S. 922 (1976). This case involved a 21-year-old girl who had suffered permanent and extensive brain damage. The patient remained in a coma for several months with little or no possibility of recovery. The trial court judge refused her parents' petition to disconnect the respirator but commented that his decision might have been different if Karen had executed a Living Will. On appeal, the New
passage in 1976 of the California Natural Death Act—the first statute to recognize the legitimacy of private medical directives. It has been estimated that over five million Living Wills have been distributed. Increasing numbers of jurisdictions are recognizing the Living Will's apparent utility. To date only twenty-two jurisdictions have made it legally enforceable. In other states, moreover, courts have recognized such a document as relevant evidence in civil suits where the withdrawal of life-support apparatus is sought.

Jersey Supreme Court reversed, holding that in the absence of legislative authorization to discontinue treatment of the terminal patient, the physician and parents should be the primary decisionmakers.

49. See Severns v. Wilmington Medical Center, Inc., 421 A.2d 1334 (Del. 1980). In Severns the husband of a comatose patient filed a complaint in the Delaware Court of Chancery seeking appointment as the patient's guardian and an order authorizing him to request removal of her life-support systems. The Delaware Court of Chancery certified several questions to the supreme court. The supreme court accepted certification as to one question only: Was the Delaware Court of Chancery, absent enabling legislation, without power to award the relief sought? Id. at 1339. The supreme court found that the lower court would have power to authorize removal of the life-supports if the evidence warranted it. Accordingly, the Wcourt instructed the lower court to conduct an evidentiary hearing rather than rely solely on the stipulated facts before it. The stipulation stated that the patient was an active member of the Euthanasia Council of Delaware, id. at 1338 n.2, that she wanted to execute a Living Will, id., and that she had made statements to third parties indicating “her desire for discontinuance of life-sustaining procedures in the event of her suffering an incapacitating injury or illness.” Id. at 1340. The supreme court implied that such evidence was relevant and should be brought out during the evidentiary hearing. Id. at 1349-50.

See also Kennedy Memorial Hosp. v. Bludworth, 432 So. 2d 611 (Fla. Dist. Ct. App. 1983) (where comatose patient previously executed a Living Will, a duly appointed guardian may petition for authority to request removal of artificial life-support).


51. In re Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, cert. denied, 454 U.S. 855 (1981). Storar was a consolidated case. The second suit, Eichner v. Dillon, involved an 83-year-old man who went into cardiac arrest during a routine hernia operation. As a result, he suffered brain damage and was placed on a respirator. After being informed that there was no reasonable chance for recovery, the patient's guardian filed suit requesting that the respirator be removed. In support of his petition, the guardian submitted evidence revealing that before the operation the patient had “made it known
In March 1983, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research reported great variety among the fifteen Living Will statutes currently in force. The most common provisions of these statutes, including those that restrict the efficacy of the Living Will, will now be explored. Of course, problems encountered in these twenty-two jurisdictions are compounded when no enabling legislation exists.

A. Procedural Requirements

All statutory provisions establishing the use of Living Wills adopt the same procedural requirements as those found in testamentary will provisions. These procedural safeguards put a declarant on notice that an important document is being executed. While most of the twenty-two states which have adopted the Living Will have provided a statutory Living Will form to be used by prospective testators, a failure to properly execute the document may still lead to the will's invalidation. However, the fear that such formalities may limit the number of valid instruments catalyzed the need for further protection through a savings clause which guarantees common law rights in the absence of a valid declaration.

The practice of cautioning a declarant to consider carefully the importance and content of the document has been extended beyond formalities of execution. The California, Texas, Idaho, and Oregon statutes also require the patient to revalidate his directive that under these circumstances [i.e., a vegetative coma] he would want a respirator removed." Id. at 373, 420 N.E.2d at 68, 438 N.Y.S.2d at 270-71. New York had not enacted legislation making the Living Will legally enforceable. The court, however, went so far as to recognize the oral Living Will as evidence of the patient's desires, and approved discontinuance of the respirator.

52. President's Commission Report, supra note 1, at 141.

53. For example, Arkansas' statute provides that "[a]ny person, with the same formalities as are required by the laws of this State for the execution of a will, may execute a document." Ark. Stat. Ann. § 82-3802 (Supp. 1983).

California, Idaho, Nevada, Oregon, Texas, and Washington also require that the will "be signed in the presence of two witnesses not related to the declarant by blood or marriage and who would not be entitled to any portion of the estate of the declarant." See, e.g., Cal. Health & Safety Code § 7188 (West Supp. 1983). California also prohibits a treating physician or healthcare facility from being a witness. Further safeguards for the patient in a nursing home are assured by the requirement that one witness must be a patient advocate, so named by the State Department of Aging for that specific purpose. Cal. Health & Safety Code § 7188.5 (West Supp. 1983).

54. Arkansas, Delaware, and New Mexico do not provide a form.

after becoming terminally ill. California adds the requirement that a patient must wait fourteen days after his terminal illness is diagnosed before revalidating his wishes. The revalidation requirement appears to be an Achilles heel to those Living Will statutes which contain them. Much of the time such provisions are unrealistic and unworkable. A recent survey conducted by Stanford University revealed that only half of California's patients who drafted directives before becoming terminally ill remained conscious for the required waiting period. The other half were either dead or legally incompetent before the fourteen day period had expired.

The Karen Ann Quinlan case offers an example of the problems inherent in the revalidation requirement. In that case, Karen's parents who sought to remove her from the respirator would not have been aided by a Living Will executed in a state which requires revalidation. Had she signed an otherwise enforceable document, Karen's physician would not have been able to determine that Karen was terminally ill until she was actually unconscious—at which time revalidation would be physically impossible.

