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Planning for Health Care Using Living Wills and Durable Powers of Attorney: A Guide for the South Carolina Attorney

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PLANNING FOR HEALTH CARE USING LIVING WILLS AND DURABLE POWERS OF ATTORNEY: A GUIDE FOR THE SOUTH CAROLINA ATTORNEY

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I. INTRODUCTION

For many people the fear of death is overshadowed by the fear of the process of dying. Fear of the dying process, implicit in such cultural shibboleths as the cowboy's preference to die "with his boots on," has been accentuated in late twentieth-century America. Medical "miracles" can prolong the dying process in ways undreamed of by the cowboys of a century ago. Machines can substitute for vital organs that are no longer functional; they can breathe for a person, cleanse the blood of toxins, and pump blood through the body. Other machines can restart a heart that has ceased functioning, or stimulate a dysfunctional heart to function properly. Medical and surgical procedures can provide nutrition and hydration to persons unable to swallow and remove waste products from a body unable to do so naturally.

Patients generally desire to use these "miracles" to restore health or to continue a cognitive and functional life. Many people, however, express the desire that procedures such as these not be administered when the procedures mar the life that they prolong with chronic pain or strip it of certain attributes normally associated with human existence, such as cognition, mobility, or the ability to interact with friends or family. For many people, "[t]he ultimate horror is not death but the possibility of being maintained in limbo, in a sterile room, by machines controlled by strangers."¹

This view became something of a "movement" after the 1976 case of Karen Quinlan² publicized the idea that prolonging life under such circumstances might be considered a mandate of law or medical ethics. Since that time, a number of persons have filed lawsuits seeking to withdraw life-sustaining procedures either from themselves or from incompetent patients for whom they are responsible. Countless persons have executed documents stating their desire that life-sustaining procedures not be administered to them. Most states have enacted statutes that expressly authorize the withdrawal or withholding of life-sustaining procedures under certain circumstances.

Public interest in the "right to die" issue surged after the June 1990 decision of the United States Supreme Court in *Cruzan v. Director, Missouri Department of Health*.³ In this case the parents of a young woman who had been in a persistent vegetative state⁴ for seven years sought removal of the gastrostomy tube⁵ that was sustaining her life. The Missouri Supreme Court denied the request, holding that life-sustaining treatment could not be withheld at the request of a surrogate in the absence of clear and convincing evidence of the patient's own desires.⁶ On appeal, the United States Supreme Court held that Missouri's requirement did not violate the United States Constitution.⁷ The Court recognized, however, that the liberties protected by the Due Process Clauses of the Constitution encompass the right of a patient to

1. Steel, *The Right to Die: New Options in California*, 93 CHRISTIAN CENTURY 996 (1976) (quoting California Assemblyman Barry Keene).

2. *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976), cert. denied, 429 U.S. 922 (1977). The New Jersey Supreme Court refined its views in *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985).

3. 110 S. Ct. 2841 (1990).

4. A persistent vegetative state is a chronic and irreversible condition in which the patient lacks interaction with the environment, awareness of pain or pleasure, and any cognitive functioning. Cohen, *Death and Dying*, in *BIOLAW R*:247, 254 (1989).

5. A gastrostomy tube is surgically implanted into the stomach to provide nutrition and hydration to the unconscious patient. See *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2845, 2856-57 (1990).

6. *Id.* at 2847.

7. *Id.* at 2854.

refuse treatment, either contemporaneously or through an advance directive.⁸

One clear principle that emerged from the spate of judicial and legislative activity that followed *In re Quinlan*, and was given new urgency by *Cruzan*, is the importance of knowing the desires of the patient for whom nontreatment is being considered. Relying on the tort doctrine of informed consent and on federal decisions that protect bodily integrity, both federal and state courts uniformly have given effect to patients' advance determinations that they do not wish to receive certain health care. In the absence of evidence of the patient's wishes, the outcome will depend on courts' and other surrogates' assessments of factors such as the comparative benefits and burdens of treatment, the likelihood that a person with the patient's attitudes and values would or would not want treatment, and the strength of the state's interest in preserving life in various circumstances.⁹ When the patient's condition is neither terminal nor irreversibly unconscious, it is likely that courts will require continuation of treatment. *Cruzan* demonstrates that this may be the result even when the patient is permanently unconscious. Persons who wish to avoid litigation or ensure nontreatment, particularly in circumstances other than irreversible unconsciousness or a terminal condition, should state their desires with particularity while they are still competent to do so.

Although a number of courts have relied upon a patient's oral expressions to establish his wishes, oral expressions are problematic in a number of ways. First, they are less trustworthy than written expressions because of the potential for error or fabrication by those persons reporting the statements. Furthermore, oral statements often do not clearly establish what the patient's desires would have been in the particular situation at hand, because they tend to be general in content. Finally, because of the informality of the circumstances in which persons tend to make these statements, they may not represent a serious and considered expression of the speaker's desires about his own future care.¹⁰ For these reasons, a court may not treat oral statements as clear and convincing evidence of the patient's wishes concerning termination of treatment.¹¹

8. *Id.* at 2853.

9. The courts will also consider the state's interest in preserving life, as well as other state interests, when the patient's wishes are known. However, the likelihood that the state's interest will be held to outweigh the patient's choice is minimal. *See infra* notes 59-62 and accompanying text.

10. *In re Westchester County Medical Center*, 72 N.Y.2d 517, 530, 531 N.E.2d 607, 613, 534 N.Y.S.2d 886, 892 (1988); *see Cruzan v. Harmon*, 760 S.W.2d 408, 424 (Mo. 1988), *aff'd sub nom. Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841 (1990).

11. This may be particularly true if the patient is a woman. A recent article that

A written expression is more likely to receive adherence from those responsible for decisions about health care. Written instruments for this purpose take two primary forms. The first form directs the provider to provide or withhold certain types of care, as is the case with a living will. The second form assigns to a named agent the power to consent to or refuse health care, as in a durable power of attorney for health care.

The existence of two different forms reflects, at least in part, the difficulties in applying the informed consent model to advance planning for health care. The informed consent model assumes that a patient can make a reasoned decision concerning his care after being informed of his condition, the alternative courses of action, and the risks and benefits of each alternative. When the patient is incompetent, however, decision making must follow one of two alternative models, each of which is deficient when measured against the informed consent model of patient autonomy. The patient may make the decision in advance, but without knowledge of the specific circumstances in which he will find himself or the precise options available. Alternatively, a fully informed surrogate, ideally a person chosen by the patient, may make a contemporaneous decision. The living will represents the first option; the durable power of attorney represents the second.

A living will generally states that in the event the patient's condition is hopeless, treatment that merely postpones the moment of death should not be provided. A living will can take many forms. An individual may write a living will in his own words, or he may use the statutory living will form set forth in the South Carolina Code,¹² or a form distributed by a religious or advocacy group. Both statutory and non-statutory forms of a living will can have a legal effect on the course of treatment; hence both will be discussed.

A durable power of attorney for health care appoints an agent, called an attorney-in-fact, with the power to make specified decisions on the principal's behalf. The principal may define the authority of

surveyed judicial treatment of patients' expressions of intent found that appellate courts tend to give minimal weight to female patients' expressions, adopting a protective stance to prevent medical neglect of these patients. On the other hand, appellate courts tend to view male patients as susceptible to medical assault rather than medical neglect and perhaps read more into their statements than the patients intended. Miles & August, *Courts, Gender and "The Right to Die,"* 18 LAW, MED. & HEALTH CARE 85 (1990). These findings reinforce the need for clarity in recording the wishes of both male and female clients. They suggest that a female must fully set forth the breadth of her desire for withdrawal or withholding of treatment, whereas a male must explicitly state any limitations on his desire for nontreatment.

12. S.C. CODE ANN. § 44-77-50 (Law. Co-op. Supp. 1990), as amended by R. 220, H. 3090 (1991).

this agent in any way that he chooses and may include specific instructions on how the agent should treat certain situations. For example, the principal might instruct the attorney-in-fact to refuse cardiopulmonary resuscitation if the principal's life expectancy is less than six months, or to make treatment decisions according to his assessment of the principal's best interests.

South Carolina and federal laws presently establish the legal foundation for use of either the living will or durable power of attorney by persons who wish to plan for their future health care. This Article will discuss the use of each of these types of health care planning instrument. Discussion of living wills will cover both the form of living will set forth in the South Carolina Death With Dignity Act, as amended in 1991,¹³ and other forms. The use of durable powers of attorney will be examined from the perspective of the 1990 amendments to the South Carolina Probate Code¹⁴ and South Carolina's new Adult Health Care Consent Act.¹⁵ Initially, the nature, legal status, and effect on health care of each type of instrument will be discussed. Thereafter, information on drafting, executing, and revoking each instrument will be provided.

II. THE SOUTH CAROLINA DEATH WITH DIGNITY ACT

The South Carolina Death With Dignity Act (Act)¹⁶ establishes a legislatively approved mechanism for directing that life-sustaining treatment be withheld or withdrawn in the event of terminal illness or permanent unconsciousness. The mechanism is a particular form of living will called a "Declaration of a Desire for a Natural Death"¹⁷ (Declaration). The Declaration operates only in a specified set of circumstances, which may or may not coincide with the circumstances in which a particular individual wishes to refuse treatment.¹⁸ Nonetheless, it is a valuable tool for planning future health care because it requires health care providers to honor the patient's wishes and protects them from liability.

13. *Id.* §§ 44-77-10 to -160.

14. 1990 S.C. Acts 521.

15. *Id.*

16. S.C. CODE ANN. §§ 44-77-10 to -160 (Law. Co-op. Supp. 1990), as amended by R. 220, H. 3090 (1991).

17. See *id.* § 44-77-50.

18. For instance, a recent study found that 73% of the patients studied would want certain forms of treatment withheld if they were severely demented. Emanuel, Barry, Stockle, Ettelson & Emanuel, *Advance Directives for Medical Care—A Case for Greater Use*, 324 NEW ENG. J. MED. 889, 892 (1991). The Declaration does not provide for nontreatment in situations of dementia.

A. *Effect of a Declaration in Treatment Settings*

The attorney for a person considering use of a Declaration should make sure that the client fully understands the effect of the Declaration on the future course of his medical care, and should encourage the client to discuss the medical aspects of the document with his physician. It is important to ensure that the client actually wants the course of care that the Declaration provides for, and to determine if the client has additional wishes about nontreatment that should be expressed in the Declaration¹⁹ or in a separate instrument.²⁰

A Declaration instructs health care providers to withhold or withdraw life-sustaining procedures from a patient whose condition is terminal or who is permanently unconscious.²¹ The declarant may choose from alternative statements indicating whether artificial nutrition and hydration are to be considered life-sustaining procedures that may be withheld or withdrawn.

1. *Terminal Conditions*

A condition is "terminal" for purposes of the Act if it is "incurable or irreversible" and "within reasonable medical judgment, could cause death within a reasonably short period of time if life-sustaining procedures are not used."²² Life-sustaining procedures include any form of medical intervention that serves "only to prolong the dying process and where, in the judgment of the attending physician, death will occur whether or not the procedures are utilized."²³ Therefore, a Declaration instructs a provider to withhold or withdraw a life-sustaining procedure if: (1) the patient suffers from an incurable or irreversible condition; (2) this condition could cause death within a reasonably short time if the procedure is not used; (3) use of the procedure will postpone, but not prevent, death; and (4) the patient's condition during the added time can reasonably be characterized as "the dying process." For example, a patient whose only affliction is pneumonia is not suffering from a terminal condition, because pneumonia is not incurable or irreversible, and the proffered antibiotic treatment does more

19. See *infra* note 173 (effect of supplemental instructions within the declaration itself).

20. A separate instrument could be either a nonstatutory living will, see *infra* notes 46-93 and accompanying text, or a durable power of attorney, see *infra* notes 94-143 and accompanying text.

21. S.C. CODE ANN. § 44-77-30 (Law. Co-op. Supp. 1990), as amended by R. 220, H. 3090 (1991).

22. *Id.* § 44-77-20(4).

23. *Id.* § 44-77-20(2).

than merely prolong the dying process.

The wording of the definition of "terminal condition" is changed by the 1991 amendments. The amended definition uses more flexible language in recognition of the uncertainties of medical prognosis. The only change that may be of substantive significance is the substitution of the word "could" for "will" in the phrase "could cause death within a reasonably short period of time." Read literally, this change would significantly broaden the class of conditions that could be considered terminal: an irreversible condition that presents a one percent possibility of impending death would satisfy the statutory standard. This interpretation, however, is contrary to the intent of the legislators, to medical and societal ethics, and to the intent of persons who execute declarations. The word "could" here should be read as merely an acknowledgement of medical uncertainty.²⁴ Rather than demanding that the physician be certain that the condition will cause death within a short time, the statute merely requires the exercise of reasonable medical judgment and a probability, rather than a certainty, of near-term death.

2. Long-Term Chronic Conditions

If the patient who contracted pneumonia was already suffering from a long-term chronic condition such as Alzheimer's disease, the analysis would be somewhat different. Alzheimer's disease is an irreversible and incurable condition; however, Alzheimer's disease will not necessarily cause the patient's death within a relatively short time.²⁵ If the physician can determine that the patient is in the final stage of the disease²⁶ and "could" die within a reasonably short time regardless of

24. The language of the definition was changed at a meeting of the General Laws Subcommittee of the House Judiciary Committee, which the author attended. The discussion regarding this change focused on accommodating the law to the realities of medical practice and providing physicians with appropriate protections from liability. The amendment to the definition of terminal condition was approved in conjunction with an amendment to immunize from liability a physician who in good faith certifies that a patient's condition is terminal. *Id.* § 44-77-90.

25. It is not certain that Alzheimer's disease can cause death, though it often is assumed that it can. OFFICE OF TECHNOLOGY ASSESSMENT, U.S. CONGRESS, LOSING A MILLION MINDS: CONFRONTING THE TRAGEDY OF ALZHEIMER'S DISEASE AND OTHER DEMENTIAS 14 (1987) [hereinafter ALZHEIMER'S REPORT]. Patients with Alzheimer's disease generally die of some other illness. *Id.* at 14-15.

The average duration of Alzheimer's disease is eight years. *Id.* at 14. However, the duration of the disease can be as long as 25 years. *Id.* During a significant portion of this time the patient is likely to be incompetent in some or all areas of decision making. *Id.* at 13-16, 62-67, 68-79, 149-50.

26. See, e.g., *id.* at 62-67; Reisberg, Ferris & Franssen, *An Ordinal Functional As-*

the pneumonia, the Act considers the patient's condition terminal. Antibiotic therapy could prevent the pneumonia from causing death, but would not affect the patient's impending death from Alzheimer's-related disease. In the interval between cure of the pneumonia and death from Alzheimer's disease, the patient would be immobile and profoundly demented; hence, extension of this patient's life reasonably could be characterized as merely a prolongation of the dying process, and the provision of antibiotics consequently would be a life-sustaining procedure that could be withheld under the Act.

If, on the other hand, the patient, though severely demented, was in an earlier stage of Alzheimer's, and an Alzheimer's-related death could not reliably be foreseen within a relatively short period of time, the patient's condition would not be terminal as defined by the Act. Therefore, providers could not withhold antibiotic therapy pursuant to the Declaration. For the patient's condition to be considered terminal, the impending death must be causally linked to an irreversible condition. Alzheimer's disease is irreversible, but will not cause death for this patient within a short period of time. Pneumonia could cause imminent death, but it is reversible. Hence, a Declaration would not authorize providers to withhold treatment from this patient.

3. *Permanently Unconscious Patients*

The 1991 amendments to the Death With Dignity Act added "permanent unconsciousness" as a second condition in which life-sustaining procedures could be withheld or withdrawn from a declarant.²⁷ Permanent unconsciousness is defined to include a persistent vegetative state or other irreversible condition in which the person has no upper brain function, but only the involuntary vegetative or primitive reflex functions controlled by the brain stem.²⁸ A diagnosis of permanent unconsciousness may not be certified for purposes of the Act until the patient has remained unconscious for ninety days, unless the patient's condition is such that the diagnosis can be made with a high degree of medical certainty without ninety days of observation.²⁹

essment Tool for Alzheimer's-Type Dementia, 6 HOSP. & COMMUNITY PSYCHIATRY 593 (1985) (description of the stages of Alzheimer's disease).

27. S.C. CODE ANN. § 44-77-30 (Law. Co-op. Supp. 1990), as amended by R. 220, H. 3090 (1991).

28. *Id.* § 44-77-20(7). For a discussion of medical conditions that are associated with permanent unconsciousness, see Cranford, *The Persistent Vegetative State: The Medical Reality (Getting the Facts Straight)*, HASTINGS CENTER REP., Feb.-Mar. 1988, at 27.

29. S.C. CODE ANN. § 44-77-30 (Law. Co-op. Supp. 1990), as amended by R. 220 H. 3090 (1991).

The language of the Act retains some ambiguity concerning what procedures may be withheld or withdrawn from a permanently unconscious person. However, any ambiguity is easily resolved by referring to the legislative intent as embodied in the statute itself. Life-sustaining procedures, which may be withheld or withdrawn, are defined as medical interventions that “would serve only to prolong the dying process,” where “death will occur whether or not the procedures are utilized.” Because permanent unconsciousness may be of extended duration,³⁰ it might be argued that a permanently unconscious patient is not in the process of dying. The legislature, however, made the judgment that permanent unconsciousness is a form of the “dying process” when it designated permanent unconsciousness as a condition in which life-sustaining procedures, and specifically nutrition and hydration,³¹ may be withheld or withdrawn. Whereas a person with a terminal condition is in the process of dying in a temporal sense, a person who is permanently unconscious is in the process of dying in a qualitative sense. Therefore, a medical intervention that will merely prolong a state of permanent unconsciousness is a life-sustaining procedure.

4. *Nutrition and Hydration*

A person executing a declaration has a choice of whether or not he wants to receive artificial nutrition and hydration. The declarant indicates by initialing applicable statements on the Declaration form whether he wants artificial nutrition and hydration if his condition is terminal and whether he wants such procedures if he is permanently unconscious.³²

If the declarant has not initialed an applicable statement, nutrition and hydration necessary for comfort care or alleviation of pain will be provided.³³ Under pre-1991 law, nutrition and hydration for comfort

30. Cranford, *supra* note 28, at 31 (it is not uncommon for patients to survive in this condition from five to twenty years).

31. See S.C. CODE ANN. § 44-77-20(2) (Law. Co-op. Supp. 1990), as amended by R. 220, H. 3090 (1991).

32. *Id.* §§ 44-77-20(2), -50.