If Karen Quinlan had executed a Living Will in the majority of states with enabling legislation, no revalidation nor waiting period would be required. However, nearly all states place legislative limitations on the conditions under which a directive may become operative. Typical provisions specify that a physician must determine “that the declarant's present condition is terminal and incurable,” and that death is “imminent.” Critical conditions—where the possibility of death is a danger but not absolute—and chronic vegetative states are not included. Arguably, at the time Karen Quinlan's father sought permission to remove her from the respirator, she had been diagnosed as terminal. In retrospect,
her physicians were wrong; Karen continues to survive in a permanent vegetative state. Interestingly, the presence of a valid Living Will would still be of little use to Karen since she does not suffer from a terminal illness, nor is she faced with "imminent" death.

These points are further illustrated by the facts of a recent criminal case in California, *Barber v. Superior Court.* Clarence Herbert, like Karen Quinlan, suffered apparently irreversible brain damage due to a cardiorespiratory arrest following an otherwise successful and routine surgery. After a short period of respiratory treatment, he was removed from the respirator and continued to breathe. Because of the overly restrictive revalidation requirement in the California statute, a Living Will would have been useless to Herbert, his family, and physicians. Such a will would require a two week waiting period before becoming enforceable. Herbert stopped breathing in the recovery room and never became conscious from that moment until his death eleven days later. Moreover, following removal of the respirator, Herbert’s vegetative state, like that of Karen Quinlan, did not qualify as a "terminal condition." Until diagnosis of a terminal condition can be made, all patient and family rights are determined solely by common law. The appellate court, which exonerated Doctors Barber and Nejdl on October 12, 1983, noted that Living Will provisions are "so cumbersome that it is unlikely that any but a small number of highly educated and motivated patients will be able to effectuate their desires." Even then such a patient’s desire would be honored only if the terminal illness does not result in unconsciousness before completion of the waiting period.

Although Clarence Herbert’s actual expressed desire prior to his surgery was not to “become another Karen Ann Quinlan,” existing Living Will legislation gives no legal credence to such expressions. Though common law remedies remain, they cannot alleviate the emotional suffering and economic loss to the family

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64. *Id.* at —, 195 Cal. Rptr. 494, 492 (1983). Doctors Nedjl and Barber were unable to diagnose the precise amount of brain damage suffered by Clarence Herbert. They determined that Herbert exhibited minimal brain activity and, as such, could not be pronounced brain dead. *Id.* at —, 195 Cal. Rptr. at 488. Beyond this, however, Nedjl and Barber could conclude only that Herbert had virtually no chance of recovering his cognitive functions. *Id.* at —, 195 Cal. Rptr. at 492.
65. *See supra* note 53.
66. *Id.* at —, 195 Cal. Rptr. at 493 (citing *In re Quinlan,* 70 N.J. 10, 50-51, 355 A.2d 647, 669, *cert. denied,* 429 U.S. 922 (1976)).
that the Living Will acts were intended to prevent. In addition to all of this, the medical staff remains exposed to the complex uncertainties of both civil and criminal liability.

B. Physician Immunity

In Barber, Doctors Barber and Nejdl relied, in part, on the written informed consent of the family in discontinuing Mr. Herbert's life-support. Had a Living Will been executed by Herbert, how secure would the Doctors have been when life-sustaining equipment was turned off? Ironically, in nearly all jurisdictions, Herbert's execution of a Living Will would have afforded less protection to his physicians than that provided by common law doctrines of informed consent and malpractice, which they argued in defense against the charges of murder and conspiracy leveled against them.

As is the case with the other Living Will statutes, California's Natural Death Act grants civil and criminal immunity to health care personnel and institutions that act in good faith to remove or withhold life-sustaining procedures when the patient suffers from a terminal, incurable illness. Assuming Mr. Herbert's condition could be defined as "terminal," the meaning of the phrase "life-sustaining procedures," is still not clear. Although a respirator probably qualifies as a life-sustaining procedure, the Act's definition does not state whether feeding tubes of various descriptions, blood transfusions, or even arterial blood gas studies also fall within its ambit. Judicial clarification of such an issue would

68. See supra notes 16-23 and accompanying text.
69. See supra notes 24-25 and accompanying text.
70. 137 Cal. App. 3d at —, 195 Cal. Rptr. at 489. The physicians argued that they consistently acted with the informed consent of the family. In August 1981, Clarence Herbert successfully underwent an ileostomy. While in the recovery room, he suffered cardiorespiratory arrest. He was treated and attached to a respirator. Subsequent neurological tests revealed that Herbert was comatose with little chance of recovery. He had suffered severe brain damage and was likely to remain in a permanent vegetative state. Physicians communicated the prognosis to the Herbert family who met and drafted a memorandum requesting that "all machines [be] taken off that are sustaining life." Id. at —, 195 Cal. Rptr. at 486. The memo was signed by Herbert's wife and eight children. Upon removal of the respirator, Herbert continued to breathe. Acting in accordance with their own professional judgment and without written consent of the family, Herbert's physicians ordered removal of all intravenous fluid and nourishment tubes. Herbert received only nursing care until his death eleven days after surgery.
71. See supra note 50.
73. Id. § 7187(c).
74. California's Natural Death Act defines "life-sustaining procedure" as "medical or other artificial means to sustain, restore, or supplant a vital function"
probably require costly guardianship or conservatorship proceedings.\textsuperscript{75}

Necessarily then, courts and medical decisionmakers remain subject to common law notions of propriety; hence, Doctors Nejdl and Barber could well remain vulnerable to legal attack for their behavior during the entire course of medical treatment despite the presence of a valid Living Will. Thus, if Clarence Herbert's hypothetical Living Will was construed to include termination of a respirator, but not feeding tubes, the common law doctrine of informed consent would govern the latter issue. The requirements of material disclosure and clear consent, and the determination of whether the relatives acted in the best interests of the patient would determine the sufficiency of the physicians' communications with Herbert's relatives.\textsuperscript{76} Similarly, criminal law concepts such as "malice," "intent" or "unlawful" behavior would govern a murder indictment.\textsuperscript{77} However, physicians relying on a document may forget these obligations. Consequently, a validly executed Living Will could mislead a physician when it is, in fact, legally inoperative and provides no immunity in a medical situation.

Given the limited scope and concomitant immunity under the Act, physicians have little motivation to follow the dictates of a Living Will. This article is reinforced by additional provisions that give the physician who \textit{fails} to comply with an advance directive both criminal and civil immunity.\textsuperscript{78} Only Vermont and Wyoming

\textsuperscript{75} See supra note 35. California requires conservatorship, \textit{Cal. Prob. Code} \textsection 2300 (West 1981), unless there is no ongoing need for a conservator, in which case a single court hearing can be held. \textit{Id.} \textsection 3200. Though simplified, this procedure requires the determinations of which person will make the medical decision and authorization of the medical treatment recommended.

\textsuperscript{76} California has led the way in articulating these elements. \textit{See}, \textit{e.g.}, \textit{Truman v. Thomas}, 27 Cal. 3d 285, 611 P.2d 902, 165 Cal. Rptr. 308 (1980); \textit{Cobbs v. Grant}, 8 Cal. 3d 229, 505 P.2d 1, 104 Cal. Rptr. 505 (1972).

\textsuperscript{77} When forced to categorize intravenous feeding tubes and respirators in a murder-conspiracy case, the appellate court in \textit{Barber} relied on a benefit-burden analysis derived from civil cases and the writings of ethicists. 137 Cal. App. 3d 1006, —, 195 Cal. Rptr. 484, 490-92 (1983). The court found a murder prosecution to be "a poor way to design an ethical and moral code for doctors," \textit{id.} at —, 195 Cal. Rptr. at 486, and requested legislative clarification in distinguishing between "lawful" and "unlawful" withholding of treatment. Reversing the lower court's ruling that any intentional conduct which shortened the patient's life was unlawful, the appellate court said such conduct was not unlawful if the physicians' acts were consistent with accepted medical practice in the community in which physicians practice. \textit{Id.} at —, 195 Cal. Rptr. at 492.

\textsuperscript{78} California law provides: "No physician . . . shall be criminally or civilly liable for failure to effectuate the directive of the qualified patient . . . ." \textit{Cal. Health & Safety Code} \textsection 7191(b) (West Supp. 1983).
require the physician to transfer the patient to another physician's
care or, in the alternative, to inform the patient or his family of his
inability to follow the directives.\textsuperscript{79} The other states generally fol-
low the Virginia provision: "An attending physician who refuses to
comply with the declaration of a qualified patient . . . shall make a
\textit{reasonable effort} to transfer the patient to another physician."\textsuperscript{80}
The physician's refusal to withhold treatment or transfer the pa-
tient brings no statutory penalty in most jurisdictions and the pos-
sibility of professional censure in only a few.\textsuperscript{81}

C. Summary

Current Living Will legislation attempts to facilitate an individ-
ual's use of advance directives in medical decisionmaking. How-
ever, in most cases the legislation actually impairs the use of
advance directives. Although procedural prerequisites and
revalidation requirements exist for the declarant's protection, they
also drastically limit the scope of the patient's decisionmaking au-
thority. Similarly, immunity provisions for health care personnel
raise difficult questions. The physician immunity issue is a partic-
ularly serious one, because it operates as a two-edged sword.
Broad immunity is necessary to preserve responsible medical
practice. However, because the medical decisionmaker is under
no threat of penalty if the Living Will is disregarded, and is given
scant protection if it is followed, he has gained little incentive to
follow the patient's wishes, and even greater control over sobering
life and death issues.

Despite problems with their use, Living Wills perform a valua-
ble function: They allow a person to express a desire to die with-
out unnecessary medical intervention. Because it may be difficult
to talk about these matters with family or physicians, a simple doc-
ument allows for expression of the patient's deeply held beliefs.
When the patient is no longer able to communicate, such a docu-
ment may be the only vestige of autonomous intent.

\textsuperscript{79} VT. \textsc{Stat. Ann.} tit. 18, § 5256 (1982); WYO \textsc{Stat.} § 33-26-147(b) (1984).
\textsuperscript{80} VA. \textsc{Code} § 54-325.8:7 (Supp. 1983) (emphasis added).
\textsuperscript{81} One commentator argues that courts have generally denied civil immunity
unless the legislation or case law clearly requires it. Freamon, \textit{Death With
Dignity Laws: A Plea For Uniform Legislation}, 5 \textsc{Seton Hall Legis. J.} 105,
136 (1982). Living Will statutes retain the physician's liability for negligence
or failure to act on the informed consent of patient or family. See, \textit{e.g.}, \textsc{Cal.
III. THE DURABLE POWER OF ATTORNEY AND MEDICAL DECISIONMAKING

A. Generally

Morally, medical decisionmaking for the terminally ill should remain with the patient. Nevertheless, a legal gap between life and death remains. Although a dying patient may attempt to dignify the final stages of life by expressing his desires in a Living Will, existing legislation does not guarantee that the patient's values will control.

In Barber v. Superior Court, California's Second District Court of Appeals echoed the need expressed by other courts for legislation to guide health care decisionmaking so that guardians, relatives, hospital ethics committees, and courts would no longer be required to substitute their values for those of the patient. The California legislature had, in fact, been hard at work while Barber was pending. On September 29, 1983, two weeks prior to the Barber decision, it passed the Durable Power of Attorney for Health Care Act. Known as S.B. 762, the Act was drafted by the California Law Revision Commission, following passage of the 1981 Uniform Durable Power of Attorney Act, in order to make clear that health care decisions are covered in the general durable power authority. Introduced by Senator Barry Keene on March 2, 1983, S.B. 762 passed both houses of the California legislature within six months, and became law without the Governor's signature on September 29, 1983. The Durable Power of Attorney for Health Care Decisions Act became operative on January 1, 1984.