33. *Id.* § 44-77-20(2). The language of the applicable provision reads: “Pursuant to a lawfully executed declaration if the declarant fails to give instructions by initialing the appropriate statements concerning nutrition and hydration, nutrition and hydration necessary for comfort care or alleviation of pain will be provided.” The introductory clause was added to indicate that the provision was referring only to the effect of the Declaration, and was not intended to prevent the withdrawal or withholding of artificial nutrition and hydration pursuant to other sources of legal authority. See also *id.* § 44-77-140 (“This chapter applies only to persons who have executed a declaration in accordance with this chapter. Nothing in this chapter impairs any other legal right or legal responsibility which a person may have to effect the withholding or withdrawal or the provision

care or alleviation of pain was excluded from the definition of life-sustaining procedures;³⁴ withdrawal or withholding of nutrition and hydration thus was not authorized by a Declaration so long as those procedures were necessary to the patient's comfort. The 1991 amendments continue this approach when the declarant has not indicated a preference for an alternative approach in the Declaration.

The "comfort care" approach might seem to impose a blanket prohibition on withholding or withdrawal of nutrition and hydration, since discomfort is normally associated with dehydration or starvation. It may be possible, however, to avoid discomfort through the administration of appropriate medications.³⁵ Moreover, in some circumstances the patient may lack the capacity to experience pain. The most notable of these conditions is permanent unconsciousness, in which the absence of neocortical functioning prevents the patient from experiencing pain or suffering.³⁶ Thus, under the "comfort care" approach, nutrition and hydration may be withdrawn from a declarant who will not experience pain because of medication or neocortical dysfunction if the means for providing nutrition and hydration constitutes a medical procedure³⁷ and the provision of nutrition and hydration merely prolongs the dying process.

of life-sustaining procedures in any lawful manner.").

34. *Id.* § 44-77-20(2).

35. *Cf. In re Estate of Greenspan*, 137 Ill. 2d 1, 4, 558 N.E.2d 1194, 1196 (1990) (noting that "[a]nalgesics could be given to relieve any pain associated with withdrawal of the feeding tube").

36. *See* American Medical Association Council on Scientific Affairs and Council on Ethical & Judicial Affairs, *Persistent Vegetative State and the Decision to Withdraw or Withhold Life Support*, 263 J. A.M.A. 426, 428 (1990) [hereinafter AMA Council Report]; Cranford, *supra* note 28, at 27, 31. Cranford quotes from the amicus curiae brief filed by the American Academy of Neurology in *Brophy v. New England Sinai Hosp.*, 398 Mass. 417, 497 N.E.2d 626 (1986):

No conscious experience of pain and suffering is possible without the integrated functioning of the brain stem and cerebral cortex. Pain and suffering are attributes of consciousness, and PVS patients like Brophy do not experience them. Noxious stimuli may activate peripherally located nerves, but only a brain with the capacity for consciousness can translate that neural activity into an experience. That part of Brophy's brain is forever lost.

Cranford, *supra* note 28, at 31.

37. Provision of nutrition and hydration through a surgically implanted gastrostomy tube, a nasogastric tube, or other medically implanted mechanism repeatedly has been held to be a medical procedure. *E.g.*, *Gray v. Romeo*, 697 F. Supp. 580, 586-87 (D.R.I. 1988); *In re Browning*, 543 So. 2d 258, 271 (Fla. Dist. Ct. App. 1989); *see also* *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2857 (1990) (O'Connor, J., concurring); *In re Conroy*, 98 N.J. 321, 372-74, 486 A.2d 1209, 1235-36 (1985). This conceptualization is also apparent in the 1991 amendments to the Death With Dignity Act.

B. Procedures for Implementation

Before effectuating a Declaration, the health care provider must determine its validity, as the duties and immunities created by the Act apply only when the provider is presented with a valid Declaration. However, the Act does not require the provider to go beyond the face of the Declaration to determine its validity.³⁸ Thus, a provider can determine validity by comparing the patient's Declaration with the statutory model, and checking to see that (1) the document has been signed and dated by the patient, (2) the affidavit has been signed by two witnesses, and (3) the notary's statement has been completed, signed, and sealed. The physician is not required to conduct an inquiry into the qualifications of the witnesses or the circumstances under which the Declaration was signed.³⁹

38. S.C. CODE ANN. § 44-77-90 (Law. Co-op. Supp. 1990). One of the objectives of the 1988 amendments to the Act was to limit a provider's duty to ensure the validity of the Declaration. The 1988 amendments to the Death With Dignity Act were drafted by an ad hoc committee of the Probate Section of the South Carolina Bar. The language proposed by that committee, which was chaired by the author, was enacted virtually without change. The comment to § 7 of that proposal (codified at S.C. CODE ANN. § 44-77-90 (Law. Co-op. Supp. 1990)) states that a purpose of the amendments was to clarify that a physician or other health care provider called upon to implement a declaration is not responsible for confirming that the witnesses are qualified, that an ombudsman witness has signed where necessary, whether the witnesses signed in the presence of the declarant and of each other, or any other requirements pertaining to execution of the declaration that do not appear on the face of the document itself.

AD HOC COMMITTEE, PROBATE SECTION OF S.C. BAR, PROPOSED ACT TO AMEND THE ACT TO AUTHORIZE AN ADULT TO MAKE A WRITTEN DIRECTIVE INSTRUCTING HIS PHYSICIAN TO WITHHOLD OR WITHDRAW LIFE-SUSTAINING PROCEDURES IN THE EVENT OF A TERMINAL CONDITION 28 (1988) [hereinafter Probate Section Proposal]. It was intended that the provider's duty to assure the validity of the Declaration be satisfied by an examination of the face of the document and the patient's medical record.

Although the physician or hospital may seek a legal opinion, they usually should be able to make the determination of validity without legal advice. If a Declaration contains substantive or potentially substantive deviations from the statutory form, however, legal advice will be necessary to determine the applicability of the statute or common-law principles. Therefore, those who draft Declarations should be careful to avoid such deviations unless they are necessary to express the intent of the declarant.

39. Similarly, a revocation binds the physician only if he has actual notice of it. S.C. CODE ANN. § 44-77-80(3) (Law. Co-op. Supp. 1990), *as amended by* R. 220, H. 3090 (1991) (the various forms of revocation are effective only when communicated to the attending physician); *id.* § 44-77-90 (a person may rely upon a Declaration unless he has actual notice of revocation). The provider is not required to make inquiry of an agent who has been given power to revoke, or otherwise investigate whether a revocation has taken place.

It is uncertain whether actual notice exists when an attending physician discovers in the patient's medical record a notation made by another physician documenting the lat-

In addition to determining the validity of the Declaration, the provider must certify that the declarant's condition is terminal⁴⁰ or that the declarant is permanently unconscious before giving effect to the Declaration. Two physicians, one of whom is the attending physician, must personally examine the declarant to confirm the diagnosis.⁴¹

After the certification of terminal condition or permanent unconsciousness is made, the declarant must receive at least six hours of active treatment before the Declaration may be given effect.⁴² Active treatment is defined as the standard of care that would be administered to the declarant if he had not executed the Declaration⁴³ and life-sustaining procedures were not going to be withheld or withdrawn within a short time. The purpose of the "active treatment" provision seemingly is to allow for more certainty in the diagnosis by requiring providers to observe the patient and his response to treatment for six hours after the terminal condition or permanent unconsciousness initially is diagnosed.

If the Declaration is valid, no notice of revocation has been received, the patient's condition has been certified by two physicians, and active treatment has been provided for at least six hours, then the physician and hospital have a duty to see that the Declaration is given effect. They do not, however, have a duty to effectuate it themselves. Rather, they may either effectuate it, or "make a reasonable effort to locate a physician or health care facility that will effectuate the declaration and . . . transfer the patient to that physician or facility."⁴⁴ It is unclear whether the unwilling physician or hospital has any further duty to the declarant if the reasonable search fails to locate a physician or hospital willing to carry out the Declaration. The language of the Act does not explicitly impose any such duty; however, the few cases that have addressed this issue indicate that a duty may exist to effectuate the Declaration if for some reason the patient cannot or should

ter's receipt of notice of revocation pursuant to § 44-77-80. Although the revocation may not have been communicated directly to him, if it was communicated to a prior attending physician in the manner required by § 44-77-80, the notation should be construed as actual notice to the subsequent attending physician.

40. For discussion of the meaning of "terminal condition" under the Act, see *supra* notes 22-24 and accompanying text.

41. S.C. CODE ANN. § 44-77-30 (Law. Co-op. Supp. 1990), as amended by R. 220, H. 3090 (1991).

42. *Id.* § 44-77-30(2).

43. *Id.* § 44-77-20(5).

44. *Id.* § 44-77-100. The 1991 amendments added an analogous "conscience clause" for nurses and other hospital employees. If notified of the employee's objection to participating in the withholding or withdrawal of life-sustaining procedures, a hospital or physician must make a reasonable effort to effectuate the Declaration without the employee's participation. *Id.*

not be transferred.⁴⁵

III. NONSTATUTORY INSTRUCTIONS

Because of the lack of flexibility in the statutory living will, some persons prefer to leave nonstatutory instructions concerning life-sustaining treatment. These instructions may be given in the form of a nonstatutory living will or as an addendum to a statutory living will. A nonstatutory living will is a living will that does not conform to the Declaration form in the South Carolina Death With Dignity Act.⁴⁶ This includes form living wills distributed by religious or other organizations, as well as statements composed by the individual. Although non-

45. *Elbaum v. Grace Place of Great Neck, Inc.*, 148 A.D.2d 244, 256, 544 N.Y.S.2d 840, 848 (1989); *Gray v. Romeo*, 697 F. Supp. 580, 590-91 (D.R.I. 1988); *In re Jobes*, 108 N.J. 394, 425-26, 529 A.2d 434, 450 (1987); *In re Requena*, 213 N.J. Super. 475, 487-88, 517 A.2d 886, 893 (Super. Ct. Ch. Div.), *aff'd per curiam*, 213 N.J. Super. 443, 517 A.2d 869 (Super. Ct. App. Div. 1986). *But cf. In re Morrison*, 206 Cal. App. 3d 304, 310-12, 253 Cal. Rptr. 530, 534-35 (Ct. App. 1988) (physician should not be forced to act against personal moral beliefs if patient can be transferred to physician who will carry out decision, and in absence of efforts to transfer, the court will not decide whether patient's or physician's rights would prevail if transfer were impossible); *Brophy v. New England Sinai Hosp.*, 398 Mass. 417, 440-41 & n.39, 497 N.E.2d 626, 639 & n.39 (1986) (hospital could not be compelled to violate policy against withholding nutrition and hydration when the hospital policy would have no impact on patient's right of self-determination). All of the above cases recognize the legitimacy of a provider's moral or ethical principles precluding participation in the withdrawal of life-sustaining treatment. When the conflict between the provider's right to adhere to his ethical principles and the patient's right to refuse treatment has been presented directly to the court, however, the court has ruled in favor of the patient. In *Requena* the court ordered the objecting hospital to carry out the patient's wishes despite the availability of a suitable alternative provider when the evidence indicated that removal from the familiar facility and its personnel would be psychologically harmful to the patient. *Requena*, 213 N.J. Super. at 480-81, 517 A.2d at 889.

In *Elbaum*, *Morrison*, and *Jobes* the court made a specific finding that the patient was not given notice of the facility's policy at the time of admission, and an estoppel theory seemed to guide the analysis. The *Jobes* court stated, "We do not decide the case in which a nursing home gave notice of its policy . . ." *Jobes*, 108 N.J. at 425, 529 A.2d at 450. No court has yet considered a case in which the patient had either actual or constructive notice of such a policy. It is hard to believe, however, that by entering a facility with notice of its policy not to withhold or withdraw life-sustaining treatment, a patient would be deemed to give up control over such a fundamental aspect of his being. This interpretation would be all the more unlikely if the patient had little choice among facilities or if all facilities that offered needed care had similar policies. *Cf. id.* (noting difficulty of finding an alternative facility that might accept the patient); *Morrison*, 206 Cal. App. 3d at 311, 253 Cal. Rptr. at 534 (plaintiff testified that she had tried and failed to find nursing facilities that would take the patient under the circumstances).

46. S.C. CODE ANN. § 44-77-50 (Law. Co-op. Supp. 1990), *as amended by* R. 220, H. 3090 (1991).

statutory instructions are incapable of invoking the duties and immunities of the Act,⁴⁷ they have practical and legal effects that make them a desirable adjunct to, or substitute for, a statutory Declaration in some circumstances.

A. Legal Basis for Nonstatutory Instructions

The legal significance of nonstatutory instructions derives from the common law and constitutional right to refuse medical treatment. The guiding principle in this area of law was forcefully stated by Justice (then Judge) Cardozo in 1914: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body"⁴⁸ The South Carolina Court of Appeals in *Hook v. Rothstein*⁴⁹ expressly recognized this concept, which lies at the foundation of the common-law requirements of consent and informed consent to medical treatment. Control over one's body requires the right to refuse treatment as a corollary to the right to consent. Thus, all cases considering the issue since at least 1980 have recognized that a competent individual has the right to refuse unwanted care.⁵⁰ In *Cruzan v. Director, Missouri Department of Health*⁵¹ the Supreme Court recognized that this right is protected by the Due Process Clause of the United States Constitution.⁵²

47. Cf. *id.* § 44-77-30.

48. *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914), *overruled on other grounds*, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957), *quoted in* *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2847 (1990).

49. 281 S.C. 541, 547-48, 316 S.E.2d 690, 695 (Ct. App.) (recognizing "the patient's right to exercise control over his or her own body by deciding intelligently for himself or herself whether or not to submit to the particular procedure"), *cert. denied*, 283 S.C. 64, 320 S.E.2d 35 (1984).

50. Although earlier decisions often were limited to their facts and usually involved the refusal of "extraordinary" treatment by terminally ill patients, *see, e.g.*, *Satz v. Perlmutter*, 362 So. 2d 160, 162 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980), the judicial language defining the right to refuse treatment has become broader and more decisive as public and judicial opinion have jelled around the importance of medical self-determination. Recent cases emphasize that the right is not dependent upon the type of treatment being refused or the gravity of the patient's condition. *E.g.*, *Tune v. Walter Reed Army Medical Hosp.*, 602 F. Supp. 1452, 1455 (D.D.C. 1985); *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 1137, 225 Cal. Rptr. 297, 300 (1986) (patient was physically helpless, dependent on others for all of her needs, in continual pain, but had life expectancy of 15 to 20 years).

51. 110 S. Ct. 2841 (1990).

52. The overwhelming majority of lower court cases that considered the issue prior to *Cruzan* decided that the constitutional right to privacy encompasses the right to refuse unwanted medical treatment. *E.g.*, *Gray v. Romeo*, 697 F. Supp. 580, 585-86 (D.R.I. 1988); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 739, 370 N.E.2d 417, 424 (1977). The Supreme Court recognized these holdings in *Cruzan*, but

A patient does not lose the right to refuse treatment if incapacity disables him from exercising it.⁵³ Rather, under the holdings of most courts, a guardian or close relative may exercise the right on the patient's behalf.⁵⁴ More importantly for present purposes, the *Cruzan* decision and all state cases considering the issue have allowed a competent individual to exercise the right on behalf of his future incompetent self.⁵⁵ These courts have held that treatment should be withheld when clear and convincing evidence exists that this is what the incompetent patient would have desired.⁵⁶ It is as evidence of the incompetent patient's wishes that a nonstatutory living will has legal effect, as the patient's written instructions concerning care will normally be accepted as clear and convincing evidence of his wishes.⁵⁷ There is no requirement that expressions of intent be in the statutory form⁵⁸ or any other form.

The courts have not been oblivious to the possibility that recognition of treatment refusals in some circumstances might contravene

stated that "this issue is more properly analyzed in terms of a Fourteenth Amendment liberty interest." 110 S. Ct. at 2851 n.7.

53. *E.g.*, *Rasmussen v. Fleming*, 154 Ariz. 207, 219, 741 P.2d 674, 686 (1987) (en banc); *In re Quinlan*, 70 N.J. 10, 41-42, 355 A.2d 647, 664, cert. denied, 429 U.S. 922 (1976).

54. *E.g.*, *In re Jobs*, 108 N.J. 394, 420, 529 A.2d 434, 446-47 (1987); *In re Hamlin*, 102 Wash. 2d 810, 818-20, 689 P.2d 1372, 1377 (1984). But see *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988), *aff'd sub nom. Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841 (1990).

55. See *Cruzan*, 110 S. Ct. at 2852.

56. See, *e.g.*, *id.* at 2847-52.

57. *In re Browning*, 568 So. 2d 4, 16 (Fla. 1990); *In re Conroy*, 98 N.J. 321, 361, 486 A.2d 1209, 1229-30 (1985); *In re Westchester County Medical Center*, 72 N.Y.2d 517, 531, 531 N.E.2d 607, 613-14, 534 N.Y.S.2d 886, 892-93 (1988).

58. The statutory forms and procedures in South Carolina's Death With Dignity Act are not the exclusive means for expressing and implementing a patient's intent to refuse future treatment. Section 44-77-140 of that Act expressly preserves mechanisms that might be available under the common law for accomplishing this purpose. That section provides:

The absence of a declaration by an adult patient does not give rise to any presumption as to his intent to consent to or refuse death-prolonging procedures. Nothing in this chapter impairs any other legal right or legal responsibility which any person may have to effect the withholding or withdrawal or the provision of life-sustaining procedures in any lawful manner.

S.C. CODE ANN. § 44-77-140 (Law. Co-op. Supp. 1990), as amended by R. 220, H. 3090 (1991). This language was intended to allow withholding and withdrawal of life-sustaining treatment pursuant to expressions of intent by the patient or a surrogate in a form other than that expressly provided for in the statute, and similar language has been so interpreted in other jurisdictions. *E.g.*, *In re Drabick*, 200 Cal. App. 3d 185, 214-15, 245 Cal. Rptr. 840, 859-60, cert. denied, 488 U.S. 958 (1988). The 1988 amendments added the second sentence of § 44-77-140 to clarify the intent to preserve common-law rights and remedies regarding refusal of treatment by or on behalf of the patient.

public policy. They have enunciated four state interests that might be disserved by withdrawing or withholding treatment at the direction of a patient: protecting life,⁵⁹ third parties,⁶⁰ and the ethical integrity of the medical profession,⁶¹ and preventing suicide.⁶² The state courts, however, have rejected resoundingly the idea that the state has broad interests capable of overriding a patient's interest in making the choice to accept or reject health care.⁶³

59. The state's interest in preserving life encompasses both an interest in the life of the particular patient and an interest in protecting the sanctity of life within our society. *E.g.*, *In re Conroy*, 98 N.J. 321, 349, 486 A.2d 1209, 1223 (1985). This interest is weak when the patient suffers from a condition that significantly impairs the quality of his or her remaining life, even if that life span is likely to be lengthy. *See, e.g.*, *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 1142-44, 225 Cal. Rptr. 297, 304-05 (1986). A frequently quoted passage from Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977), demonstrates the courts' viewpoint:

The constitutional right to privacy, as we conceive it, is an expression of the sanctity of individual free choice and self-determination as fundamental constituents of life. The value of life as so perceived is lessened not by a decision to refuse treatment, but by the failure to allow a competent human being the right of choice.