The durable power concept originated in the common law principal-agent context and traditionally has been used for business, property, or investment purposes. It is intended to transfer man-
e management of one's property to another without the necessity of court supervision. Consequently, personal rights, such as marrying, voting or the drafting of a will, cannot be transferred to an attorney-in-fact.

In some states, court supervision of a guardian is not enough to allow one to exercise such private rights. If these personal rights are lost due to incompetency, then arguably, medical care decisions based directly on the right to privacy should also be deemed non-transferable. Recognizing that health care decisions cannot be ignored, however, courts have often extended the guardian's power to include health care decisionmaking on behalf of the incompetent person.

It is questionable whether the durable power concept should transfer such authority in the absence of court supervision. On the one hand, many, including the President's Commission, have recognized the need for a relatively simple procedure to transfer medical decisionmaking authority. The durable power concept seems adaptable to such a use. On the other hand, the lack of historical basis for such an adaptation, combined with the need to clarify issues which occur primarily in the context of health care decisionmaking has led the commission's chairman, Alexander Capron, to recommend “supplement[ing] the existing statutes with specific provisions . . . covering . . . the patient's understanding of the range of choices the surrogate might need to make about medical treatment [and] means of resolving any disputes that arise between surrogate and caretakers.” Capron's remarks about the utility of current legislation remain hypothetical, since state courts have yet to rule on the extension of a general durable power to health care situations.

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89. Id. at 1009.
92. Alexander M. Capron, Chairman of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, commented on the possible use of existing durable power legislation for healthcare decisionmaking. He stated that “many legal mechanisms have been found to have broader uses over time than when they were first created.” Letter from Alexander M. Capron, Chairman, President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research to Mrs. Lynn B. Jacobs (July 20, 1983).
93. Id.
Specific enabling legislation is not only feasible but also extant at the state level. California leads the way and, with time, will undoubtedly face legal challenges to its Natural Death Act and Durable Power of Attorney for Health Care Decisions Act. The Living Will might also be a valuable adjunct to the durable power for health care, despite flaws and complex language which might threaten its utility. In the event that a probate court is asked to determine whether the attorney-in-fact acted in accordance with the desires or best interests of the principal, a Living Will could provide a more complete expression of the principal's desires.

Legislating the Living Will enables the patient to express his personal desires regarding the administration or withdrawal of life-support procedures. Enactment of a durable power of attorney for health care decisions gives the patient an expanded opportunity to articulate these desires and, in addition, to designate the person to whom such decisionmaking authority should be transferred. Because the patient controls the language appearing in the document, medical decisionmaking should be far less susceptible to the vagaries of statutory interpretation. Of course, the inability to foresee precise circumstances remains a problem only partially resolved by the current legislative models.

B. Key Provisions of the California Act

Under the California Durable Power of Attorney for Health Care Decisions Act, in order to appoint an attorney-in-fact for medical decisionmaking, the patient (or principal) must specify that his trusted relative, friend, or other surrogate is empowered to make health care decisions on his behalf. The attorney-in-fact must be a California citizen who, under this specified designation of authority, may not combine medical decisionmaking with other authority granted him by a general durable power of attorney.

94. See supra notes 47-81 and accompanying text.

95. This is particularly true in states where one may execute a Living Will to suit his specific needs. See, e.g., Ark. Stat. Ann. § 82-3802 (Supp. 1983).

96. President's Commission Report, supra note 1, at 146.

97. See Durable Power Health Care Act, supra note 86, § 2433(a)(1). This section provides:

This document gives the person you designate as your attorney in fact the power to make health care decisions for you, subject to any limitations or statement of your desires that you include in this document. The power to make health care decisions for you may include consent, refusal of consent, or withdrawal of consent to any care, treatment, service, procedure to maintain, diagnose, or treat a physical or mental condition. You may state in this document any types of treatment or placements that you do not desire.

Id.

98. Id. § 2410(c).
Restrictions on who may serve as agent protect the principal from conflicts of interest. An attorney-in-fact may not be the principal's treating health care provider or one of its employees, nor may he be the operator or employee of a community care facility. The agent's decisionmaking power is limited only by the principal's own ability to give informed consent.99

A valid document must follow one of two prescribed methods of execution: (1) at least two "qualified" witnesses100 must attest to the principal's signature or must acknowledge his signature; or (2) the document must be acknowledged by the principal before a notary of public in California. If the patient is confined to a community care facility, the Act requires one witness to be a patient advocate or an ombudsman so designated by the State Department of Aging for that purpose.101 The caveat "Warning to [the] Person Executing This Document" must appear in ten point boldface type if the document is printed, or all capital letters if it is typed. This serves to further alert the principal to the significance of the document he has created.102 Alternatively, the drafting attorney may sign a statement certifying that he has informed his client of the legal consequences of signing the document.103 These provisions have been incorporated into a statutory form that becomes effective Jan. 1, 1985.104

Finally, the durable power of attorney is invalid if it has been allowed to expire. Section 2436.5 states that it expires seven years after the date of execution, unless the principal lacks the capacity to make health care decisions for himself, in which case the document remains valid until the principal regains the capacity to make health care decisions. Of course, the principal retains power to revoke the document at any time prior to the statutory limit. His

99. Id. §§ 2432(b), 2434(a).
100. Id. § 2432(a), (d). These provisions state that the following may not serve as witnesses: (1) health care providers or employees of health care providers; (2) attorneys-in-fact, and (3) operators or employees of community care facilities. Additionally, § 2432(e) (1)-(2) requires that at least one witness must be either unrelated to the principal by blood, marriage, or adoption, or unnamed as a beneficiary under the principal's will at the time of execution of the durable power.
101. Id. § 2432(f).
102. Id. § 2433(a).
103. Id. § 2433(c)(2). This provision is consistent with the requirements of good legal practice. See Model Rules of Professional Conduct Rule 1.4 (1983). See also Martyn, Informed Consent In The Practice of Law, 48 GEO. WASH. L. REV. 307 (1980).
104. Keene Health Care Agent Act, S.B. 1365, ch. 602 (to be codified at CAL. CIV. CODE § 2500 (1984)), authorizes use of a particular form in the creation of a durable power of attorney for health care. The form is set out in full in Appendix I.
competence to revoke is presumed.105 This power of revocation extends both to the removal of the attorney-in-fact (either orally or by writing) and to his authority for health care decisionmaking, through notification of the health care provider.106 Once notified, the provider must add the revocation to the patient's medical records and must make a reasonable effort to notify the attorney-in-fact.107 Unless otherwise stated, a valid durable power of attorney for health care revokes any prior version.108