Id. at 742, 370 N.E.2d at 426.

60. The interest in protecting third parties can refer to protection of the public health, *see Jacobson v. Massachusetts*, 197 U.S. 11 (1905) (refusal of vaccination), or to protection of the emotional or financial interests of the patient's children or other dependents, *see In re President & Directors of Georgetown College, Inc.*, 331 F.2d 1000, 1008 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964). It has never been used, however, as the basis for overriding a refusal of life-sustaining, as opposed to life-saving, treatment. The patients in these cases are not generally in a position to provide either emotional or financial benefits to their children, and in fact, the opposite may be the case. *See, e.g.*, *In re Farrell*, 108 N.J. 335, 352-53, 529 A.2d 404, 412-13 (1987).

61. The interest in protecting the ethical integrity of the medical profession is generally given short shrift because current precepts of medical ethics do not require provision of life-sustaining treatment to incompetents under all circumstances. *See, e.g.*, *Rasmussen v. Fleming*, 154 Ariz. 207, 217, 741 P.2d 674, 684 (1987) (quoting Opinion of the American Medical Association Council on Ethical and Judicial Affairs (March 15, 1986)). Further, recent cases have stated that this interest is not capable of outweighing the patient's interest in self-determination. *E.g.*, *Elbaum v. Grace Plaza of Great Neck*, 148 A.D.2d 244, 256, 544 N.Y.S.2d 840, 847 (1989).

62. The courts uniformly have held that refusal of life-sustaining treatment does not constitute suicide. They draw a distinction between affirmative action which intentionally and directly causes death, and the withholding of medical intervention, which allows the underlying disease to cause death. *E.g.*, *Tune v. Walter Reed Army Medical Hosp.*, 602 F. Supp. 1452, 1455 n.8 (D.D.C. 1985); *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 1144-45, 225 Cal. Rptr. 297, 306 (1986); *In re Farrell*, 108 N.J. 335, 349-50, 529 A.2d 404, 411 (1987). *But see Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2859-63 (1990) (Scalia, J., concurring).

63. *See, e.g.*, *In re Estate of Longeway*, 133 Ill. 2d 33, 549 N.E.2d 292, 299 (1990); *In re Conroy*, 98 N.J. 321, 349-53, 486 A.2d 1209, 1223-25 (1985); *Delio v. Westchester County Medical Center*, 129 A.D.2d 1, 26, 516 N.Y.S.2d 677, 693 (1987); *see also supra* note 50 and accompanying text.

B. Substance of the Nonstatutory Living Will

Although a written expression of intent will be given great weight in determining the appropriateness of any form of nontreatment, its effect will depend upon the substance of the instructions. In order to ensure that the instructions will be given determinative weight, the expression must clearly indicate that the declarant desires nontreatment in the specific situation at issue. Lack of specificity in the patient's instructions has been the basis for refusing to discontinue treatment in several cases involving both oral and written statements.⁶⁴ In *In re*

The Supreme Court in *Cruzan* recognized the importance of the state interest in protection and preservation of human life, stating: "We do not think a State is required to remain neutral in the face of an informed and voluntary decision by a physically-able adult to starve to death." 110 S. Ct. at 2852. A complete reading of the opinions in the case, however, supports the inference that all members of the majority except Justice Scalia, *see id.* at 2859-63 (Scalia, J., concurring), believe that the state may indeed be required to remain neutral when the patient who refuses nutrition and hydration suffers from severe physical and mental disabilities and provision of nutrition and hydration requires medical intervention. In any event, the Supreme Court's view of the legitimacy and weight of the state's interest becomes relevant only when the state uses that interest to override the patient's decision.

Some courts have allowed state interests to override the patient's wishes in limited situations. The state's interest in protecting the patient's dependent children has been found strong enough to outweigh the patient's interest in bodily autonomy in a few cases involving the refusal of treatment capable of restoring the patient to a normal life. *E.g.*, *In re President*, 331 F.2d at 1008. Other courts have stated that this might be a basis for overriding the patient's choice. *E.g.*, *Rasmussen*, 154 Ariz. at 218, 741 P.2d at 685; *Conroy*, 98 N.J. at 353, 486 A.2d at 1225; *Delio*, 129 A.D.2d at 25, 516 N.Y.S.2d at 693. This interest would not be a factor, however, in most situations in which an individual would want to direct nontreatment by a living will, because in those situations the patient would be incapable of contributing to the economic or emotional well-being of the children because of severe disability. Indeed, it generally is recognized that caring for a family member in a persistent vegetative state or a condition with severe and irreversible dementia extracts both an emotional and a financial toll from the family. *See, e.g.*, *Grau, Social Stress and Family Care of the Elderly*, in *ALZHEIMER'S DISEASE AND RELATED DISORDERS* 175 (1988); *Brody, Caring for Chronically Ill Heavy Burden for Well Family Members*, *The State*, Feb. 28, 1989, at 5-B, col. 1.

64. *See, e.g.*, *In re Westchester County Medical Center*, 72 N.Y.2d 517, 526-27, 532-34, 531 N.E.2d 607, 610-11, 614-15, 534 N.Y.S.2d 886, 889-90, 893-94 (1988) (patient stated that if ill, she "would never want to be a burden on anyone" or lose her dignity, and "nature should take its course," "artificial means" should not be used and that she would not want to go on living if she could not "take care of herself and make her own decisions"); *Cruzan v. Harmon*, 760 S.W.2d 408, 411, 424 (Mo. 1988), *aff'd sub nom. Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841 (1990) (patient stated that if sick or injured she would not want to continue her life if she could not live "halfway normally"); *see also Conroy*, 98 N.J. at 362-64 & n.7, 486 A.2d at 1230-31 & n.7 (evidence of the patient's lifelong fear of doctors, and her refusal to consult them even when afflicted with pneumonia, was inadequate to establish that she would have refused nutrition and hydration in circumstances presented). *But see In re Gardner*, 534 A.2d 947,

Westchester County Medical Center,⁶⁵ for instance, the patient had made oral statements that she would not want to go on living if she could not "take care of herself and make her own decisions," that she "would never want any sort of intervention any sort of life support systems to maintain or prolong her life," and that it was "monstrous" to keep someone alive by using "'machinery, things like that' when they are 'not going to get better.'" The patient subsequently became afflicted with severe dementia resulting from multiple strokes, though she was not in a coma or vegetative state.⁶⁶ The court held that it was not sufficiently clear from the statements in evidence that she would want to decline artificial feeding through a nasogastric tube under the circumstances, and authorized the hospital to insert the tube.⁶⁷

In another case, the patient executed a living will that called for termination of life-sustaining treatment, including nutrition and hydration, if death were "imminent."⁶⁸ The patient suffered a stroke that left her almost totally paralyzed, unable to swallow, and with major irreversible brain damage. She received nourishment through a nasogastric tube. The court determined that death was not imminent, because the patient could live for an indefinite period so long as the gastrostomy tube was in place, and therefore the patient's refusal did not apply because it was conditioned on the imminence of death.⁶⁹

Some circulated "living wills" contain the kind of imprecise language from which such cases arise: "heroic measures," "artificial

953 (Me. 1987) (patient stated that he "would definitely want to die if he was ever in a vegetable state," that people kept alive only by life-sustaining procedures lose their dignity, and that "he would want to die" rather than be maintained in that condition); *Brophy v. New England Sinai Hosp.*, 398 Mass. 417, 429 n.22, 497 N.E.2d 626, 632 n.22 (1986) (patient stated that "I don't ever want to be on a life support system. No way do I want to live like that; that is not living," that "[i]f I'm ever like [a severely burned person he helped rescue from a burning truck], just shoot me, pull the plug," and that "[i]f I can't sit up to kiss one of my beautiful daughters, I may as well be six feet under.").

65. 72 N.Y.2d 517, 526-27, 531 N.E.2d 607, 611, 534 N.Y.S.2d 886, 890 (1988).

66. The patient, though conscious, was severely demented. Her daughters testified that since her hospitalization, the patient never spoke or responded to them in any way, even by facial expression or hand movement. The treating physicians testified that she was capable of responding to simple questions with sounds or words such as "ok" or "all right," though they were uncertain whether she understood the questions asked. *Id.* at 524-25, 544, 531 N.E.2d at 609-10, 621-22, 534 N.Y.S.2d at 888-89, 901.

67. *Id.* at 532-35, 531 N.E.2d at 614-16, 534 N.Y.S.2d at 893-95.

68. *In re Browning*, 543 So. 2d 258, 262 (Fla. Dist. Ct. App. 1989), *certified question approved* in 568 So. 2d 4 (Fla. 1990).

69. *Id.* at 265 (The court was applying a statutory definition of "terminal condition" that was conditioned upon the imminence of death.). The court held, however, that under new guidelines set out in the case, the guardian could authorize withdrawal of the tube under the right to privacy in the Florida constitution.

means," "extraordinary treatment," "treatment that does not offer a reasonable hope of benefit," or "terminally ill."⁷⁰ To the extent possible, nonstatutory living wills should avoid this type of general phraseology, and be as precise as possible about the types of treatment one wishes to refuse and the circumstances in which one wishes to do so.

In planning for the wide variety of treatment choices with which one might be presented in the future, it is necessary to draft a document that will be sufficiently specific to apply to conditions that actually occur, yet sufficiently general to take into consideration a broad range of potential conditions. It is impossible, of course, for the drafter to anticipate and address every possible scenario. The best course of action is to address specifically the most common conditions in which patients or their families might wish to have treatment withheld or withdrawn, and the most common forms of undesired treatment. The drafter should supplement these specific provisions with others describing more generally the categories of condition and treatment to which the patient wishes the refusal to apply. To make the patient's wishes as clear as possible, the document might spell out situations in which the patient does want treatment as well as those in which he does not want treatment.

A living will should specifically address whether the patient wants treatment if he is permanently unconsciousness or suffering from a terminal condition. If the patient desires nontreatment in case of a terminal condition, the document should explain what is meant by terminal condition. If the patient wants treatment withheld in the event of severe dementia short of permanent unconsciousness, the document should provide a particularized description of the circumstances to which these instructions apply. When the patient is not terminally ill or permanently unconscious a court is particularly likely to require treatment in the absence of clear evidence that this is contrary to the patient's wishes.⁷¹

The patients in *In re Westchester County Medical Center* and *In re Conroy* illustrate the conditions that would be reached only by specific instructions of the latter sort.⁷² Each patient was bedridden. Although conscious, each suffered from severe and irreversible dementia

70. See, e.g., Eisendrath & Jonsen, *The Living Will: Help or Hindrance*, 249 J. A.M.A. 2054, 2055 (1983) (setting forth text of living will circulated by Concern for Dying); CATHOLIC HEALTH ASS'N, *CHRISTIAN AFFIRMATION OF LIFE: A STATEMENT ON TERMINAL ILLNESS* (1982).

71. See, e.g., *In re Browning*, 568 So. 2d 4 (Fla. 1990); *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985); *In re Westchester County Medical Center*, 72 N.Y.2d 517, 531 N.E.2d 607, 534 N.Y.S.2d 886 (1988).

72. *Westchester County*, 72 N.Y.2d at 525, 544, 531 N.E.2d at 609, 622, 534 N.Y.S.2d at 888, 901; *Conroy*, 98 N.J. at 337, 486 A.2d at 1217.

that profoundly restricted awareness of and ability to interact with the environment. The patient in *Westchester County* was somewhat more interactive, having the ability to state her name and say a few words such as "ok" and "fine." She responded to questions, though not necessarily appropriately, about fifty percent of the time, but her physicians were not certain that she understood the questions. Despite frequent visits from her two daughters, she had not spoken or responded to them in any way, even by facial expression or hand movement.⁷³ The patient's dementia in *Conroy* was even more profound. The most that could be said of her mental state and capacity for interaction was that her eyes followed people around the room, her facial expressions were different when she was awake and asleep, and she sometimes smiled when her hair was combed or when she received a comforting rub. She was unable to speak, and her physician believed she was unable to respond to verbal stimuli.⁷⁴

As these cases illustrate, dementia can occur in different degrees and with different characteristics.⁷⁵ It is important, therefore, to describe those characteristics of dementia that would give rise to the patient's desire to refuse treatment. Some of the characteristics that might be mentioned include loss of the ability to recognize family members, loss of mobility, loss of multiple sensory functions, and loss of ability to understand, engage in, or respond to verbal communications. The inability to swallow might also be included because this condition not only creates a substantial dependence on medical technology and a concurrent loss of mobility, but also tends to be associated with the more serious levels of brain damage.⁷⁶ The characteristics noted are exemplary only; the patient must give careful consideration to her own values and beliefs concerning the attributes of a meaningful life, and the language of the living will must be carefully tailored to capture those values and beliefs.⁷⁷

The patient may also wish to specify the means by which his condition and prognosis are to be determined. For instance, he may want to specify the number or qualifications of the physicians who are empowered to make any medical determination that will cause the refusal

73. *Westchester County*, 72 N.Y.2d at 525, 544, 531 N.E.2d at 609, 622, 534 N.Y.S.2d at 888, 901.

74. *Conroy*, 98 N.J. at 337, 486 A.2d at 1217.

75. See, e.g., ALZHEIMER'S REPORT, *supra* note 25, at 59-79.

76. *Cranford*, *supra* note 28, at 27.

77. Examples of personalized nonstatutory living wills are found in Modell, A "Will" to Live, 290 NEW ENG. J. MED. 907, 908 (1974), and Cantor, *My Annotated Living Will*, 18 LAW, MED. & HEALTH CARE 114, 115 (1990). See also the detailed decisionmaking grid in Emanuel & Emanuel, *The Medical Directive: A New Comprehensive Advance Care Document*, 261 J. A.M.A. 3288, 3290 (1989).

to become effective.

In addition to specifying the conditions under which one would want treatment withheld and the procedures for determining whether those conditions exist, the document should state which forms of treatment should be withheld under each of the specified conditions. It is particularly important to clearly state one's intentions concerning resuscitation, artificial nutrition and hydration, antibiotics for treatment of infection, and other medications, as these have often been problem areas in law and in medical practice.⁷⁸ If the patient would desire pain medication although it indirectly hastened death, this should also be stated.⁷⁹ One would normally refer to respirator therapy as well. Because the respirator has become the prototype of "life-sustaining therapy" in the public mind, however, even vague statements of intent are likely to be construed as a refusal of respirator therapy.

An attorney should advise the signatory of a living will of the importance of periodically updating the signature, if not the content, of the document. Health care providers, courts, and family members will be more likely to treat the document as a legally effective expression of the incompetent patient's intent if it was executed within a reasonable time before the patient became incompetent.

C. Implementation of Nonstatutory Instructions

The South Carolina courts have not established legal guidelines for the implementation of a nonstatutory living will. Thus, judicial intervention may be necessary to effectuate a patient's intent that is expressed in such a document. The financial and emotional burden of achieving implementation through the courts will normally fall on the patient's family.⁸⁰ Although this situation is not ideal, the costs of litigation may be less than the costs of long-term care, making the imple-

78. See, e.g., Areen, *Death and Dying*, in 1 *BIOETHICS* 289-93 (1988). One physician included in a living will the following definition of "interventions" that should be withheld: "all positive medical and surgical procedures and nursing procedures which would tend to preserve my life, operations on the brain, intravenous feeding, blood transfusions, tube feeding, implantation of radium, amputation, etc." Modell, *supra* note 77, at 908. A recent study indicated that large proportions of persons executing advance directives would want to refuse these procedures. Emanuel, Barry, Stoeckle, Ettelson & Emanuel, *Advance Directives for Medical Care—A Case for Greater Use*, 324 *NEW ENG. J. MED.* 889, 893 (1991).

79. In a recent study, almost 80% of the participants stated that they would want to receive potentially life-shortening pain medications in some circumstances. Emanuel, Barry, Stoeckle, Ettelson & Emanuel, *supra* note 78, at 893.

80. Although the judicial process is sometimes initiated by the provider, in judicial proceedings a provider almost always advocates continued treatment, whether it is appearing as plaintiff or defendant.

mentation of the living will the more cost-effective course of action even when litigation is necessary. Furthermore, an attorney should bear in mind that by the time implementation of a nonstatutory living will becomes appropriate, new case law or statutory enactments may have clarified the legal effectiveness of nonstatutory instructions in South Carolina.⁸¹ Indeed, two developments within the past two years have eliminated much uncertainty and made implementation without judicial intervention more likely. First, the *Cruzan* decision affirmed the constitutional stature of the patient's right to refuse life-sustaining treatment through prior written instructions. Second, the South Carolina legislature enacted the Adult Health Care Consent Act, which denies to surrogates the authority to consent to health care contrary to the known wishes of the patient.⁸²

Litigation generally has been the result of providers' uncertainty about the legal or ethical consequences of implementing the patient's instructions. Ethical uncertainties were diminished significantly by a 1986 policy statement on life-sustaining procedures issued by the American Medical Association (AMA). This statement permits, but does not require, physicians to participate in the implementation of nontreatment decisions, stating:

For humane reasons, with informed consent, a physician may do what is medically necessary to alleviate severe pain, or cease or omit treatment to permit a terminally ill patient whose death is imminent to die. . . . In deciding whether the administration of potentially life-prolonging medical treatment is in the best interest of the patient who is incompetent to act in his own behalf, the physician should deter-

81. Another option that has been used by at least one signatory of a living will is an action for a declaratory judgment about the legal effect of the document. Significant obstacles exist, however, to obtaining a declaratory judgment on the effect of a living will. In particular, a court will entertain an action for declaratory judgment only if the plaintiff demonstrates a "case or controversy." *E.g.*, *Power v. McNair*, 255 S.C. 150, 177 S.E.2d 551 (1970). It may be difficult to convince a court that a case or controversy exists if the plaintiff does not know whether he ever will experience a condition that would invoke the living will, what that condition might be, what form of treatment might be proffered, whether any person would object to implementation of the living will, and what the identity of that person might be. *See generally* S.C. CODE ANN. §§ 15-53-10 to -140 (Law. Co-op. 1976) (South Carolina Uniform Declaratory Judgments Act).

In the sole appellate case on point, the court accepted jurisdiction and declared that the document was effective as "an informed medical consent statement" so that no further judicial proceedings were necessary to discontinue medical treatment as specified in the document. *Saunders v. State*, 129 Misc. 2d 45, 54-55, 492 N.Y.S.2d 510, 517 (Sup. Ct. 1985). The state, as defendant, raised the case or controversy issue. The court did not address directly the problems noted above. Instead, it focused on the public importance of the issue raised, the recurring nature of the issue, and the difficulties in obtaining timely review. *Id.* at 48, 492 N.Y.S.2d at 513.

82. S.C. CODE ANN. § 44-66-60(B) (Law. Co-op. Supp. 1990).

mine what the possibility is for extending life under humane and comfortable conditions and what are the prior expressed wishes of the patient and attitudes of the family or those who have responsibility for the custody of the patient.

Even if death is not imminent but a patient's coma is beyond doubt irreversible and there are adequate safeguards to confirm the accuracy of the diagnosis and with the concurrence of those who have responsibility for the care of the patient, it is not unethical to discontinue all means of life prolonging medical treatment.

Life prolonging medical treatment includes medication and artificially or technologically supplied respiration, nutrition or hydration. In treating a terminally ill or irreversibly comatose patient, the physician should determine whether the benefits of treatment outweigh its burdens. At all times, the dignity of the patient should be maintained.⁸³

The AMA position does not represent a mandate for physicians, nor does it specify what type of consent the physician should rely on. Furthermore, it does not address situations where the patient's condition is neither terminal nor permanently unconscious. Uncertainties remain, therefore, about how an individual physician will view his ethical responsibilities.⁸⁴ The physician's willingness to effectuate instructions will be affected by his personal values, his view of his obligations to the patient, his sense of obligation to the patient's family, and his estimation of the legal risk entailed in various courses of action.

The instructions themselves will influence the physician's view of his obligations to the patient. Discussions with the patient about the living will while the patient is still competent will give the physician a greater assurance that he understands the patient's wishes. Regardless of such an understanding, however, the physician may place his own ethical views, such as his interpretation of the Hippocratic oath or his religious beliefs, ahead of the patient's wishes. This possibility again counsels in favor of the patient's discussing the living will with his physician. If the physician feels constrained from carrying out the patient's instructions, the patient needs to know in advance so that he can decide whether to continue his relationship with that physician.

Although a physician's ethical obligations normally run to the patient, many physicians feel an ethical obligation to the family of a dying patient.⁸⁵ This sense of obligation merges with a fear that family

83. Statement of AMA Council on Ethical & Judicial Affairs (March 15, 1986), quoted in *Rasmussen v. Fleming*, 154 Ariz. 207, 217, 741 P.2d 674, 684 (1987).

84. Despite the prior issuance of the AMA statement, the American Academy of Medical Ethics and various physicians filed amicus briefs in *In re Estate of Greenspan*, 137 Ill. 2d 1, 5, 558 N.E.2d 1194, 1197 (1990), arguing that no clear medical consensus supports the withdrawal of artificial nutrition and hydration.

85. Zinberg, *Decisions for the Dying: An Empirical Study of Physicians' Re-*

members may file a lawsuit if their wishes are not followed, a possibility that looms larger when compared with the irreversibly incompetent patient's inability to litigate in support of his wishes. Thus, recent studies of physicians' responses to living wills have found pervasive unwillingness to effectuate a living will, whether statutory or nonstatutory, if family members did not concur in that course of action.⁸⁶ To ensure effectuation, therefore, it is imperative that the patient discuss the living will with close family members and attempt to secure their cooperation. The patient can obtain further assurance by executing a durable power of attorney⁸⁷ that names a sympathetic person as a substitute decision maker⁸⁸ or instructs that person to take the necessary steps to enforce the living will.⁸⁹

sponses to Advance Directives, 13 Vt. L. Rev. 445, 477-79 (1989).

86. *Id.* In a series of forums that the South Carolina Bar held with elderly persons around the state, the participants frequently expressed the concern that family members might prevent the implementation of a living will. The Hospital and Health Law Committee of the South Carolina Bar and the South Carolina Commission on Aging held the four forums in July 1989 in various parts of the state. The forums were attended by elderly persons and persons who work with the elderly. Their purpose was to elicit information concerning problems that elderly patients have encountered in obtaining or rejecting treatment when they were incompetent to make treatment decisions on their own. As a coordinator of this project, the author attended two of these forums. A written summary and tape recordings of all four forums are on file at the offices of the South Carolina Bar.

87. See *infra* notes 94-143 and accompanying text.

88. But see, e.g., *In re Peter*, 108 N.J. 365, 380, 529 A.2d 419, 427 (1987) (judicial review of surrogate's decision is necessary when family members and guardian do not agree on whether treatment should be provided, even when patient left instructions).

89. Under the 1991 amendments to the Death With Dignity Act, a declarant may appoint an agent with authority to enforce a Declaration. A space for doing so is included in the revised Declaration form. S.C. CODE ANN. § 44-77-50 (Law. Co-op. Supp. 1990), as amended by R. 220, H. 3090 (1991). This agent may petition the court of common pleas for an order directing providers to effectuate the Declaration. *Id.* § 44-77-85.

An attorney-in-fact or other surrogate might enforce a nonstatutory living will through a similar action, see *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988) (action for declaratory judgment), *aff'd sub nom. Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841 (1990); *Foody v. Manchester Memorial Hosp.*, 40 Conn. Supp. 127, 482 A.2d 713 (Super. Ct. 1984) (action for injunction), or an action for appointment of a guardian with specific authority to refuse the unwanted treatment, see *Delio v. Westchester County Medical Center*, 129 A.D.2d 1, 516 N.Y.S.2d 677 (1987). It may be possible to recover attorneys' fees in such an action. See *Gray v. Romeo*, 709 F. Supp. 325 (D.R.I. 1988) (action for declaratory judgment that failure to remove feeding tube was civil rights violation). Alternatively, the patient could authorize the surrogate to file an action for damages against providers refusing to implement the living will. For example, the South Carolina Death With Dignity Act creates a duty in physicians to comply with the living will, breach of which could be the basis for a damage action. S.C. CODE ANN. § 44-77-100 (Law. Co-op. Supp. 1990). Furthermore, courts in several jurisdictions have recognized common-law causes of action, though none has awarded damages. See generally *Miller, Right-to-Die Damage Actions: Developments in the Law*, 65 DEN. U.L. REV. 181 (1988);

Even if the family concurs with the instructions in the living will, the physician may perceive that the legal risk of withholding or withdrawing treatment is too great to permit him to proceed without judicial approval. Family cooperation dramatically reduces the risk that a lawsuit will be filed. When assessing the legal risk, however, the physician must consider not only the probability of a lawsuit, but also the severity of the adverse effect if a lawsuit is filed. This requires the physician to consider the probability that he would be found liable and the probability that public knowledge of the lawsuit would adversely affect his reputation or practice.⁹⁰ The decided cases suggest that the risk of liability is low when the instructions for withholding treatment are clearly applicable to the situation at hand and were executed within a reasonable time before the patient became incompetent; the patient is suffering from a terminal condition as defined in the Death With Dignity Act or is in a state of permanent loss of cognition; and the treatment would have no effect on the patient's terminal or noncognitive condition.⁹¹ Furthermore, significant public support exists for non-treatment in these circumstances,⁹² and consequently damage to the physician's reputation or practice is not likely. Ethical guidelines are clear in these circumstances as well.⁹³ Thus, it is most likely that physicians will be willing to implement the living will without resorting to litigation when these criteria are satisfied.

The physician is less likely to implement instructions that relate to other circumstances without judicial approval. The greater probability of litigation, however, should not preclude the patient and his attorney from addressing additional matters in the living will. Rather, it suggests the importance of considering measures to assure that judicial sanction will be obtained if necessary: for instance, appropriate discussions with family members, appointment of an attorney-in-fact with power to ensure that his wishes are carried out, or an action by the patient for a declaratory judgment on the legal effect of the

Civil Liability for Providing Unwanted Life Support, II BIOLAW § 12-4, at U:499 (Supp. May/June 1987).

90. Fear of criminal prosecution for wrongfully ending a patient's life may also affect the physician's attitude, even though the only relevant case soundly rejected the application of homicide law to situations in which the physician, with family concurrence and in accordance with professional standards, withholds life-sustaining treatment. *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983). This fear is particularly likely to be encountered among South Carolina physicians because of concern generated by provisions of the original Death With Dignity Act that classified certain vaguely defined acts related to a Declaration as "murder." See S.C. CODE ANN. § 44-77-150 (Law. Co-op. Supp. 1986) (repealed by implication by 1988 S.C. Acts 586).

91. See *supra* notes 64-79 and accompanying text.

92. See *infra* note 195 and accompanying text.

93. See *supra* notes 83-86 and accompanying text.

living will.

IV. DURABLE POWERS OF ATTORNEY

A power of attorney is an instrument whereby a person appoints someone else as his agent to act in a particular matter or class of matters.⁹⁴ The durable power of attorney holds great promise for expanding an individual's ability to influence future decisions concerning his health care. A living will must anticipate the infirmities that the declarant may experience in the future and indicate whether particular types of care will be accepted or refused. Advance decision making of this sort deviates from the ideal of informed consent, in which treatment decisions are based on particularized information concerning the patient's condition, the alternative courses of care that are available, and the risks and benefits of each.⁹⁵

Contemporaneous decision making by a carefully chosen agent who possesses information about the patient's values and preferences, the patient's condition, and available treatment alternatives, is viewed by some commentators as a closer approximation of the informed consent model.⁹⁶ An individual who prefers this form of decision making

94. *E.g.*, *Peterson v. Peterson*, 10 Kan. App. 2d 437, 442, 700 P.2d 585, 589 (1985); F. COLLIN, J. LOMBARD, A. MOSES, & H. SPITLER, *DRAFTING THE DURABLE POWER OF ATTORNEY: A SYSTEMS APPROACH* 5 (2d ed. 1989) [hereinafter *SYSTEMS APPROACH*].

95. *See, e.g.*, *Cruzan v. Harmon*, 760 S.W.2d 408, 417 (Mo. 1988), *aff'd sub nom. Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841 (1990); *cf. Hook v. Rothstein*, 281 S.C. 541, 547-48, 316 S.E.2d 690, 694-95 (Ct. App.), *aff'd*, 283 S.C. 64, 320 S.E.2d 35 (1984) (describing doctrine of informed consent).

96. *See, e.g.*, Note, *Appointing an Agent to Make Medical Treatment Choices*, 84 COLUM. L. REV. 985, 1005 (1984); *cf. PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT* 136-37 (1983) (advance directive as imperfect instrument for exercise of self-determination).

A durable power of attorney is preferable to a guardianship as a mechanism to appoint a substitute decisionmaker for several reasons. For example, delegation of health care decisions to an attorney-in-fact provides greater assurance that the principal's wishes about health care will be carried out. Furthermore, one of the original rationales for the Durable Power of Attorney statutes was to avoid the cost and administrative inconvenience of appointing a guardian or conservator. *See SYSTEMS APPROACH, supra* note 94, at 6-8; Note, *supra*, at 1015 n.119; *see generally* UNIF. DURABLE POWER OF ATTORNEY ACT, *Prefatory Note*, 8A U.L.A. 275 (1983) (dominant idea underlying Uniform Act was that durable powers would be alternatives to judicial protective proceedings). In addition, procedures for appointment of a guardian normally involve delays that render this mechanism impractical for some situations that require surrogate decision making for health care. Finally, the use of a durable power is more private than proceedings for appointment of a guardian, particularly now that the instrument need no longer be recorded. This distinction is important because of the highly personal facts involved in competency proceedings and the effect on personal dignity of publication of these facts.

can execute a durable power of attorney authorizing an agent to make health care decisions and enunciating general or specific principles to guide those decisions.

Although a power of attorney is a common-law instrument, the validity of a durable power of attorney is dependent upon a statutory grant of authority. The common-law power of attorney is terminated or suspended when the principal becomes disabled and is therefore unable to supervise the agent's activities.⁹⁷ Because periods of disability constitute the very time when many persons wish to have an agent authorized to act on their behalf, all states, including South Carolina, have enacted statutes that authorize the creation of a power of attorney that remains effective during the principal's disability.⁹⁸ Because of its capacity to endure beyond the traditional condition of termination or suspension, this instrument is called a durable power of attorney. An alternative form of durable power of attorney, sometimes called a springing durable power of attorney, does not become effective until the disability of the principal.⁹⁹ The South Carolina Legislature amended the probate code in 1990 to allow the creation of springing, as

97. *E.g.*, RESTATEMENT (SECOND) OF AGENCY § 122 (1957); Bos, *The Durable Power of Attorney*, 64 MICH. B.J. 690, 691 (1985); Note, *supra* note 96, at 1014. An attorney-in-fact is not supervised by courts or other authority, but only by the principal. *See, e.g.*, SYSTEMS APPROACH, *supra* note 94, at 79-80. Decisions of several courts have limited the effect of disability on the agent's authority under a nondurable power of attorney. They held that unless it is known "from the outset" that the principal's disability is permanent, contracts entered into by the agent while the principal is disabled are not void, but voidable at the option of the principal or his authorized representative. *United States v. Manny*, 645 F.2d 163, 168 (2d Cir. 1981); *Campbell v. United States*, 657 F.2d 1174 (Ct. Cl. 1981); *United States v. Price*, 514 F. Supp. 477 (S.D. Iowa 1981); *Bankers Trust Co. v. Martin*, 51 A.D.2d 411, 381 N.Y.S.2d 1001 (1976). The decisions draw an analogy to the rule that contracts and other acts of incompetents are voidable rather than void. *Price*, 514 F. Supp. at 480; *Manny*, 645 F.2d at 167-68. The courts refused to read statutes authorizing durable powers of attorney as requiring that noncomplying powers of attorney terminate automatically upon the principal's disability. *Price*, 514 F. Supp. at 480-81 (applying Iowa law); *Campbell*, 657 F.2d at 1177-78 (applying Texas law). *But see* Jorrie & Standley, *The Tax Advantages of Lingering Death*, 48 TEX. B.J. 1070, 1077 n.5 (1985) (suggesting that the *Campbell* case "should not be totally relied upon" as a statement of Texas law concerning the effect of powers of attorney during disability). Some of the decisions are limited expressly to situations in which no committee or conservator had been appointed for the principal. *Manny*, 645 F.2d at 166; *Campbell*, 657 F.2d at 1176. Moreover, they do not deal with situations of long-term disability or with noncontractual decisions by the agent, and extension to these areas seems unlikely because of the principal's inability to exercise meaningful control over the agent and questions concerning the principal's intent to delegate such broad discretion to the agent. There are no South Carolina cases discussing these issues.

98. Collin, *Planning and Drafting Durable Powers of Attorney*, 15 Prob. Notes 27 (1989).

99. SYSTEMS APPROACH, *supra* note 94, at 10.

well as immediately effective, durable powers of attorney.¹⁰⁰

Until 1990 South Carolina's statute authorizing the creation of durable powers of attorney contained several features that raised questions about the validity and utility of a durable power of attorney for health care. The statute did not limit the types of decisions that the attorney-in-fact could be authorized to make. Certain aspects of the statute, however, suggested that the durable power could delegate only decisions concerning asset management. For instance, the statutes governing durable powers and conservatorship were integrated, while no similar integration existed in relation to guardianship.¹⁰¹ This suggested that the scope of the durable power was limited to the type of decision that could be made by a conservator. The powers of a conservator relate to asset management,¹⁰² while the powers of a guardian relate to the person of the ward, including the authority to consent to health care provided to the ward.¹⁰³

The 1990 amendments eliminate any doubt whether a durable power of attorney can be used to delegate authority to make health care decisions by expressly stating, "The authority of the attorney-in-fact to act on behalf of the principal . . . may relate to any act, power, duty, right, or obligation which the principal has or may acquire . . ., including the power to consent or withhold consent on behalf of the principal to health care."¹⁰⁴ The amendments also created linkages between durable powers and guardianship similar to those that already existed with conservatorship.¹⁰⁵

The 1990 amendments made several other changes that increased the utility of durable powers of attorney in the health care setting. For example, the authorization of the springing durable power of attorney makes the instrument suitable for people who want to retain control of their health care until they no longer have legal capacity to do so. Removal of the recording requirement for durable powers of attorney that

100. S.C. CODE ANN. § 62-5-501 (Law. Co-op. Supp. 1990).

101. For example, the prior durable power statute stated that the "appointment of an attorney in fact under this section shall not prevent a person or his representative from applying to the court and having a conservator appointed, after which the power of attorney shall become inoperative." *Id.* § 62-5-501(b) (Law. Co-op. 1987). No similar provision regarding appointment of a guardian existed. Similarly, an attorney-in-fact was given priority in the appointment of a conservator, *id.* § 62-5-410(a)(3), but was not mentioned in the provision that governed the appointment of a guardian, *see id.* § 62-5-311.

102. *See id.* § 62-5-424 (Law. Co-op. 1987 & Supp. 1990).

103. *See id.* § 62-5-312 (Law. Co-op. 1987).

104. *Id.* § 62-5-501(A) (Law. Co-op. Supp. 1990). Similarly, the Adult Health Care Consent Act, *id.* §§ 44-66-10 to -80, also enacted in 1990, includes an appropriately authorized attorney-in-fact among its list of persons who may make health care decisions for a patient who is unable to make decisions on his own behalf. *Id.* § 44-66-30(A)(2).

105. *Id.* § 62-5-501(B).

relate solely to the person¹⁰⁶ protects the privacy of what is often, in the health care context, a very private document. Other changes, such as the inclusion of the attorney-in-fact among those having priority for appointment as guardian¹⁰⁷ and the principal's authorization to direct that the power of attorney survive the appointment of a guardian,¹⁰⁸ solidify the principal's control over the identity of the person who will make health care decisions on his behalf. Present South Carolina law, therefore, makes the durable power of attorney a very useful instrument in planning for future health care.

A. Effect of a Durable Power of Attorney on Health Care Decision Making

A durable power of attorney, when in effect, places the attorney-in-fact in the shoes of the principal with authority to make decisions on the principal's behalf.¹⁰⁹ Health care providers are bound to honor these decisions as if they were decisions of the principal himself.¹¹⁰ The minimal evidence on this subject indicates that providers do honor the decisions of persons who hold powers of attorney. Indeed, providers may not be sufficiently discriminating when determining whether the attorney-in-fact actually has been delegated power of the type he or she seeks to exercise.¹¹¹

1. Determining Whether the Durable Power of Attorney is Effective

Some persons may wish to make a durable power of attorney for health care immediately effective, so that the attorney-in-fact can make health care decisions even when the principal is competent. Of

106. *Id.* § 62-5-501(C).