C. Legal Effects of the California Act

Under the Durable Power of Attorney for Health Care Decisions Act, the attorney-in-fact exercises broad health care decisionmaking power encompassing both the administration and termination of medical treatment for the unconscious patient. Unlike a Living Will that is catalyzed by a diagnosis of terminal illness and imminent death,109 the agent appointed under this Act may give "consent, refusal of consent, or withdrawal of consent to health care,"110 which includes "any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition."111 For example, the attorney-in-fact may make a disposition under the Uniform Anatomical Gift Act, receive information regarding proposed treatment, and review and release information found in medical records.112 In short, any decision-making power that the principal himself might have exerted, including the power to demand the termination of life-supports, is within the purview of the attorney-in-fact's authority, absent an expression of contrary intent by the principal. Despite this broad grant of power, the statute places certain absolute limitations on the agent's decisionmaking authority. The attorney-in-fact may not commit the principal to a mental institution, and may not authorize psychosurgery, electroconvulsive treatment, sterilization, or abortion.113

D. The Limits of Health Care Decisionmaking Power

Under the California Statute, the attorney-in-fact is prohibited from exercising his statutory authority: (1) after expiration of the

105. Durable Power Health Care Act, supra note 86, § 2437(c).
106. Id. § 2437(a)(1)-(2).
107. Id. § 2437(b).
108. Id. § 2437(d).
109. See supra notes 58-60 and accompanying text.
110. Id. § 2430(c).
111. Id. § 2430(b).
112. Id. §§ 2434(b)-(c), 2436.
113. Id. § 2435(a)-(e).
seven-year statute of limitations;\(^{114}\) (2) to revoke the agent's authority;\(^{115}\) (3) where he lacks the capacity to give informed consent on the part of the principal;\(^{116}\) (4) in dereliction of his duty to act consistent with the principal's expressed desires;\(^{117}\) or (5) in a manner clearly contrary to the principal's best interests, if his desires are unknown.\(^{118}\) Section 2411 sets up elaborate procedures whereby interested parties (including both principal and agent) can petition the probate court for determination of these issues.

Nowhere does the Durable Power of Attorney for Health Care Decisions Act define the best interests of the principal. The common law standard of "best interests," which relies heavily on prior expressed intentions, was recommended for use in durable power statutes by the President's Commission.\(^{119}\) Under the common law "best interests" standard, the principal may choose to communicate his express desires privately to his chosen surrogate or more formally through a Living Will or express language in the durable power of attorney document. The attorney-in-fact would then have a duty to act in accordance with the principal's wishes, as expressed in the Durable Power of Attorney, Living Will, or otherwise. If the principal's wishes are not known, the agent must act in the best interests of the principal, with knowledge that his decision, whether to act by affirmation or omission, will be subject to the scrutiny of the probate court through the petition process initiated by interested parties who challenge the attorney-in-fact's interpretation of the best interests of the principal.\(^{120}\)

\(^{114}\) Id. § 2436.5.

\(^{115}\) Id. § 2437(a)(2).

\(^{116}\) Id. § 2437(a).

\(^{117}\) Id. § 2412(d)(3).

\(^{118}\) Id. § 2412.5(b).

\(^{119}\) President's Commission Report, supra note 1, at 134-36. In re Phillip B., 92 Cal. App. 3d 796, 156 Cal. Rptr. 48 (1979), cert. denied, 445 U.S. 949 (1980), involved a 12-year-old boy who suffered from Down's Syndrome. In 1973, physicians discovered a congenital heart defect and recommended that the boy undergo surgery. The patient's parents refused to consent to the operation. The juvenile probation department thereafter filed a petition requesting that the child be declared a dependent of the court for the purpose of ensuring that he receive cardiac surgery. In determining whether or not to order medical treatment, which was rejected by the parents, the court found it necessary to weigh several factors. Noting that the "underlying consideration is the child's welfare and whether his best interests will be served by the medical treatment," id. at 802, 156 Cal. Rptr. at 51, the court stated that the following must be taken into consideration: (1) the seriousness of the harm the child is suffering or the substantial likelihood that he will suffer serious harm; (2) the evaluation for the treatment by the medical profession; (3) the risks involved in medically treating the child; and (4) the expressed preferences of the child. Id.

\(^{120}\) Durable Power Health Care Act, supra note 86, § 2412.5. This procedure is a
treatment, however, may be provided without the attorney-in-fact's authorization if unavailable because of time restraints.

The physician immunity provision of the Durable Power of Attorney for Health Care Decisions Act is a source of added concern. Section 2438 states that there shall be immunity from civil and criminal liability as well as from professional censure for health care providers who act on the basis of a good faith belief that the attorney-in-fact is authorized by the statute to make a health care decision. The Act imposes additional duties on the health care provider: (1) the provider must believe, in good faith, that the decision is not inconsistent with the principal's wishes; and, (2) if the decision is to withhold or withdraw health care necessary to keep the principal alive, the provider must make a "good faith" effort to determine the desires of the principal (to the extent that the principal is able to convey those desires to the health care provider) and log those desires in the principal's medical records.\(^\text{121}\)

Despite frequent statutory references to "good faith," health care provider immunity appears to be based on a higher standard. Good faith efforts, as previously discussed, are valid only if the health care provider relies on a health care decision made by the attorney-in-fact pursuant to the statute.\(^\text{122}\) In other words, the physician is granted immunity only if he agrees to subordinate his own judgment to that of the surrogate decisionmaker.

Like the Natural Death Act, the Durable Power of Attorney for Health Care Decisions Act's immunity provision frees health care providers from the vague restrictions of civil, criminal, and professional sanctions. Unlike similar Living Will immunity provisions, however, the scope of immunity is not limited to terminal illness and imminent death. As long as the decisionmaker acts within the scope of delegated authority, the number of occasions and kinds of decisions that can be ruled on are unlimited.

Extended immunity solves the twofold problem of Living Will immunity provisions. Extending the scope of physician immunity gives health care personnel more incentive to discuss and listen to patient and surrogate decisionmakers. Patient autonomy is also reinforced by allowing principals to delegate decisionmaking to the entire range of decisions while incompetent. Thus, patient and physician are encouraged to act in tandem, rather than concerning themselves with conflicting personal or legal obligations. The Durable Power of Attorney Act resolves legal conflicts by clarifying

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\(^{\text{121}}\) See supra note 74 and accompanying text.

\(^{\text{122}}\) Durable Power Health Care Act, supra note 86, § 2438(a)(1)-(2).
and focusing on the primary moral right—personal autonomy in decisionmaking.

E. Summary

Although Delaware, Pennsylvania, Virginia and Wyoming have also enacted specific legislation addressing the issue of proxy health care decisionmaking on behalf of the incompetent terminal patient, their statutes do not begin to approach the comprehensiveness of the California statutes. Courts have not yet ruled on the right of a principal to delegate health care decisionmaking by use of the general durable power of attorney acts now existing in forty-nine states. The California legislature's foresight and concern for the human, medical, and economic realities of an aging population is to be admired. It may be some time before the new durable power for health care statute is judicially tested. In the meantime, the need to protect self-determination has resurfaced in California with the 1983 Durable Power of Attorney for Health Care Decisions Act.

IV. CONCLUSIONS

Both Living Will and durable power of attorney legislation have strengths and weaknesses. Neither provides facile answers to the difficult dilemma faced by the competent adult seeking to ensure some measure of control over the increasingly dehumanizing process of dying. Both options, however, could create a synergistic effect which neither completely achieves alone.

Recourse to common law and constitutional rights is no longer

123. Delaware's general durable power provisions appear in the state's probate code under fiduciary relationships. Del. Code Ann. tit. 12, §§ 4901-4905 (Supp. 1982). Its proxy health care authorization appears elsewhere, however. See Del. Code Ann. tit. 16, § 2502(b) (1983) ("An adult person by written declaration may appoint an agent who will act on behalf of such appointer, if, due to a condition resulting from illness or injury and, in the judgment of the attending physician, the appointer becomes incapable of making a decision in the exercise of the right to accept or refuse medical treatment.").


126. See supra note 41.
a practicable alternative. Legislation, while clearly able to reflect some public values, necessarily runs the risk of too tightly con-
straining moral or medical judgment. A harmonious pattern of communication and cooperation among the patient, his caring fam-
ily, and trained empathetic health care professionals must be en-
couraged in medical decisionmaking for the critically ill.

The exploding technology of medicine and the escalation of costs, both for terminal medical care and for the legal procedures required to appoint a proxy decisionmaker if one does not exist, make legislative enactment imperative. When a patient's only con-
nection to life is through a respirator or intravenous tube, the length of his life should not be determined by the amount or dura-
tion of Medicare benefits.127

We all deserve to face the inevitable finality of life with strength and dignity. Legislating advance directives for the terminally ill may motivate the physician, patient, and other interested parties to better communicate in a common quest for control over our ulti-
mate demise.

127. New federal regulations establish diagnosis-related groups which determine, in advance of hospitalization, what reimbursement costs will be covered by Medicare. See 42 C.F.R. § 405 (1983); 49 Fed. Reg. 234 (1984); 49 Fed. Reg. 27422 (1984). Though it is hoped this system gives hospitals a financial incentive to control costs, it may also pressure hospitals to curtail certain expensive pro-
cedures or treatments. See Wasserman, The Doctor, the Patient and the D.R.G., 13 HASTINGS CENTER REP., Oct. 1983, at 23.
APPENDIX I

STATUTORY FORM DURABLE POWER OF ATTORNEY FOR HEALTH CARE
(California Civil Code Section 2500)
WARNING TO PERSON EXECUTING THIS DOCUMENT

THIS IS AN IMPORTANT LEGAL DOCUMENT WHICH IS AUTHORIZED BY THE KEENE HEALTH CARE AGENT ACT. BEFORE EXECUTING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

THIS DOCUMENT GIVES THE PERSON YOU DESIGNATE AS YOUR AGENT (THE ATTORNEY-IN-FACT) THE POWER TO MAKE HEALTH CARE DECISIONS FOR YOU. YOUR AGENT MUST ACT CONSISTENTLY WITH YOUR DESIRES AS STATED IN THIS DOCUMENT OR OTHERWISE MADE KNOWN.

EXCEPT AS YOU OTHERWISE SPECIFY IN THIS DOCUMENT, THIS DOCUMENT GIVES YOUR AGENT THE POWER TO CONSENT TO YOUR DOCTOR NOT GIVING TREATMENT OR STOPPING TREATMENT NECESSARY TO KEEP YOU ALIVE.

NOTWITHSTANDING THIS DOCUMENT, YOU HAVE THE RIGHT TO MAKE MEDICAL AND OTHER HEALTH CARE DECISIONS FOR YOURSELF SO LONG AS YOU CAN GIVE INFORMED CONSENT WITH RESPECT TO THE PARTICULAR DECISION. IN ADDITION, NO TREATMENT MAY BE GIVEN TO YOU OVER YOUR OBJECTION AT THE TIME, AND HEALTH CARE NECESSARY TO KEEP YOU ALIVE MAY NOT BE STOPPED OR WITHHELD IF YOU OBJECT AT THE TIME.