107. *Id.* § 62-5-311(B)(2).

108. *See id.* § 62-5-501(B).

109. *See, e.g., id.* § 62-2-501(A).

110. *Id.*

111. The South Carolina Bar conducted a survey of South Carolina hospitals and nursing homes which revealed a willingness to recognize the authority of persons holding a power of attorney from the patient, although no distinction seemed to be drawn between powers of attorney and durable powers of attorney. *See* Survey Summary of Hospitals, Emergency Rooms and Nursing Homes (on file in the office of the South Carolina Bar) (summarizing results of survey conducted in 1989 by South Carolina Bar and South Carolina Commission on Aging). The author's discussions with providers indicate that neither this distinction nor the distinction between durable powers for health care and those for asset management are well understood. This problem emphasizes the importance of prominently stating and labeling any limitations on the powers of the attorney-in-fact.

course, the competent principal can revoke the durable power or otherwise reassert control over his health care at any time simply by informing the physician. As a practical matter, a physician will not act contrary to the wishes of a competent patient who tells the physician that he wishes to make decisions concerning his own care or who consents to or refuses treatment on his own behalf. Nor is it likely that the attorney-in-fact will seek to assert decision-making authority while the principal is clearly competent. Nonetheless, the physician and the attorney-in-fact have legal authority to bypass the principal if they are so inclined. It is not unforeseeable that they might choose to do so if the principal is seriously ill or debilitated, or is difficult to communicate with, or cantankerous.

Most principals tend to prefer a "springing" durable power that does not become effective until the principal is incompetent to make decisions on his own behalf. A primary problem with a springing power has been the inability of parties dealing with the attorney-in-fact to determine whether the power is effective, because effectiveness is dependent upon the principal's incompetence. This should not be a significant problem in the health-care setting, since the party with whom the attorney-in-fact is dealing is the principal's physician. Traditionally, it has been the role of physicians to determine whether a patient is incompetent to make decisions concerning his care.

Under South Carolina's Adult Health Care Consent Act such determinations must be made by two physicians who have personally examined the patient and noted in the medical record the cause, nature, extent, and probable duration of the patient's incompetence.¹¹² Because the principal will be in a health-care setting at the time that the determination of incompetence needs to be made, the statutory system generally will provide a trustworthy and efficient mechanism for making this determination. In addition, the Adult Health Care Consent Act immunizes the attorney-in-fact for making health care decisions in good faith¹¹³ and immunizes the physician for relying in good faith on those decisions.¹¹⁴ Conformity with the Act thus protects the participants in making and implementing decisions, thereby helping to ensure their participation.

The Adult Health Care Consent Act does not, however, limit the scope of a durable power of attorney for health care. The instrument may specify conditions of effectiveness and methods to determine

112. S.C. CODE ANN. § 44-66-20(6) (Law. Co-op. Supp. 1990).

113. *Id.* § 44-66-70(A). The Act also provides that a person consenting to health care pursuant to its provisions "does not by virtue of that consent become liable for the costs of the care" *Id.* § 44-66-70(B).

114. *Id.* § 44-66-70(C).

whether those conditions have been satisfied. Those provisions of the durable power may deviate from the substantive and procedural standards of the Act.

2. *Physician's Duty to Honor the Durable Power of Attorney*

If the substantive and procedural standards for determining effectiveness have been satisfied, health care providers have a legal duty to honor the durable power of attorney and, hence, to honor the decisions of the attorney-in-fact as if the patient made them himself.¹¹⁵ Consequently, a legal duty to honor a refusal of treatment by the attorney-in-fact arises from the law of battery, which prohibits the provision of most health care without consent from an authorized person.¹¹⁶ A duty to honor a consent from an attorney-in-fact arises from the law of negligence; the failure to provide medically indicated care when an authorized person has consented thereto ordinarily violates professional standards and hence constitutes a breach of the provider's duty of care.¹¹⁷

The physician's duty to honor the decisions of the attorney-in-fact as if they were the principal's decisions does not require the physician to honor a decision of an attorney-in-fact in all situations. In some circumstances a physician may refuse to carry out a patient's own decision or may petition a court to override it. These same options are open to the physician in dealing with an attorney-in-fact. A physician who is uncomfortable performing a procedure requested by a patient or his representative may refuse to do so unless his refusal would amount to either negligence or abandonment¹¹⁸ of the patient. On the other hand, if a physician questions a refusal of treatment by a patient or his representative, he is not free to impose the unwanted treatment on the patient, but may petition the probate court to override the refusal. It is in this fashion that many of the cases involving refusal of life-sus-

115. See *id.* § 44-66-30(A).

116. See RESTATEMENT (SECOND) OF TORTS § 18 comment, illustration 1 (1965); 1 F. HARPER, F. JAMES & O. GRAY, *THE LAW OF TORTS* § 3.10, at 305 & n.32 (2d ed. 1986) [hereinafter HARPER, JAMES, & GRAY].

117. See 3 HARPER, JAMES & GRAY, *supra* note 116, § 17.3.

118. Once a provider-patient relationship is established, it may be terminated only by the cessation of the necessity which gave rise to the relationship, or by the discharge of the physician by the patient, or by the withdrawal from the case by the physician after giving the patient reasonable notice so as to enable the patient to secure other medical attention.

Ricks v. Budge, 91 Utah 307, 314, 64 P.2d 208, 211-12 (1937). A physician's termination of the relationship under other circumstances is considered an abandonment of the patient, and violates both legal and ethical duties. See Annas, *Not Saints, But Healers: The Legal Duties of Health Care Professionals in the AIDS Epidemic*, 78 AM. J. PUB. HEALTH 844, 845 (1988).

taining treatment have made their way into the judicial system. The probate court normally will base its decision on a balancing of the patient's interest in nontreatment and autonomy against any asserted interests in mandating treatment. In the Death With Dignity Act this balancing of interests occurred at the legislative level, and hence the courts have no authority to override the declarant's instructions.¹¹⁹ The durable power of attorney statute and the Adult Health Care Consent Act, however, are broader, more general statutes, which do not represent a specific legislative weighing of the interests in life-sustaining procedures. Therefore, the court retains the authority to perform this weighing and to override the surrogate's decision if the state's interest in treatment is found to predominate. Nevertheless, the enactment of these statutes evidences a legislative preference for private decision making, which suggests that courts should be conservative in substituting their own authority for the decisions made by patients or their authorized representatives.

B. Discretion of the Attorney-in-Fact

The durable power of attorney statute is an enabling act. It does not establish the scope of the agent's authority, but leaves it to the individual principal to define in the instrument the extent of the authority delegated to the agent. Thus, the effect of the instrument on health care is determined primarily by the terms of the durable power itself and the nature of the decisions made by the attorney-in-fact.

Effectuation of the principal's intent thus requires that the authority of the attorney-in-fact be carefully defined in the instrument. Among the matters that should be considered are (1) specifying the areas within which the agent is authorized to act, (2) establishing a standard for decision making by the agent, and (3) giving specific instructions to the agent.

The definition of the agent's authority should be considered from two perspectives. First, the principal may wish to limit the areas in which the agent is authorized to make health care decisions. For instance, a principal might wish to withhold authority to make decisions concerning the principal's reproductive capacity or commitment to a mental health treatment facility or other long-term care facility. A principal may wish to authorize one agent to make decisions concerning only life-sustaining procedures and another agent to make all other health care decisions. Any such limitations should be clearly and prominently set forth in the instrument.

Second, it may be useful to clearly state areas in which the princi-

119. See *infra* text accompanying notes 136-37.

pal intends the agent to have authority, if there might be any question whether a general authority to make health care decisions includes those areas. The authority to make decisions concerning life-sustaining treatment is itself such an area, and should be expressly delegated in the instrument.¹²⁰ This is particularly true in regard to the use of artificial nutrition and hydration. Other controversial forms of health care, such as sterilization, abortion, psychosurgery, and electroconvulsive therapy, should be expressly mentioned if they are to be within the agent's authority.

The standard upon which the agent's decisions are to be based also should be specified. Two general standards are used to guide surrogates in making health care decisions. One of these, the substituted judgment standard, requires the surrogate to base his decision on what he believes the patient would have desired under the circumstances.¹²¹ Courts have recently given three quite different interpretations to the substituted judgment doctrine. One interpretation holds that the doctrine goes no further than to allow the surrogate to decide in accordance with the known wishes of the patient.¹²² A second interpretation regards a decision in accordance with the patient's known wishes as not involving substituted judgment, apparently on the theory that this is merely an implementation of the patient's own judgment. Courts that take this view regard substituted judgment as a determination by a surrogate based on the values, perceptions, and perhaps the inconclu-

120. In *In re Peter*, 108 N.J. 365, 529 A.2d 419 (1987), for instance, the court stated, "It would have been better if Ms. Peter had specifically provided in her power of attorney that Mr. Johanning had authority to terminate life-sustaining treatment." *Id.* at 379, 529 A.2d at 426. The court was willing to recognize such authority because of testimony from the attorney-in-fact that he was directed orally by the principal to refuse life-sustaining treatment, and from nine other witnesses attesting to statements by the principal that she did not wish to receive such treatment. *Id.*

121. See, e.g., *In re A.C.*, 573 A.2d 1235, 1249-51 (D.C. 1990); Superintendent of Belchertown State School v. *Saikewicz*, 373 Mass. 728, 751-53, 370 N.E.2d 417, 430-31 (1977); *In re Jobs*, 108 N.J. 394, 414, 529 A.2d 434, 444 (1987). The substituted judgment standard appears to have originated in a case concerning the appropriateness of a guardian's providing an allowance to a third party from the estate of an incompetent ward when the guardian was convinced that the ward would have done so had he been competent. *Ex parte Whitbread* in *In re Hinde*, a Lunatic, 35 Eng. Rep. 878 (1816). The concept was further developed in *Saikewicz*, 373 Mass. at 751-53, 370 N.E.2d at 430-31. The *Saikewicz* court explained the substituted judgment doctrine as follows:

[T]he decision in cases such as this should be that which would be made by the incompetent person, if that person were competent, but taking into account the present and future incompetency of the individual as one of the factors which would necessarily enter into the decision-making process of the competent person.

Id. at 752-53, 370 N.E.2d at 431.

122. See *Rasmussen v. Fleming*, 154 Ariz. 207, 221-22, 741 P.2d 674, 688-89 (1987).

sive statements of the patient.¹²³ A third interpretation treats both known wishes and inferred wishes as within the substituted judgment standard.¹²⁴

The other standard is the best interests standard, which traditionally has guided the decisions of guardians.¹²⁵ Under this standard, the provision of medical care to extend a person's life generally has been presumed to be in the person's best interests.¹²⁶ Some courts still accord this presumption conclusive weight in the absence of clear and convincing evidence that the patient considered nontreatment to be in his best interests.¹²⁷ Other jurisdictions, however, have recognized that in certain circumstances a third party, such as a guardian or family member, may determine that nontreatment is in the patient's best interests.¹²⁸ The idea that nontreatment may be in the best interests of an irreversibly unconscious patient is supported by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research.¹²⁹

123. See *In re Gardner*, 534 A.2d 947, 949-50 (Me. 1987); *In re Westchester County Medical Center*, 72 N.Y.2d 517, 530, 531 N.E.2d 607, 613, 534 N.Y.S.2d 886, 892 (1988).

124. See *Foody v. Manchester Memorial Hosp.*, 40 Conn. Supp. 127, 138-40, 482 A.2d 713, 720-21 (Super. Ct. 1984); *Brophy v. New England Sinai Hosp.*, 398 Mass. 417, 427-28, 497 N.E.2d 626, 631-32 (1986); *In re Conroy*, 98 N.J. 321, 360-63, 486 A.2d 1209, 1229-30 (1985).

125. See, e.g., *Rasmussen*, 154 Ariz. at 220-22, 741 P.2d at 687-89; *In re Torres*, 357 N.W.2d 332, 337-39 (Minn. 1984).

126. See, e.g., *In re Storar*, 52 N.Y.2d 363, 380-82, 420 N.E.2d 64, 72-74, 438 N.Y.S.2d 266, 274-76, cert. denied, 454 U.S. 858 (1981).

127. E.g., *In re Browning*, 543 So. 2d 258, 273 (Fla. Dist. Ct. App. 1989), certified question approved in, 568 So. 2d 4 (Fla. 1990); *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); *Westchester County*, 72 N.Y.2d at 530-31, 531 N.E.2d at 613, 534 N.Y.S.2d at 892.

128. See, e.g., *In re Drabick*, 200 Cal. App. 3d 185, 212-14, 245 Cal. Rptr. 840, 857-58 (Ct. App.), cert. denied, 488 U.S. 958 (1988); *Torres*, 357 N.W.2d at 338-39. *In re Hamlin*, 102 Wash. 2d 810, 814-16, 689 P.2d 1372, 1375-76 (1984).

129. The President's Commission gives the following discussion of the issue:

The primary basis for medical treatment of patients is the prospect that each individual's interests (specifically, the interest in well-being) will be promoted. Thus, treatment ordinarily aims to benefit a patient through preserving life, relieving pain and suffering, protecting against disability, and returning maximally effective functioning. If a prognosis of permanent unconsciousness is correct, however, continued treatment cannot confer such benefits. Pain and suffering are absent, as are joy, satisfaction, and pleasure. Disability is total and no return to an even minimal level of social or human functioning is possible.

Any value to the patient from continued care and maintenance under such circumstances would seem to reside in the very small probability that the prognosis of permanence is incorrect. Although therapy might appear to be in the patient's interest because it preserves the remote chance of recovery of con-

The New Jersey Supreme Court, in *In re Conroy*,¹³⁰ recognized that the best interests of a conscious patient could be served by non-treatment when the patient suffers from unavoidable severe pain that is greater than the pain that would result from nontreatment and that outweighs the pleasures and satisfactions that the patient derives from life.¹³¹ Other courts have suggested additional limited situations in which nontreatment might be in the patient's best interest; the patients in these cases, however, were in a persistent vegetative state.¹³²

If the principal does not prescribe a standard, state-created standards for surrogate decision making will be applied. No South Carolina case has established such a standard, and the Adult Health Care Consent Act is silent on this issue. Therefore, to avoid the possibility of litigation and to ensure a standard acceptable to the principal, a durable power should specify and define the desired standard of decision making. The principal can provide further guidance to the agent by enunciating in the instrument the values and beliefs that he wishes to inform the agent's decision making. The principal might state, for instance, that it is important to him to experience a comfortable dying process, to avoid invasive medical procedures, or to avoid being a burden on his loved ones. Certain values may be identified as being more important than others. The principal might also state functions the absence of which would cause him to view the quality of his life as not worth preserving; these might include physical mobility, the ability to

sciousness, there are two substantial objections to providing vigorous therapy for permanently unconscious patients.

First, the few patients who have recovered consciousness after a prolonged period of unconsciousness were severely disabled. The degree of permanent damage varied but commonly included inability to speak or see, permanent distortion of the limbs, and paralysis. Being returned to such a state would be regarded as of very limited benefit by most patients; it may even be considered harmful if a particular patient would have refused treatments expected to produce this outcome. Thus, even the extremely small likelihood of "recovery" cannot be equated with returning to a normal or relatively well functioning state. Second, long-term treatment commonly imposes severe financial and emotional burdens on a patient's family, people whose welfare most patients before they lost consciousness, placed a high value on. For both these reasons, then, continued treatment beyond a minimal level will often not serve the interests of permanently unconscious patients optimally.

PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 181-83 (1983), *quoted in Torres*, 357 N.W.2d at 338-39.

130. 98 N.J. 321, 486 A.2d 1209 (1985).

131. *Id.* at 365, 486 A.2d at 1232.

132. *See, e.g., Rasmussen v. Fleming*, 154 Ariz. 207, 222, 741 P.2d 674, 689 (1987); *Drabich*, 20 Cal. App. 3d at 195-97, 245 Cal. Rptr. at 846. *Hamlin*, 102 Wash. 2d at 815, 689 P.2d at 1375-76.

recognize and interact with family members, or the ability to experience a significant level of pleasure.¹³³

In areas in which the principal does not wish the agent to exercise discretion, but only to enunciate and effectuate a decision already made by the principal, specific instructions may be given to the agent. For instance, the agent may be instructed to refuse the administration of nutrition and hydration if the principal is in a persistent vegetative state. Because the agent lacks authority to act contrary to the instruction, providers may not rely upon any decision of the agent contrary to the instruction.

The principal must determine the extent to which he wants the agent's authority to be defined by areas of authority, standards of decision making, or instructions. Any limitation placed on the agent's discretion should be clearly stated and prominently identified in the instrument. Most interactions between an attorney-in-fact and those responsible for implementing his decisions will take place in a health care, rather than a judicial, setting. Indeed, those using a durable power of attorney for health care desire to avoid judicial proceedings. Many health care providers do not understand the potential for diversity among durable powers of attorney, and they are likely to broadly construe the authority of the attorney-in-fact unless the instrument prominently identifies limitations on that authority.¹³⁴

C. Proposed Statutory Form Health Care Power of Attorney

The flexible nature of the durable power of attorney is itself a drawback in some ways. The statute is drawn in general terms to enable the durable power to be used in a variety of asset management and personal care situations.¹³⁵ As a result, the statute does not contain corollary provisions such as those in the Death With Dignity Act,¹³⁶ which are aimed at assuring that the patient's wishes will be carried out without resort to the courts.¹³⁷ Among these provisions are the explicit legal sanction for withholding or withdrawing treatment in certain circumstances, the creation of a provider's duty to honor the patient's stated intent, and the immunization of providers from liability for doing so. A legal duty to honor a decision of the attorney-in-fact

133. See generally Doukas, Lipson, & McCullough, *Value History*, in CLINICAL ASPECTS OF AGING 615-16 (1978).

134. Indeed, when a durable power of attorney does not delegate authority over health care decisions, that fact should prominently appear in the instrument to avoid mistaken reliance by health care professionals.

135. See S.C. CODE ANN. § 62-5-501 (Law. Co-op. Supp. 1990).

136. *Id.* §§ 44-77-10 to -160, as amended by R. 220, H. 3090 (1991).