THIS DOCUMENT GIVES YOUR AGENT AUTHORITY TO CONSENT, TO REFUSE TO CONSENT, OR TO WITHDRAW CONSENT TO ANY CARE, TREATMENT, SERVICE, OR PROCEDURE TO MAINTAIN, DIAGNOSE, OR TREAT A PHYSICAL OR MENTAL CONDITION. THIS POWER IS SUBJECT TO ANY STATEMENT OF YOUR DESIRES AND ANY LIMITATIONS THAT YOU INCLUDE IN THIS DOCUMENT. YOU MAY STATE IN THIS DOCUMENT ANY TYPES OF TREATMENT THAT YOU DO NOT DESIRE. IN ADDITION, A COURT CAN TAKE AWAY THE POWER OF YOUR AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU IF YOUR AGENT (1) AUTHORIZES ANYTHING THAT IS ILLEGAL, (2) ACTS CONTRARY TO YOUR KNOWN DESIRES, OR (3) WHERE YOUR DESIRES ARE NOT KNOWN, DOES ANYTHING THAT IS CLEARLY CONTRARY TO YOUR BEST INTERESTS.

UNLESS YOU SPECIFY A SHORTER PERIOD IN THIS DOCUMENT, THIS POWER WILL EXIST FOR SEVEN YEARS FROM THE DATE YOU EXECUTE THIS DOCUMENT AND, IF YOU ARE UNABLE TO MAKE HEALTH CARE DECISIONS FOR YOURSELF AT THE TIME WHEN THIS SEVEN-YEAR PERIOD ENDS, THIS POWER WILL CONTINUE TO EXIST UNTIL THE TIME WHEN YOU BECOME ABLE TO MAKE HEALTH CARE DECISIONS FOR YOURSELF.

YOU HAVE THE RIGHT TO REVOKE THE AUTHORITY OF YOUR AGENT BY NOTIFYING YOUR AGENT OR YOUR TREATING DOCTOR, HOSPITAL, OR OTHER HEALTH CARE PROVIDER ORALLY OR IN WRITING OF THE REVOCATION.

YOUR AGENT HAS THE RIGHT TO EXAMINE YOUR MEDICAL RECORDS AND TO CONSENT TO THEIR DISCLOSURE UNLESS YOU LIMIT THIS RIGHT IN THIS DOCUMENT.

UNLESS YOU OTHERWISE SPECIFY IN THIS DOCUMENT, THIS DOCUMENT GIVES YOUR AGENT THE POWER AFTER YOU DIE TO DONATE YOUR
BODY OR PARTS THEREOF FOR TRANSPLANT OR THERAPEUTIC OR EDUCATIONAL OR SCIENTIFIC PURPOSES.

THIS DOCUMENT REVOKES ANY PRIOR DURABLE POWER OF ATTORNEY FOR HEALTH CARE.

YOU SHOULD CAREFULLY READ AND FOLLOW THE WITNESSING PROCEDURE DESCRIBED AT THE END OF THIS FORM. THIS DOCUMENT WILL NOT BE VALID UNLESS YOU COMPLY WITH THE WITNESSING PROCEDURE.

IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER TO EXPLAIN IT TO YOU.

YOUR AGENT MAY NEED THIS DOCUMENT IMMEDIATELY IN CASE OF AN EMERGENCY THAT REQUIRES A DECISION CONCERNING YOUR HEALTH CARE. EITHER KEEP THIS DOCUMENT WHERE IT IS IMMEDIATELY AVAILABLE TO YOUR AGENT AND ALTERNATE AGENTS OR GIVE EACH OF THEM AN EXECUTED COPY OF THIS DOCUMENT. YOU MAY ALSO WANT TO GIVE YOUR DOCTOR AN EXECUTED COPY OF THIS DOCUMENT.

DO NOT USE THIS FORM IF YOU ARE A CONSERVATEE UNDER THE LANTERMAN-PETRIS-SHORT ACT AND YOU WANT TO APPOINT YOUR CONSERVATOR AS YOUR AGENT. YOU CAN DO THAT ONLY IF THE APPOINTMENT DOCUMENT INCLUDES A CERTIFICATE OF YOUR ATTORNEY.

1. DESIGNATION OF HEALTH CARE AGENT.

I, ________________________________

(Insert your name and address)

do hereby designate and appoint ________________________________

(Insert name, address, and telephone number of one individual only as your agent to make health care decisions for you. None of the following may be designated as agent: (1) your treating health care provider, (2) a nonrelative employee of your treating health care provider, (3) an operator of a community care facility, or (4) a nonrelative employee of an operator of a community care facility.)

as my attorney-in-fact (agent) to make health care decisions for me as authorized in this document. For the purposes of this document, "health care decision" means consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition.

2. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE.

By this document I intend to create a durable power of attorney for health care under Sections 2430 to 2443, inclusive, of the California Civil Code. This power of attorney is authorized by the Keene Health Care Agent Act and shall be construed in accordance with the provisions of Sections 2500 to 2506, inclusive, of the California Civil Code. This power of attorney shall not be affected by my subsequent incapacity.

3. GENERAL STATEMENT OF AUTHORITY GRANTED. Subject to any limitations in this document, I hereby grant to my agent full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In exercising this authority, my agent shall make health care decisions that are consistent with my desires as stated in this document or otherwise made known to my agent, including, but not limited to, my desires concerning obtaining or refusing or withdrawing life-prolonging care, treatment, services, and procedures.

(If you want to limit the authority of your agent to make health care decisions for you, you can state the limitations in paragraph 4 ("Statement of Desires, Special
4. STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS.
(Your agent must make health care decisions that are consistent with your known desires. You can, but are not required to, state your desires in the space provided below. You should consider whether you want to include a statement of your desires concerning life-prolonging care, treatment, services, and procedures. You can also include a statement of your desires concerning other matters relating to your health care. You can also make your desires known to your agent by discussing your desires with your agent or by some other means. If there are any types of treatment that you do not want to be used, you should state them in the space below. If you want to limit in any other way the authority given your agent by this document, you should state the limits in the space below. If you do not state any limits, your agent will have broad powers to make health care decisions for you, except to the extent that there are limits provided by law.)

In exercising the authority under this durable power of attorney for health care, my agent shall act consistently with my desires as stated below and is subject to the special provisions and limitations stated below:

   (a) Statement of desires concerning life-prolonging care, treatment, services, and procedures:

   (b) Additional statement of desires, special provisions, and limitations:

(You may attach additional pages if you need more space to complete your statement. If you attach additional pages, you must date and sign EACH of the additional pages at the same time you date and sign this document.)

5. INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH. Subject to any limitations in this document, my agent has the power and authority to do all of the following:

   (a) Request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records.

   (b) Execute on my behalf any releases or other documents that may be required in order to obtain this information.
(c) Consent to the disclosure of this information.
(If you want to limit the authority of your agent to receive and disclose information relating to your health, you must state the limitations in paragraph 4 ("Statement of Desires, Special Provisions, and Limitations") above.)

6. SIGNING DOCUMENTS, WAIVERS, AND RELEASES. Where necessary to implement the health care decisions that my agent is authorized by this document to make, my agent has the power and authority to execute on my behalf all of the following:

(a) Documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice."

(b) Any necessary waiver or release from liability required by a hospital or physician.

7. UNIFORM ANATOMICAL GIFT ACT. Subject to any limitations in this document, my agent has the power and authority to make a disposition of a part or parts of my body under the Uniform Anatomical Gift Act (Chapter 3.5 (commencing with Section 7150) of Part 1 of Division 7 of the Health and Safety Code).
(If you want to limit the authority of your agent to make a disposition under the Uniform Anatomical Gift Act, you must state the limitations in paragraph 4 ("Statement of Desires, Special Provisions, and Limitations") above.)

8. DURATION.
(Unless you specify a shorter period in the space below, this power of attorney will exist for seven years from the date you execute this document and, if you are unable to make health care decisions for yourself at the time when this seven-year period ends, the power will continue to exist until the time when you become able to make health care decisions for yourself.)

This durable power of attorney for health care expires on ________________.
(Fill in this space ONLY if you want the authority of your agent to end EARLIER than the seven-year period described above.)

9. DESIGNATION OF ALTERNATE AGENTS.
(You are not required to designate any alternate agents but you may do so. Any alternate agent you designate will be able to make the same health care decisions as the agent you designated in paragraph 1, above, in the event that agent is unable or ineligible to act as your agent. Also, if the agent you designated in paragraph 1 is your spouse, he or she becomes ineligible to act as your agent if your marriage is dissolved.)

If the person designated as my agent in paragraph 1 is not available or becomes ineligible to act as my agent to make a health care decision for me, or loses the mental capacity to make health care decisions for me, or if I revoke that person's appointment or authority to act as my agent to make health care decisions for me, then I designate and appoint the following persons to serve as my agent to make health care decisions for me as authorized in this document, such persons to serve in the order listed below:

A. First Alternate Agent

(Insert name, address, and telephone number of first alternate agent)

B. Second Alternate Agent

(Insert name, address, and telephone number of second alternate agent)

10. NOMINATION OF CONSERVATOR OF PERSON.
(A conservator of the person may be appointed for you if a court desires that one should be appointed. The conservator is responsible for your physical care, which under some circumstances includes making health care decisions for you. You are not required to nominate a conservator but you may do so. The court will appoint the person you nominate unless that would be contrary to your best interests. You may, but are not required
to, nominate as your conservator the same person you named in paragraph 1 as your health care agent. You can nominate an individual as your conservator by completing the space below.)

If a conservator of the person is to be appointed for me, I nominate the following individual to serve as conservator of the person

(Insert name and address of person nominated as conservator of the person)

11. PRIOR DESIGNATIONS REVOKED. I revoke any prior durable power of attorney for health care.

DATE AND SIGNATURE OF PRINCIPAL

I sign my name to this Statutory Form Durable Power of Attorney for Health Care on ___________________________ at ___________________________.

(Date) (City) (State)

(You sign here)

STATEMENT OF WITNESSES

(This document must be witnessed by two qualified adult witnesses. None of the following may be used as a witness: (1) a person you designate as your agent or alternate agent, (2) a health care provider, (3) an employee of a health care provider, (4) the operator of a community care facility, (5) an employee of an operator of a community health care facility. At least one of the witnesses must make the additional declaration set out following the place where the witnesses sign.)

I declare under penalty of perjury under the laws of California that the person who signed or acknowledged this document is personally known to me (or proved to me on the basis of convincing evidence) to be the principal, signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney-in-fact by this document, and that I am not a health care provider, an employee of a health care provider, the operator of a community care facility, nor an employee of an operator of a community care facility.

Signature: ____________________________________________
Residence Address: ______________________________________
Print Name: ___________________________________________
Date: ________________

Signature: ___________________________________________________________
Residence Address: ____________________________________________________
Print Name: __________________________________________________________
Date: ________________

(AT LEAST ONE OF THE ABOVE WITNESSES MUST ALSO SIGN THE FOLLOWING DECLARATION.)

I further declare under penalty of perjury under the laws of California that I am not related to the principal by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature: __________________________________________________________
Signature: __________________________________________________________

STATEMENT OF PATIENT ADVOCATE OR OMBUDSMEN

(If you are a patient in a skilled nursing facility, one of the witnesses must be a patient advocate or ombudsman. The following statement is required only if you are a patient in a skilled nursing facility—a health care facility that provides the following basic services: skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. The patient advocate or ombudsman must sign both parts of the "Statement of Witnesses" above AND must also sign the following statement.)

I further declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by subdivision (f) of Section 2432 of the Civil Code.

Signature: __________________________________________________________