137. See *id.*

can be grounded in common-law principles of battery and negligence.¹³⁸ Moreover, appropriate language in the durable power can give providers some security against liability for honoring the decisions of the attorney-in-fact. Even a well-drafted instrument, however, cannot provide the degree of certainty offered by the Death With Dignity Act. The Act, for instance, clearly establishes the extent of the provider's duty to determine the validity of the instrument.¹³⁹ Most importantly, the Act establishes that no state policy will stand in the way of the withholding or withdrawal of treatment under the stated circumstances.¹⁴⁰ A patient's empowerment of a third party to determine that treatment should be withheld does not bind the state, and much of the litigation concerning nontreatment has involved the issue of whether the state will allow a duly empowered guardian or other surrogate to refuse life-sustaining treatment.¹⁴¹ As a legal matter, therefore, one who executes a durable power authorizing an agent to refuse life-sustaining treatment has less certainty of the consequences of his act than one who executes a Declaration.

To address these areas of uncertainty, as well as other issues, legislation was introduced in the 1991-1992 session of the South Carolina General Assembly to create a statutory form Health Care Power of Attorney and define its effect.¹⁴² A statutory form makes the durable power of attorney accessible to a much wider segment of the public because it can be executed without the assistance of an attorney. Furthermore, it enables attorneys who are not experts in drafting durable powers of attorney to prepare these documents for clients with the assurance that the document will contain key provisions. Because a statutory form would be used by the majority of persons who execute a durable power of attorney for health care, providers would become familiar with the form and have a better understanding of their legal duties when presented with it.

The form in the proposed statute balances these objectives against the planning flexibility that is a primary objective in using a durable power of attorney rather than a Declaration. It attempts to provide some degree of flexibility without making execution of the document so

138. See *supra* notes 116-17 and accompanying text.

139. See S.C. CODE ANN. §§ 44-77-30 to -40 (Law. Co-op. Supp. 1990), as amended by R. 220, H. 3090 (1991). It also provides a legally authoritative statement that providers will not be liable for certain acts or omissions. *Id.* § 44-77-90.

140. See *id.* § 44-77-30.

141. See, e.g., *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985); *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976), cert. denied, 429 U.S. 922 (1977).

142. A number of other states have enacted statutes that designate the form of the durable power. See, e.g., CAL. CIV. CODE § 2500 (West Supp. 1991); NEV. REV. STAT. ANN. § 449.830 (Michie Supp. 1989); WIS. STAT. ANN. § 155.30 (West Supp. 1990).

complex that it would thwart the objective of accessibility to a wide segment of the public. The principal is given the choice of three alternative statements concerning life-sustaining procedures, or, if none of these satisfactorily expresses his wishes, space is provided for instructions or guidelines in his own words. In addition, the principal may choose from two alternative statements concerning nutrition and hydration, and may indicate whether or not he wishes the agent to have authority to consent to donations of organs or tissue for transplantation. Finally, space is provided for the principal to state any further limitations on the agent's authority.

The proposed statutory form is adapted from a form developed by the American Bar Association and the American Association of Retired Persons.¹⁴³ It creates a "springing" durable power of attorney, effective only at times when the principal is incompetent. The agent is given broad general authority to make all health care decisions on behalf of the principal at such times, as well as corollary powers necessary to effectuate those decisions. These powers may be limited by the principal as indicated above.

The statutory framework is in many ways similar to the Death With Dignity Act. It imposes on health care providers a legal duty to honor the decisions of the agent to the same extent as if they were made by the principal, and it immunizes them from liability for doing so. It also immunizes the agent acting in good faith from liability based on the substance of his decisions. In addition, the bill contains a number of protective features adapted from the Death With Dignity Act, including the limitations on who may serve as a witness, the disallowance of mercy killing, and penalties for coercive behavior in obtaining execution of the instrument.

Enactment of this bill would significantly improve South Carolinians' options for health care planning, and increase the likelihood that the decisions of an attorney-in-fact would be honored without resort to the courts. In the absence of legislation of this sort, attorneys must carefully draft durable powers of attorney to achieve the principal's objectives concerning care and lessen the likelihood of medical or judicial obstacles to the agent's exercise of the intended authority.

143. A modified version of the proposed statutory form, suitable for use pending enactment of a statute, is contained in Appendix A to this Article.

V. EXECUTION OF A HEALTH PLANNING INSTRUMENT: CAPACITY TO EXECUTE

A. Declaration

A Declaration may be executed only by a person who is eighteen years old or older.¹⁴⁴ Because this age limit is set forth in the statute, there is no flexibility for inclusion of the mature minor.

The statutory requirements for execution of a Declaration do not explicitly require that the declarant be competent. General principles of law, however, disallow the execution of important documents by incompetent persons,¹⁴⁵ and the legislature demonstrated its intent to apply these principles to Declarations by requiring that witnesses attest to the declarant's "sound mind."¹⁴⁶

Competence typically is measured by the capacity of the individual to understand and make decisions concerning the transaction at hand.¹⁴⁷ Thus, a person who is incompetent to manage his financial affairs is not necessarily incompetent to execute a Declaration. A person for whom a guardian has been appointed, however, lacks the legal capacity to act in areas that are subject to the guardianship, even if he has a lucid interval, regains his reason, or otherwise appears to have sufficient understanding of the matter at hand to make a reasoned decision.¹⁴⁸

B. Nonstatutory Instructions

In the absence of specific rules to govern the competence of a person who executes a nonstatutory living will, it is reasonable to adapt the rules governing competence to execute a statutory Declaration or other legal document and rules governing competence to make decisions concerning health care. The general principle that bars execution of legal documents¹⁴⁹ and medical decision making¹⁵⁰ by a person who

144. S.C. CODE ANN. § 44-77-30 (Law. Co-op. Supp. 1990).

145. See sources cited *infra* notes 147-51.

146. See S.C. CODE ANN. § 44-77-50 (Law. Co-op. Supp. 1990) (witness affidavit form).

147. See, e.g., *In re Schiller*, 148 N.J. Super. 168, 180-81, 372 A.2d 360, 367 (Ch. Div. 1977) (This case defines competence to consent to health care in terms of whether the patient has "sufficient mind to reasonably understand the condition, the nature and effect of the proposed treatment, attendant risks in pursuing the treatment, and not pursuing the treatment . . .").

148. 2 S. WILLISTON, A TREATISE ON THE LAW OF CONTRACTS § 257 (3d ed. 1959).

149. See, e.g., T. ATKINSON, HANDBOOK OF THE LAW OF WILLS § 51 (2d ed. 1953); W. SEAVEY, HANDBOOK OF THE LAW OF AGENCY § 14 (1964).

150. E.g., S. HERR, S. ARONS & R. WALLACE, LEGAL RIGHTS AND MENTAL HEALTH

is not "of sound mind" surely applies to living wills. As in other contexts,¹⁵¹ the "sound mind" criterion should be satisfied by the signatory's capacity to understand the nature and effect of the document and to make a reasoned decision about whether he should sign.

The law that affects the capacity of minors to make an advance decision to refuse treatment is inconclusive. The South Carolina Death With Dignity Act does not allow minors to execute a Declaration.¹⁵² The Act expressly preserves, however, "any other legal right . . . which any person may have to effect the withholding or withdrawal of life-sustaining procedures in any lawful manner."¹⁵³ Other South Carolina statutes allow certain minors to make decisions that concern their health care. For example, married minors may consent to health care.¹⁵⁴ A minor who is sixteen years old or older may consent to health care other than "operations."¹⁵⁵ Although this statute affirms the capacity of the mature minor to make certain health care decisions, it suggests that the finding of capacity does not extend to decisions that pose a significant net risk to the minor's life or health. The statute should not be construed, however, to express a clear public policy against the refusal of life-sustaining treatment by a minor in all circumstances, as well-being is generally viewed differently when a patient is in a terminal, permanently unconscious, or other extreme condition.¹⁵⁶

CARE 31-32 (1983).

151. See, e.g., *Stockmeyer v. Tobin*, 139 U.S. 176, 188 (1891) (contractual incapacity exists when individual is unable to understand the character of the transaction in question); *Jackson v. Pillsbury*, 380 Ill. 554, 561, 44 N.E.2d 537, 546 (1942) (test of mental capacity is whether a person is capable of understanding the nature and effect of the act in which the person is engaged); *New York City Health & Hosp. Corp. v. Stein*, 70 Misc. 2d 944, 946-47, 335 N.Y.S.2d 461, 465 (Sup. Ct. 1972) (individual can be incompetent to manage his affairs, yet competent to make decisions concerning medical treatment); 2 S. WILLISTON, *supra* note 148, § 256 (person may be mentally incompetent for some purposes, but not others).

152. See *supra* text accompanying note 144.

153. S.C. CODE ANN. § 44-77-140 (Law. Co-op. Supp. 1990), as amended by R. 220, H. 3090 (1991).

154. *Id.* § 20-7-270 (Law. Co-op. 1976).

155. *Id.* § 20-7-280. An operation may be performed "only if such is essential to the health or life of such child" *Id.*

156. See, e.g., *In re Browning*, 543 So. 2d 258, 268 (Fla. Dist. Ct. App. 1989), *certified question approved in*, 568 So. 2d 4 (Fla. 1990) (discontinuance of life-sustaining treatment inherently justified when patient irreversibly unconscious, but not when patient experienced a lesser degree of mental limitation); *In re Peter*, 108 N.J. 365, 374, 529 A.2d 419, 424 (1987) (different standards apply to patient in persistent vegetative state than to patient who is conscious and capable of limited interaction with environment); cf. *Rasmussen v. Fleming*, 154 Ariz. 207, 211, 741 P.2d 674, 678 (1987) (*Rasmussen* appears to recognize a state of existence between life and death to which separate rules can be applied: "Medical technology has effectively created a twilight zone of suspended ani-

In *In re Swan*,¹⁵⁷ the Maine Supreme Court held that oral statements made when the patient was sixteen and seventeen years old constituted clear and convincing evidence of his decision to refuse life-sustaining procedures, and that this decision must be honored. The court held that the patient's minority at the time of the statements "is at most a factor to be considered by the factfinder in assessing the seriousness and deliberateness with which his declarations were made."¹⁵⁸

This case is consistent with the United States Supreme Court decision in *Bellotti v. Baird*,¹⁵⁹ upholding the right of a mature minor to choose to have an abortion by requiring a state with a parental consent statute to provide an alternative procedure to allow the minor to demonstrate her maturity.¹⁶⁰ The Court recognized in *Bellotti* that mature minors, like adults, have a constitutional right to make certain important decisions. The maturity requirement in *Bellotti*, like the "seriousness and deliberateness" requirement in *Swan*, indicates that the decisive factor in determining whether important decisions by a minor must be honored is the same as that which determines which adults are entitled to constitutionally protected decisions: the ability to understand the nature and effect of the refusal of treatment and to make a reasoned decision on the matter.¹⁶¹

It is thus likely that a living will executed by a minor will be given legal effect as an expression of intent if it evidences a mature and carefully considered decision. This result is especially likely when the parents of the minor are in accord with the intent expressed in the living will. In order to facilitate establishment of the minor's maturity and seriousness of purpose, it is advisable to attach to the instrument affidavits from one or more objective adults, such as the minor's minister or physician, who have discussed the matter with the minor and can attest to these facts.

Because of the uncertainties that surround the effectiveness of a living will that is executed by a minor, any such instrument should be

mation where death commences while life, in some form, continues.").

157. 569 A.2d 1202, 1206 (Me. 1990); see also *In re E.G.*, 161 Ill. App. 3d 765, 771-72, 516 N.E.2d 286, 290-91 *aff'd in part, rev'd in part*, 133 Ill. 2d 98, 549 N.E.2d 322 (1987) (recognizing the right of a mature minor who was a Jehovah's Witness to refuse transfused blood, a decision in which his parents concurred); *In re Long Island Jewish Medical Center*, 147 Misc. 2d 724, 557 N.Y.S.2d 239 (1990) (suggesting that refusal of transfusion by mature minor might be honored, but holding that patient was not a mature minor).

158. *Swan*, 569 A.2d at 1205 (Me. 1990).

159. 443 U.S. 622 (1979).

160. *Id.* at 643-44.

161. See *supra* notes 149-51 and accompanying text.

reviewed by the signatory when he attains the age of eighteen. If no changes are desired, he can simply re-sign the document and date the new signature to evidence an adult ratification of his earlier decision.

C. Durable Power of Attorney

As with any legally effective act, a person executing a durable power of attorney must be competent to understand the nature and significance of the instrument that he is executing. The statute contains no minimum age requirement for execution of a valid durable power of attorney, leaving limits to be inferred from analogous sources of law. South Carolina law allows a person to nominate his own conservator at the age of fourteen, so long as the court believes that he has sufficient mental capacity to make an intelligent choice.¹⁶² Fourteen is also the age at which a person may nominate his own guardian under common-law principles.¹⁶³ A person may make decisions concerning health care other than surgery at the age of sixteen¹⁶⁴ and may make decisions concerning all forms of health care at any age if he is married.¹⁶⁵ On the other hand, a person must be eighteen years of age or married to make a will.¹⁶⁶ The durable power of attorney statute incorporates the requirements for a will only in regard to the formalities of execution and attestation, and the requirements concerning witnesses.¹⁶⁷ The age at which a person may execute an instrument would not seem to fall within these categories.

One approach to determining the age at which a person may execute a durable power of attorney is to apply the age requirements applicable to the decisions delegated by the durable power of attorney. This approach is consistent with the *Restatement (Second) of Agency*, which states: "A person who has capacity to affect his legal relations by

162. S.C. CODE ANN. § 62-5-410 (Law. Co-op. 1976).

163. See, e.g., J. SCHAUER, A TREATISE ON THE LAW OF DOMESTIC RELATIONS 445 (4th ed. 1889). The 1990 amendments to the South Carolina Probate Code give a person nominated by the incapacitated person priority for appointment as guardian. S.C. CODE ANN. § 62-5-311(B)(1) (Law. Co-op. Supp. 1990). Prior to the amendment, no statutory provision allowed a person to nominate his own guardian. Because the amended statute contains no age limit, it could be construed to adopt the common-law age limit of 14 years or to allow the court to consider age as a factor in rejecting a nominee for good cause.

164. S.C. CODE ANN. § 20-7-280 (Law. Co-op. 1976). The minor may not consent to surgery under this provision.

165. *Id.* § 20-7-270. A minor of any age may also make decisions that concern health care for a child of the minor. *Id.* § 20-7-300. These statutes contain no exceptions related to the type of care.

166. *Id.* § 62-2-501.

167. See *id.* § 62-5-501(C) (Law. Co-op. Supp. 1990).

giving consent to a delegable act or transaction has capacity to authorize an agent to do such act or to conduct such transaction for him with the same effect as if he were to act in person.”¹⁶⁸ Thus, it should be possible to execute a durable power of attorney that nominates a conservator at the age of fourteen and one that authorizes an agent to make health care decisions other than surgery at the age of sixteen.¹⁶⁹ The agent would have the power to refuse life-sustaining treatment to the extent that the principal possessed the power.

An alternative approach is to compare the appointment of an attorney-in-fact under a durable power of attorney to the designation of a guardian, as the result of invalidating the durable power on the grounds of incapacity would be a transfer of decision-making authority to a guardian or other surrogate. Under this analysis, the criteria for capacity to appoint a guardian would determine the validity of an appointment of an attorney-in-fact to make health care decisions. The validity of instructions to the attorney-in-fact, however, would be determined by the criteria for making decisions of the type embodied in the instructions.

VI. EXECUTION OF A DECLARATION

A. *Form*

To invoke the operative provisions of the Death With Dignity Act,¹⁷⁰ a Declaration must be “substantially in the form set forth in Section 44-77-50.”¹⁷¹ The language “substantially in the form” has not received judicial interpretation. To be on the safe side, however, the statutory language should be followed as closely as possible and the typeface requirements set forth in the Act should be precisely adhered to.¹⁷² Minor deviations from the statutory language, however, such as those contained in some forms that have been distributed in the state,¹⁷³ will not likely render the Declaration invalid under the

168. RESTATEMENT (SECOND) OF AGENCY § 20 (1958).

169. As with a nonstatutory living will, the principal should re-execute the instrument when he attains majority. See *supra* notes 152-61 and accompanying text.

170. S.C. CODE ANN. §§ 44-77-10 to -160 (Law. Co-op. Supp. 1990), as amended by R. 220, H. 3090 (1991).

171. *Id.* § 44-77-40.

172. The Code requires the procedure and requirements for revocation of the Declaration to appear either in boldface print or in all upper case letters. In either case, the characters must be at least the same size as those in the rest of the Declaration. *Id.* § 44-77-50.

173. The Society for the Right to Die has distributed a form for use in South Carolina that inserts after the third paragraph of the statutory language a space for “Other Directions.” This insertion, and the inclusion of statements by the declarant in this

statute.

The Death With Dignity Act was amended in 1988 and 1991, and the language of the form was changed to reflect the amendments.¹⁷⁴ These modifications did not, however, invalidate Declarations executed under earlier version of the Act. The amendments express the legislature's intent that Declarations in the 1986 and 1988 forms should remain valid.¹⁷⁵ Prior versions of the Declaration, however, do not have the same effect as the 1991 version. The 1986 and 1988 Declarations¹⁷⁶ instruct the physician to withhold "life-sustaining procedures" if the declarant's condition is "terminal," as those terms were defined in the 1986 and 1988 statutes. They do not instruct that artificial nutrition and hydration be withheld or withdrawn, except where discomfort would not result from withholding or withdrawal. Nor do they explicitly instruct that life-sustaining procedures be withheld if the declarant is permanently unconscious. If a person wishes his Declaration to have these effects, he should execute a new Declaration using the 1991 form.¹⁷⁷

space, should not have any effect on the validity of the Declaration under the Act. However, two cautions are in order. First, any directions that go beyond the scope of the Act will be treated under the principles that are applied to nonstatutory instructions. See *infra* notes 192-97 and accompanying text. The Act does not determine the legal effect of instructions related to situations that are not included within its language. See S.C. CODE ANN. § 44-77-140 (Law. Co-op. Supp. 1990), as amended by R. 220, H. 3090 (1991) (no presumption of intent arises from the absence of a Declaration, and the Act does not impair other legal rights). Second, if directions set forth in this section of the document conflict with the statements in the statutory document, the entire Declaration may be invalid. It would still be possible to have the document examined under the principles applied to nonstatutory living wills. A basic principle of the law in that area, however, is a search for the declarant's intent. If the conflict renders intent ambiguous, the document would not be given effect as a nonstatutory living will.

A form distributed by the Joint Legislative Committee on Aging under the 1988 version of the Act inserted "(optional)" before the blank for entry of the name of a designee. Because appointment of a designee is not mandated by the statute, this addition clearly was insubstantial. See *infra* notes 229-31 and accompanying text.

174. Compare S.C. CODE ANN. § 44-77-50 (Law. Co-op. Supp. 1987) with *id.* (Law. Co-op. Supp. 1990).

175. See *id.* § 44-77-20(1) (Law. Co-op. Supp. 1990), which defines a "declarant" as "a person who has signed a declaration in accordance with Sections 44-77-40 and 44-77-50, [or] in accordance with earlier versions of this chapter . . ." (emphasis added); see also *id.* § 44-77-30 (giving effect to a Declaration that "on its face is in compliance with the law of the state of the declarant's domicile at the time that the declaration is adopted, if the declaration provided for by the law expresses an intent that is substantially the same as the intent of the declaration provided in Section 44-77-40 . . .").

176. The differences between the 1986 and 1988 Declaration forms are insubstantial.

177. The Act allows a person who has executed a Declaration using one of the earlier forms, or who has executed a similar document in accordance with the law of another state, to execute a supplementary document providing instructions concerning nutrition and hydration. S.C. CODE ANN. § 44-77-65 (Law. Co-op Supp. 1990), as amended by R.

Declarations or similar documents executed in accordance with the law of another state are to be given the same effect as a South Carolina Declaration, provided that the statement of intent expressed in the foreign document calls for results similar to those provided for in the Act.¹⁷⁸ Because this provision appears in both the 1988 and 1991 versions of the Act, foreign documents should be given effect under either version, depending upon which most closely approximates the intent stated in the document.

B. Formalities of Execution

The formalities for execution of a Declaration closely resemble those for the execution of a will.¹⁷⁹ The similarity is intentional because these two documents often are executed at the same time. The declarant must date and sign the Declaration and two witnesses must sign an affidavit that is included in the Declaration form.¹⁸⁰ The document must also be notarized. The notary may serve as one of the witnesses, in which case he notarizes only the signature of the other witness.¹⁸¹ All parties must sign in each other's presence.¹⁸²

The Act also sets forth a number of qualifications that witnesses must meet, and attestations to this effect are included in the affidavit. The first group of qualifications is aimed at eliminating persons who might gain financially from the declarant's death. Thus, a witness must not be closely related to the declarant,¹⁸³ directly financially responsible for his medical care, entitled to any portion of his estate under an

220, H. 3090 (1991). This document must be in the form of the "Instructions Concerning Artificial Nutrition and Hydration" in the Declaration, *see id.* § 44-77-50, and the execution formalities are the same as for a Declaration. *Id.* § 44-77-65.

In most circumstances, however, it would seem preferable to execute a new Declaration rather than supplementing an old one with this codicil-like document. The codicil would only cover artificial nutrition and hydration, and would not explicitly provide for withholding or withdrawal of other life-sustaining procedures from permanently unconscious patients. Nor does it allow the declarant to authorize an agent to assure that his wishes are carried out. Further, as a practical matter, the risk of separation of the two documents also militates against the codicil approach.

178. *Id.* §§ 44-77-20(1), -30.

179. *Compare id.* §§ 44-77-40(2), -50 with *id.* §§ 62-2-502, -503.

180. *Id.* §§ 44-77-40(2), -50.

181. *Id.*

182. *Id.* §§ 44-77-40(2), (4). Recent amendments to the Probate Code have eliminated this requirement for the execution of wills. *See S.C. CODE* § 62-2-502 & reporter's comments.

183. *S.C. CODE* § 44-77-40(2), as amended by R. 220, H. 3090 (1991) (witness must not be "related to the declarant by blood, marriage, or adoption, either as a spouse, lineal ancestor, descendant of the parents of the declarant, or spouse of any of them . . .").

existing will or by intestate succession, a beneficiary of an insurance policy on his life, or a potential claimant against any portion of his estate.¹⁸⁴ Another set of qualifications limits the role of health care providers as witnesses. No more than one witness may be an employee of a health facility in which the declarant is a patient, and the declarant's attending physician and the physician's employees are barred from serving as witnesses.¹⁸⁵ Finally, because persons institutionalized in a hospital or a nursing care facility often are isolated and dependent, a designee of the State Ombudsman must witness their Declarations to ensure that the Declarations are executed voluntarily.¹⁸⁶

The 1991 form contains several choices that must be made by the declarant when executing the Declaration. The declarant must give instructions concerning nutrition and hydration by initialing the statements that reflect his wishes.¹⁸⁷ If he fails to initial an appropriate statement, nutrition and hydration will be provided if necessary for the declarant's comfort.¹⁸⁸ It should be noted that the "comfort care" option is different from either of the choices provided on the form, and it is possible that a declarant would want to deliberately choose this alternative.

An additional issue to which attention must be given in executing a Declaration is whether the declarant wishes to authorize an agent to enforce the Declaration, to revoke it, or to do either.¹⁸⁹ If so, the name, address, and telephone number of the agent or agents must be entered on the form.¹⁹⁰ The declarant does not have to authorize an agent to perform either function, however, and the Declaration is valid regardless of whether an agent is designated.¹⁹¹

VII. EXECUTION OF A NONSTATUTORY LIVING WILL

A. *Formalities of Execution*

The cases do not suggest any particular formalities for the execu-

184. *Id.*

185. *Id.*

186. *Id.* § 44-77-40(3). The emphasis on voluntariness is also evidenced by the statute's bar on requiring a person to sign a Declaration as a condition for obtaining insurance or medical treatment, or for being admitted to a hospital or nursing home. *Id.* § 44-77-120.

187. *See id.* § 44-77-50.

188. *Id.* § 44-77-20(2); *see supra* notes 32-37 and accompanying text.

189. The declarant may delegate these two areas of authority to different persons. *Id.* § 44-77-50.

190. *Id.*

191. *See infra* note 230 and accompanying text.

tion of a nonstatutory living will other than date, signature, and some method for ascertaining the competency of the signatory. In fact, one can infer from the decided cases that formalities are not crucial to legal effectiveness.¹⁹² The reason for this is the dilemma faced by parties who must make a life or death decision that concerns life-sustaining treatment for an incompetent patient. The patient possesses both a right to life and a right "to die a natural death without undue dependence on medical technology or unnecessarily protracted agony"¹⁹³ Our legal system embodies a preference for prolongation of life,¹⁹⁴ but a significant majority of the public has expressed a preference for death when the indicia of life have been reduced to a certain minimum.¹⁹⁵ Faced with the need to make a treatment decision in these complex situations, the courts have been willing to consider any expression of intent by the patient, and a recent written expression, even a relatively informal one, is considered highly probative of the patient's intent, and hence is given great weight.¹⁹⁶

Despite the leniency of the courts with respect to the form of a

192. See, e.g., *John F. Kennedy Memorial Hosp. v. Blutworth*, 452 So. 2d 921, 922, 926 (Fla. 1984) (stating "great weight" should be given to a nonstatutory living will, but not discussing any specific requirements); *In re Conroy*, 98 N.J. 321, 361 n.5, 486 A.2d 1209, 1229 n.5 (1985) (stating, with no mention of formalities, that a written document is evidence of patient's intent); *In re Westchester County Medical Center*, 72 N.Y.2d 517, 531-32 & n.4, 531 N.E.2d 607, 613-14 & n.4, 534 N.Y.S.2d 886, 892-93 & n.4 (1988) (emphasizing the need for evidence of patient's "seriousness of purpose" and referring to the formalities required for an effective will, but stating that "some form of writing" is sufficient evidence in context of treatment refusal); see also cases cited *infra* note 221 (accepting even informal oral statements as evidence of intent).

193. *Conroy*, 98 N.J. at 343, 356, 486 A.2d at 1220, 1227.

194. See, e.g., *In re Longeway*, 133 Ill. 2d 33, 51, 549 N.E.2d 292, 300 (1990); *Rasmussen v. Fleming*, 154 Ariz. 207, 224, 741 P.2d 674, 691 (1987) (presumption that patient wants medical treatment); *Westchester County*, 72 N.Y.2d at 530-31, 531 N.E.2d at 613, 534 N.Y.S.2d at 892; see also *Cruzan v. Harmon*, 760 S.W.2d 408, 419-20 (Mo. 1988), *aff'd sub nom. Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841 (1990).

195. See, e.g., *Butler, Ruling May Help Plug Loophole in SC's 'Living Will' Law*, *The State*, July 1, 1990, at 1-B, col. 1 (New York Times and CBS News poll showed 85% would want feeding tube removed if they were in a coma); *John, To Smoke or Not to Smoke*, *Wash. Post Nat'l Weekly Ed.*, Apr. 20, 1987, at 39, col. 1 (70% of adults surveyed in Gallup poll would be "very willing" to have life-support devices disconnected); *Right to Die Polls Continue on Upswing*, *Society for the Right to Die Newsletter*, Spring 1985, at 5, col. 1 (reporting three polls in which large majorities favored withholding or withdrawal of life-sustaining treatment).

196. See, e.g., *Blutworth*, 452 So. 2d at 922-26; *Conroy*, 98 N.J. at 361-63, 486 A.2d at 1230; *Westchester County*, 72 N.Y.2d at 530-31, 531 N.E.2d at 613-14, 534 N.Y.S.2d at 892-93 (none of these cases expresses concern about the formalities of the writing). Earlier statements, when considered in conjunction with recent statements, may help to establish consistency of purpose or to define the specific nature of the patient's intent. See, e.g., *Brophy v. New England Sinai Hosp.*, 398 Mass. 417, 428-29, 497 N.E.2d 626, 631-32 (1986).

written expression of intent, one should pay heed to the formalities required by the Death With Dignity Act when drafting a nonstatutory living will.¹⁹⁷ Although these formalities are not required for the document to represent a legally cognizable expression of the signatory's intent, they will demonstrate to the provider, the provider's attorney, the court, family members, and any other interested party that the signatory was aware of the seriousness and legal implications of his execution of the document. The formalities also are helpful in establishing the signatory's voluntariness and his competence. Moreover, to the extent that the Act's requirement of formalities represents a statement of public policy about the execution of documents with life or death consequences, compliance with the formalities will eliminate the minimal risk that implementation of a more informal document might be considered contrary to public policy.

VIII. EXECUTING A DURABLE POWER OF ATTORNEY

A. Formalities

The South Carolina statute requires that a durable power of attorney be "executed and attested with the same formality and with the same requirements as to witnesses as a will."¹⁹⁸ Those requirements are that the instrument be in writing,¹⁹⁹ that it be signed, and that it be witnessed by two persons.²⁰⁰ Although South Carolina law requires that a durable power of attorney be recorded to be effective,²⁰¹ this requirement does not apply if the instrument relates solely to the person of the principal.²⁰² Thus, a durable power of attorney that delegates authority related only to health care need not be recorded. Additionally, in 1990 the legislature eliminated the requirement that a durable

197. See *supra* notes 179-91 and accompanying text.

198. S.C. CODE ANN. § 62-5-501(C) (Law. Co-op. Supp. 1990).

199. The requirement of a writing is also expressed in the statute that authorizes durable powers of attorney. *Id.* § 62-5-501(A).

200. *Id.* § 62-2-502. The signature can be that of the principal or of some other person who signs in the principal's presence and at his direction. Persons that sign as witnesses of a will must have witnessed either the signing of the will or the testator's acknowledgement of the signature or of the will. *Id.*

201. *Id.* § 62-5-501(C). If it is to be effective during periods of the principal's disability, a durable power of attorney that is not related solely to personal matters must be recorded in the same manner as a deed in the county where the principal resides at the time of recordation. *Id.* The statute does not specify when the instrument may be recorded and specifically allows for recordation after the onset of the principal's disability. *Id.*

202. *Id.*

power of attorney be probated.²⁰³

B. Form

The statute imposes no requirements on the form or content of a durable power of attorney other than the mandate that certain statutory language “or similar words” appear in the document. The statutory language for creating an immediately effective durable power is as follows: “This power of attorney is not affected by physical disability or mental incompetence of the principal which renders the principal incapable of managing his own estate.”²⁰⁴ Alternative statutory language creates a springing durable power: “This power of attorney becomes effective upon the physical disability or mental incompetence of the principal.”²⁰⁵ It is not necessary to use the precise statutory language, which may not adequately express the intention of a particular principal. The statute was intended to allow substantial flexibility to those wishing to delegate authority over their affairs. Consequently, nonstatutory language is acceptable if it shows the intent of the principal to confer authority that is exercisable notwithstanding his physical disability or mental incompetence.²⁰⁶ A deviation from the statutory language that will often be desirable in a health care power of attorney is removal of physical disability as a circumstance in which the instrument becomes effective. The principal generally will want to retain authority to make health care decisions until he is legally disabled from doing so by mental incompetence.

C. Drafting Considerations

This Article will not attempt to set out all of the issues that should be considered in drafting a durable power of attorney.²⁰⁷ There are, however, several issues relating specifically to the durable power of attorney for health care that deserve mention.

203. *See id.*

204. *Id.* § 62-5-501(A).

205. *Id.*

206. *Id.*

207. Among the other issues that should be addressed in a durable power of attorney for health care are (1) access to medical records, (2) payment for health care, including the interaction of the attorney-in-fact with any conservator that might be appointed, (3) protection of third parties relying on the agent’s decisions, and (4) successor attorneys-in-fact. For further information on drafting considerations, as well as suggested language, see SYSTEMS APPROACH, *supra* note 94, at 23, 41-48, 74-102, 139-56, 266-75; Collin, *supra* note 98, at 51-66.

1. *Choice of Attorney-in-Fact*

The draftsman should not automatically include a provision relating to health care in a durable power of attorney that also concerns an assortment of other matters. Health care providers may have difficulty identifying provisions related to health care and defining their scope in an instrument conferring a variety of powers. In addition, the inclusion of both personal and asset management authority in the same instrument necessitates that it be recorded.²⁰⁸ Furthermore, the principal may want different persons to make health care decisions and to manage his assets. A principal might want a person experienced in asset management to perform tasks of the latter sort, while desiring that health care decisions be made by a close family member or friend with a broad understanding of the principal's values and attitudes. The law does not bar a person from executing more than one durable power of attorney empowering different persons to act in different areas.²⁰⁹

Nor does South Carolina law limit who may be appointed as attorney-in-fact under a durable power of attorney. The policies that support exclusion of close family members and others from serving as witnesses to a Declaration of a Desire for a Natural Death apply with even more force to serving as an attorney-in-fact with power to make decisions concerning life-sustaining treatment, because the interested party is in a position to make a death-causing decision. The potential for a conflict of interest in this situation, however, is outweighed by the importance of allowing the principal to have highly subjective decisions concerning health care made by a person with whom he has a close relationship. A close friend or relative is most likely to be familiar with the principal's values and attitudes and replicate the decisions the principal would have made.²¹⁰ Judicial intervention, including appointment of a guardian, may be initiated if a conflict of interest leads to abuse of the delegated authority.²¹¹

208. S.C. CODE ANN. § 62-5-501(C) (Law. Co-op. Supp. 1990). Similarly, the principal may not want the provisions of a power of attorney relating to financial matters to become part of his medical record.

209. Indeed, South Carolina statutory law implicitly endorses this concept by dividing protective functions between guardian and conservator, who need not be the same person. *See generally id.* §§ 62-5-101 to -435 (Law. Co-op. 1987 & Supp. 1990).

210. When the issue is whether family members can serve as witnesses to a document, the policy balance is much different because it is less important that a person functioning as a witness have a close personal relationship with the person who signs the document.

211. This possibility should be considered when drafting provisions for termination of the agency and determining whether to provide that the durable power survives appointment of a guardian. These concerns should be balanced against the possibility that judicial intervention might be employed by persons wishing to terminate the authority of

2. *Instructions Regarding Establishment of Principal's Incompetence*

Whenever the powers of an attorney-in-fact depend upon the incompetence of the principal, the determination of incompetence is an important issue. Those who are asked to accept the authority of the attorney-in-fact may be reluctant to do so because they are uncertain whether the principal actually is incompetent.²¹² The instrument may provide a method for determining incompetence, such as certification by two physicians. Even with such language, however, uncertainties arise from the possibility that the principal has regained competence since the physician's certification.

This issue is much less troublesome with respect to health care than in other contexts. In the health care setting, the person asked to accept the authority of the attorney-in-fact is a health care provider who is capable of determining competence. Indeed, providers in this state have specific statutory authority to determine incompetency as a basis for accepting health care decisions made by an attorney-in-fact.²¹³ South Carolina's Adult Health Care Consent Act,²¹⁴ which establishes the framework for surrogate decision making concerning health care in South Carolina, requires that incompetence ("inability to consent") be certified by two licensed physicians who have personally examined the patient.²¹⁵ In addition to certifying "inability to consent," these physicians must state an opinion regarding the cause and nature of the inability, its extent, and its probable duration.²¹⁶ This opinion obviates the need for obtaining recertification for each medical procedure when the patient's incompetence is expected to be of extended duration. Recertification should be necessary only if the patient's mental capabilities have changed.

The Adult Health Care Consent Act does not purport to limit the flexibility of persons who execute durable powers of attorney for health

an attorney-in-fact who is acting consistently with the principal's wishes. Much of the uncertainty in this choice can be eliminated by including in the instrument appropriate instructions to the attorney-in-fact as to how his authority is to be exercised.

212. See SYSTEMS APPROACH, *supra* note 94, at 94-95; Bos, *supra* note 97, at 696.

213. S.C. CODE ANN. § 44-66-20(6) (Law. Co-op. Supp. 1990).

214. *Id.* §§ 44-66-10 to -80.

215. *Id.* § 44-66-20(6). A certification of inability to consent shifts the authority to make health care decisions from the patient to a surrogate. The Act establishes priority among surrogates. An attorney-in-fact with authority to make health care decisions is second in priority, following a court-appointed guardian. *Id.*

In emergencies, when the delay in obtaining certification from two physicians would jeopardize the patient's health, the health care professional primarily responsible for the patient's care may certify that the principal is unable to consent. *Id.*

216. *Id.*

care. The Act instead establishes a decision-making framework for persons who meet statutorily defined criteria for incompetence, and recognizes the authority of an attorney-in-fact within that framework. A durable power of attorney may specify different criteria for incompetence²¹⁷ and different processes for determining when those criteria are satisfied. It is nonetheless advisable to adhere to the statutory criteria unless good reasons for deviation exist, because these criteria are familiar to health care professionals and consistent with their customary practices. In addition, these criteria are expeditious and trustworthy, and should satisfy the needs of most persons executing durable powers for health care.

3. *Effect of Subsequent Appointment of a Guardian*

Under the amended durable power of attorney statute, the appointment of a guardian terminates any part of a power of attorney that relates to matters within the scope of the guardianship, unless the power of attorney provides otherwise.²¹⁸ The objective of this provision presumably is to prevent two different persons from holding the same power. It can be inferred, therefore, that if the power of attorney provides that it shall not be terminated by the appointment of a guardian, the guardian's powers will not include the powers reserved to the attorney-in-fact.

Because an attorney-in-fact under a durable power of attorney for health care would have priority for appointment as guardian unless the principal designated someone else,²¹⁹ one might question whether any reason exists to specify that the durable power of attorney survive appointment of a guardian. Because the probate court is allowed to deviate from the statutory priorities upon a finding of good cause, it is possible that the attorney-in-fact will be bypassed, even if he has been specifically nominated as guardian by the principal. This might occur, for instance, if a principal nominated someone other than an immediate family member to serve as attorney-in-fact because of concern that immediate family members did not understand or agree with the principal's wishes concerning his future health care. In this circumstance the court might determine that a close family member was a more appropriate person to have the range of powers associated with guardian-

217. A durable power of attorney also may be made effective in times when the principal is competent.

218. S.C. CODE ANN. § 62-5-501(B) (Law. Co-op. Supp. 1990).

219. *Id.* § 62-5-311(B). The principal may nominate the attorney-in-fact to serve as guardian, either in the durable power of attorney or some other document, in which case the attorney-in-fact would have first priority for appointment. The probate court can vary the statutory order of priority only upon a finding of good cause. *Id.*

ship. Indeed, the principal might well agree, while nonetheless desiring that the attorney-in-fact retain authority over certain aspects of health care. If it is foreseeable that a court could bypass the attorney-in-fact for appointment as guardian, the lawyer preparing a durable power of attorney for health care should explore these issues with the principal and ensure that the principal's wishes concerning the division of authority between an attorney-in-fact and a guardian are clearly set forth. This is particularly important when the attorney-in-fact will be someone other than a close family member.

Another reason the principal may want the durable power of attorney to survive appointment of a guardian is to preserve the effect of instructions to the attorney-in-fact that are included in the instrument. A guardian's authority derives from the probate court, rather than from the incapacitated person. Thus, the instructions and authorizations in the durable power of attorney do not constitute limitations on the authority of the guardian.²²⁰ Instructions that evidence the patient's wishes concerning certain proposed health care, however, would have the status of nonstatutory instructions and would bind the guardian and third parties.²²¹ Authorizations, such as a statement that the

220. The guardian's authority may be limited by the court. *Id.* § 62-5-304(C). The proposed Health Care Power of Attorney statute provides that instructions contained in a power of attorney executed under the statute are binding on a guardian or other surrogate. S. 541 (1991).

221. With one exception, the cases hold that a guardian is bound by the patient's desires if they are clearly evidenced. *See* cases cited *supra* notes 121-24 and accompanying text. The exception is *In re Drabick*, 200 Cal. App. 3d 185, 210-12, 245 Cal. Rptr. 840, 856-57 (Ct. App.), *cert. denied*, 488 U.S. 958 (1988), in which the court held that a conservator has exclusive authority to make a treatment decision based on the conservatee's best interests and is not bound by the conservatee's prior expressed preferences. *Drabick*, however, was grounded on a statute stating, "If the conservatee has been adjudicated to lack the capacity to give informed consent for medical treatment, the conservator has the exclusive authority to give consent for such medical treatment to be performed on the conservatee as the conservator in good faith based on medical advice determines to be necessary and the conservator may require the conservatee to receive such medical treatment, whether or not the conservatee objects." *Id.* at 200, 245 Cal. Rptr. at 849 (citing CAL. PROB. CODE § 2355(a) (West 1981)). South Carolina statutes, in contrast, bar a guardian from consenting to health care contrary to the known wishes of the ward. S.C. CODE ANN. § 44-66-60(B) (Law. Co-op. Supp. 1990).

Any evidence of the patient's wishes is given consideration in these cases, including nonspecific oral statements made years before the situation at issue arose. *See* *Brophy v. New England Sinai Hosp.*, 398 Mass. 417, 428-29, 497 N.E.2d 626, 631-32 (1986) (nonspecific statements, some of them made years earlier); *In re Gardner*, 534 A.2d 947, 953 (Me. 1987). Written instructions of the patient are considered highly probative if the writing is of recent vintage. *See* authorities cited *supra* note 196. As written expressions of the patient's wishes, instructions contained in a durable power of attorney should be given effect even though the instrument is no longer capable of empowering a particular individual to enunciate or enforce those wishes.

agent has authority to refuse artificial nutrition and hydration, would not seem to be sufficient evidence of whether or not the patient wanted to receive the indicated care. They could be construed, however, as evidencing the patient's intent that his surrogate have discretion to determine whether the patient should receive such care. This is particularly true if the guardian is a person to whom the durable power of attorney expressly gave such authority.

IX. REVOCATION

A. Declaration

A Declaration may be revoked through any one of five mechanisms, three of which are also methods for revoking a will.²²² First, a Declaration may be revoked by being torn, defaced, or otherwise destroyed.²²³ So long as this act is pursuant to the declarant's intent to revoke, it is immaterial whether the act is performed by the declarant himself or by some other person. If another person performs the act, however, he must do so in the presence and at the direction of the declarant.²²⁴ A Declaration may also be revoked by a writing signed and dated by the declarant,²²⁵ or by the declarant's oral expression.²²⁶ No particular language is required as long as the intent to revoke is clear.²²⁷ None of these forms of revocation is effective until communicated to the attending physician.²²⁸

222. A will may be revoked by physical act, by written instrument, or by a subsequent inconsistent will. S.C. CODE ANN. § 62-2-506 (Law. Co-op. 1987).

223. *Id.* § 44-77-80(1) (Law. Co-op. Supp. 1990), as amended by R. 220, H. 3090 (1991).

224. *Id.* Destruction of one original revokes any other originals. The attending physician is entitled, however, to rely upon the validity of an original Declaration until he receives notice of the revoking act. *Id.* § 44-77-80(2). See *infra* notes 227-28 and accompanying text.

225. S.C. CODE ANN. § 44-77-80(2) (Law. Co-op. Supp. 1990), as amended by R. 220, H. 3090 (1991).

226. *Id.* § 44-77-80(3).

227. See *id.* § 44-77-80(2)-(3). The requirement that intent be clear is given particular emphasis with oral revocations in order to prevent an ambiguous statement made during a moment of consciousness from frustrating a declarant's carefully thought out intent. Thus the Act states: "To be effective as a revocation, the oral expression clearly must indicate the declarant's desire that the declaration not be given effect or that life-sustaining procedures be administered . . ." *Id.* § 44-77-80(3)(c).

228. See *id.* § 44-77-80(1)-(4). Furthermore, an oral revocation is ineffective if communicated to the attending physician by someone other than the declarant unless three conditions are met: the communicant must have been present when the declarant expressed his intent to revoke; the communicant must have communicated the declarant's statement to the physician within a reasonable time; and the physical or mental condi-

A Declaration also may be revoked by a person designated by the declarant in the Declaration.²²⁹ Although a space for designating such a person is included in the Declaration form, it is not necessary to enter a name in this space. It is up to the declarant to determine whether he wishes to give another person power to revoke the Declaration; the Declaration is valid whether or not he does so.²³⁰ If the declarant does not wish to name an agent with power to revoke, it is advisable to strike through this space or enter language indicating that no agent is being named. If an agent is named, his power to revoke exists only if the declarant is incompetent to do so.²³¹ Finally, a Declaration is revoked by execution of a subsequent Declaration.²³²

B. Durable Power of Attorney

A durable power of attorney may be revoked at any time by a competent principal.²³³ The statute does not specify methods for revocation. As a general rule, an agency can be revoked "by any word or act of the principal indicating that the agent is no longer to exercise his authority of which the agent has notice."²³⁴ It is important to assure that providers who might be asked to honor the durable power are aware of the revocation. To this end, a revocation should be communicated to the attending physician, family members, and others who are likely to be present when health care decisions are made.

tion of the declarant must make it impossible for the physician to confirm through subsequent conversation with the declarant that he did in fact express the intent to revoke. *Id.* § 44-77-80(3). These limitations on the effectiveness of an oral revocation communicated to the physician by someone other than the declarant are intended to assure the trustworthiness of the communicant's statement that the declarant revoked.

229. *Id.* § 44-77-80(4).

230. *See id.* § 44-77-50 (describing appointment of agent on Declaration form as "optional").

231. *Id.* § 44-77-80(4). The Act does not address the situation in which the declarant is intermittently competent or may be competent in the future. When a treatment decision must be made before the declarant regains his competence, the best course of action probably would be to honor the revocation by the agent. Doing so will result in continuation of the declarant's life, and may give him a subsequent opportunity to state his intentions about the withdrawal of treatment. If he opposes the revocation the overall impact would be a mere delay in effectuating his intent. Conversely, if a revocation with which he agreed was not honored, the declarant's death would foreclose any opportunity to express his concurrence.

232. *Id.* § 44-77-80(5).

233. *Bos, supra* note 97, at 693.

234. *W. SEAVEY, supra* note 149, § 46C.

C. *Nonstatutory Instructions*

Because nonstatutory instructions are not supported by a detailed legal framework, there are no specific rules concerning revocation of these instruments. Any clear and trustworthy evidence of intent to revoke, therefore, should be sufficient if it is properly communicated to the relevant parties.

X. CONCLUSION

Although there is no foolproof way to ensure that one's wishes concerning future health care will be carried out, South Carolina law now offers several options that enable a person to have substantial influence over his future care. Three types of instruments may be used either separately or in combination to bring about the desired course of treatment. A Declaration in the form set forth in the South Carolina Death With Dignity Act instructs providers to withhold life-sustaining treatment if one is permanently unconscious or suffers from a condition capable of causing death within a relatively short time. A nonstatutory living will may provide additional or alternative instructions to providers. It does not have the statutory authority of a Declaration, but is treated as an expression of intent to refuse or demand certain treatment. As such, it creates common-law duties related to principles of battery and professional standards of care. It also creates constitutional duties derived from its status as an expression of the liberty interests protected by the Due Process Clauses. A durable power of attorney may be used to authorize an agent to determine whether the principal should receive certain forms of treatment, and to provide instructions or guidance to the agent in making those decisions.

Both law and public opinion now solidly support individual autonomy in decision making concerning life-sustaining treatment. Legal institutions have taken important strides in providing mechanisms to facilitate the exercise of autonomy in this area. Lawyers should fully explore with their clients the available health planning options, encourage clients to discuss with their physicians the medical conditions that typically necessitate choices concerning life-sustaining care, and, using the available legal instruments, express their clients' decisions as clearly and specifically as possible.

APPENDIX A: FORM HEALTH CARE POWER OF ATTORNEY

The following is a modified version of the form contained in S.541, which would create a statutory form Health Care Power of Attorney. The form is modified here to incorporate certain material that is dealt with in provisions of the proposed statute, but which must be addressed in the form itself if used in the absence of a statute. The proposed statutory form was based on a form prepared by the American Bar Association and the American Association of Retired Persons.

HEALTH CARE POWER OF ATTORNEY

1. DESIGNATION OF HEALTH CARE AGENT

I, _____, hereby appoint:
(Principal)

(Attorney-in-fact's name)

(Address)

Home Telephone: _____ Work Telephone: _____
as my attorney-in-fact (or Agent) to make health and personal
care decisions for me as authorized in this document.

2. EFFECTIVE DATE AND DURABILITY

By this document I intend to create a durable power of attorney effective upon, and only during, any period of mental incompetence. Mental incompetence is to be determined according to the standards and procedures for "inability to consent" set forth in the Adult Health Care Consent Act, S.C. Code § 44-66-20(6), except that certification of mental incompetence by my Agent may be substituted for certification by a second physician.

3. AGENT'S POWERS

I grant to my Agent full authority to make decisions for me regarding my health care. In exercising this authority, my Agent shall follow my desires as stated in this document or otherwise expressed by me or known to my Agent. In making any decision, my Agent shall attempt to discuss the proposed decision with me to determine my desires if I am able to communicate in any way. If my Agent cannot determine the choice I would want made, then my Agent shall make a choice for me based upon what my Agent believes to be in my best interests. My Agent's authority to interpret my desires is intended to be as broad as possible, except for any limitations I may state below.

Accordingly, unless specifically limited by Section H below, my Agent is authorized as follows:

- A. To consent, refuse, or withdraw consent to any and all types of medical care, treatment, surgical procedures, diagnostic procedures, medication, and the use of mechanical or other procedures that affect any bodily function, including, but not limited to, artificial respiration, nutritional support and hydration, and cardiopulmonary resuscitation;
- B. To authorize, or refuse to authorize, any medication or procedure intended to relieve pain, even though such use may lead to physical damage, addiction, or hasten the moment of, but not intentionally cause, my death;
- C. To authorize my admission to or discharge, even against medical advice, from any hospital, nursing care facility, or similar facility or service;
- D. To take any other action necessary to making, documenting, and assuring implementation of decisions concerning my health care, including, but not limited to, granting any waiver or release from liability required by any hospital, physician, or other health care provider; signing any documents relating to refusals of treatment or the leaving of a facility against medical advice, and pursuing any legal action in my name, and at the expense of my estate, to force compliance with my wishes as determined by my Agent, or to seek actual or punitive damages for the failure to comply;
- E. To have access to medical records and information to the same extent that I am entitled to, including the right to disclose the contents to others;
- F. To contract on my behalf for placement in a health care or nursing care facility or for health care related services, without incurring personal financial liability for the contract;
- G. To hire and fire medical, social service, and other support personnel responsible for my care;
- H. The powers granted above do not include the following powers or are subject to the following rules or limitations:

4. ORGAN DONATION (INITIAL ONLY ONE)

My Agent may _____, may not _____ consent to the donation of all or any of my tissue or organs for purposes of transplantation.

5. EFFECT ON DECLARATION OF A DESIRE FOR A
NATURAL DEATH (LIVING WILL)

If I have a valid Declaration of a Desire for a Natural Death, the instructions contained in the Declaration will be given effect in any situation to which they are applicable. My Agent will have authority to make decisions concerning my health care only in situations to which the Declaration does not apply.

6. STATEMENT OF DESIRES AND SPECIAL PROVISIONS

With respect to any Life-Sustaining Treatment, I direct the following: (INITIAL ONLY ONE OF THE FOLLOWING FOUR PARAGRAPHS)

(A).____ GRANT OF DISCRETION TO AGENT. I do not want my life to be prolonged nor do I want life-sustaining treatment to be provided or continued if my Agent believes the burdens of the treatment outweigh the expected benefits. I want my Agent to consider the relief of suffering, my personal beliefs, the expense involved, and the quality as well as the possible extension of my life in making decisions concerning life-sustaining treatment.

OR

(B).____ DIRECTIVE TO WITHHOLD OR WITHDRAW TREATMENT. I do not want my life to be prolonged and I do not want life-sustaining treatment:

1. if I have a condition that is incurable or irreversible and, without the administration of life-sustaining procedures, expected to result in death within a relatively short period of time; or
2. if I am in a state of permanent unconsciousness.

OR

(C).____ DIRECTIVE FOR MAXIMUM TREATMENT. I want my life to be prolonged to the greatest extent possible, within the standards of accepted medical practice, without regard to my condition, the chances I have for recovery, or the cost of the procedures.

OR

(D).____ DIRECTIVE IN MY OWN WORDS:

7. STATEMENT OF DESIRES REGARDING TUBE FEEDING

With respect to Nutrition and Hydration provided by means of a nasogastric tube or tube into the stomach, intestines, or veins, I wish to make clear that (INITIAL ONLY ONE)

(A)._____ I do not want to receive these forms of artificial nutrition and hydration, and they may be withheld or withdrawn under the conditions given above.

OR

(B)._____ I do want to receive these forms of artificial nutrition and hydration.

8. SUCCESSORS

If an Agent named by me dies, becomes legally disabled, resigns, refuses to act, becomes unavailable, or (if an Agent is my spouse) is divorced from me or separated from me under the circumstances stated in S.C. Code § 20-7-473(2), I name the following as successors to my Agent, each to act alone and successively, in the order named. The word "Agent" in this document includes a Successor Agent who has assumed authority to act pursuant to this section.

A. First Alternate Agent:

Address: _____
Telephone: _____

B. Second Alternate Agent:

Address: _____
Telephone: _____

9. PROTECTION OF MY AGENT AND THIRD PARTIES WHO RELY ON MY AGENT

No health care provider or other person or entity that relies in good faith upon a person's representation that he is the person named as my Agent or who relies in good faith on a health care decision made by my Agent shall be liable to me, my estate, my heirs or assigns, for recognizing the Agent's authority or relying on the decision.

No Agent who in good faith makes a health care decision pursuant to the authority granted herein shall be liable to me, my estate, my heirs or assigns, on account of the substance of the decision.

10. ADMINISTRATIVE PROVISIONS

- A. I revoke any prior Health Care Power of Attorney and any provisions relating to health care of any other prior power of attorney.
- B. This power of attorney is intended to be valid in any jurisdiction in which it is presented.
- C. My Agent shall not be entitled to compensation for services performed under this Health Care Power of Attorney, but he or she shall be entitled to reimbursement for all reasonable expenses incurred as a result of carrying out the Health Care Power of Attorney.
- D. The powers delegated under this power of attorney are separable, so that the invalidity of one or more powers shall not affect any others.

11. UNAVAILABILITY OF AGENT

If at any relevant time the Agent and Successor Agents named herein are unable or unwilling to make decisions concerning my health care, and those decisions are to be made by a guardian, by the Probate Court, or by a surrogate pursuant to the Adult Health Care Consent Act, it is my intention that the guardian, Probate Court, or surrogate make those decisions in accordance with my directions as stated in this document.

BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE CONTENTS OF THIS DOCUMENT AND THE EFFECT OF THIS GRANT OF POWERS TO MY AGENT.

I sign my name to this Health Care Power of Attorney on this ____ day of _____, 19____. My current home address is:

Signature: _____

Name: _____

WITNESS STATEMENT

I declare, on the basis of information and belief, that the person who signed or acknowledged this document (the principal) is personally known to me, that he/she signed or acknowledged this Health Care Power of Attorney in my presence, and that he/she appears to be of sound mind and under no duress, fraud, or undue influence.

Witness No. 1

Signature: _____ Date: _____

Print Name: _____ Telephone: _____

Residence Address: _____

Witness No. 2

Signature: _____ Date: _____

Print Name: _____ Telephone: _____

Residence Address: _____

