The Health Care Agent: Protecting the Choices and Interests of Patients Who Lack Capacity

Robert N. Swidler
THE HEALTH CARE AGENT: PROTECTING THE CHOICES AND INTERESTS OF PATIENTS WHO LACK CAPACITY

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In New York, adults with decisional capacity enjoy a firmly-established right to decide whether to consent to or refuse medical treatment, including life-sustaining treatment. At the same time, most New Yorkers have little assurance, if they lose capacity, that their wishes about treatment will be honored. Nor can they be


1. See notes 12-17 and accompanying text. The term "capacity" is used instead of "competence" because (i) it relates to the ability to perform a particular function -- in this instance making health care decisions -- as opposed to the general ability to manage one's own affairs; and (ii) "incapacity," unlike "incompetence," does not suggest an adjudicated status. See United States Office Of Technology Assessment, Life-Sustaining Technologies And The Elderly 122-26 (1987); New York State Task Force On Life And The Law Life-Sustaining Treatment: Making Decisions And Appointing A Health Care Agent 100-104 (1987) [hereinafter APPOINTING A HEALTH CARE AGENT]. Cf. Rivers v. Katz, 67 N.Y.2d 485, 492-98, 495 N.E.2d 337, 341-42, 504 N.Y.S.2d 74, 78-81 (1986) (holding that patients who have "capacity" have right to refuse treatment, and requiring a judicial determination of incapacity to override a patient's objection to treatment). This article does not address legal and medical issues relating to determining patient incapacity.

2. See infra notes 18-36 and accompanying text.
confident that someone close to them will be permitted to weigh the expected benefits and burdens of a proposed treatment and make a reasoned judgment about whether the treatment serves their best interests.  

Increasingly, legislatures, courts, and commentators throughout the nation are concluding that adults can best protect their health care choices and interests by creating a durable power of attorney for health care or, in the terminology of a current New York proposal, a "health care proxy." An adult could use such document to formally appoint an attorney-in-fact, or "health care agent," who could make decisions on behalf of the adult in the event he or she loses the ability to make decisions personally.  

This article discusses a major current legislative proposal, advanced by the New York State Task Force on Life and the Law, governing the appointment of health care agents. The proposal, if enacted, would unequivocally establish an adult's right to appoint a health care agent, obligate health care providers to honor such appointments, protect them from liability for doing so, and implement special rules and safeguards beyond those afforded by ordinary agency principles.

I. BACKGROUND

In December 1984, Governor Cuomo created the New York State Task Force on Life and the Law, and directed it to study and make policy recommendations on legal and ethical issues raised by new medical technologies. Its twenty-six members include prominent physicians, nurses, lawyers, academics, and clergymen of different faiths. The Task Force's Chairman is Dr. David Axelrod, the State

3. See infra notes 136-47 and accompanying text.
4. See infra 13-38.
5. APPOINTING A HEALTH CARE AGENT, supra note 1, at 80-81.
6. The proposal is set forth in an Appendix to this article.
8. APPOINTING A HEALTH CARE AGENT, supra note 1 (list of Task Force members).
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Health Commissioner. The Task Force has issued reports on brain death, New York's Required Request Law, do not resuscitate orders, health care agent appointment, organ transplantation, fetal extrauterine survivability, and surrogate parenting.

In July 1987, after over a year of study and discussion, the Task Force issued a report on the decisions by adults to forgo treatment, both directly and by advance directive. The first half of the report addresses the ethical, legal, and social aspects of such decisions. The Task Force's analysis of the law reveals the particular difficulties faced by New Yorkers who are concerned about the use of medical technologies toward the end of life.

New York law has long recognized the right of decision-capable adults to decide about their own health care. That right encompasses the right to forgo life-sustaining treatment, including artificial nutrition and hydration. Although broad, the right to refuse

9. Id.
treatment is not absolute. For example, the state's interest in protecting third parties has been found sufficiently compelling to override treatment refusals by competent patients in cases in which the patient was pregnant or responsible for the support of minor children.

However, an adult's right to decide about life-sustaining treatment is undermined if the adult loses decisional capacity, as commonly occurs in the course of a terminal illness. This problem stems in part from Eichner v. Dillon and Matter of Storar, two cases jointly decided by the New York State Court of Appeals in 1981.

In Eichner, the court held that treatment can be withdrawn from a patient when there is "clear and convincing evidence" that the patient would want it withdrawn. The patient in that case, Brother Fox, previously stated that he would not want his life prolonged by extraordinary measures if his condition was hopeless.

15. Courts in New York and elsewhere typically recite four state interests that could, under some circumstances, override a patient's right to refuse treatment: (i) preservation of life; (ii) prevention of suicide; (iii) protection of third persons; and (iv) maintenance of the integrity of the medical profession. E.g., Delio, 129 A.D. 2d at 23, 516 N.Y.S.2d at 691. See also In re Farrell, 108 N.J. 335, 341, 529 A.2d 404, 410-11 (1987); Brophy, 398 Mass. at 432, 497 N.E.2d at 634.


17. In re Winthrop Univ. Hosp., 128 Misc. 2d 804, 490 N.Y.S.2d 996 (Sup. Ct. 1985). However, the state's interest in protecting children has been deemed satisfied where there is a surviving parent. In re Fosmire, 144 A.D.2d 8, 536 N.Y.S.2d 492 (2d Dep't 1989); Randolph v. City of N.Y., 117 A.D.2d 44, 501 N.Y.S.2d 837 (1st Dep't 1986). See also, United States v. George, 239 F. Supp. 752 (D. Conn. 1965) (overriding treatment refusal of children by Jehovah's Witness mother); Application of President and Directors of Georgetown College, Inc., 331 F.2d 1000 (D.C. Cir. 1964) reh'g denied, 331 F.2d 1010 (D.C. Cir. 1964) cert. denied, 377 U.S. 978 (1964).


20. Eichner, 52 N.Y.2d at 371-72, 420 N.E.2d at 68, 438 N.Y.S.2d at 270.
The court found that Brother Fox's oral statements constituted clear and convincing evidence that he did not want to be maintained in a vegetative coma by a mechanical respirator.\textsuperscript{21} In so holding, the court emphasized that it was not permitting someone else to decide on behalf of Brother Fox to discontinue treatment, but was instead giving effect to the decision that Brother Fox had made for himself before he became incompetent.\textsuperscript{22}

The companion case, \textit{Matter of Storar}, involved a 52 year old man, John Storar, who had been retarded since birth.\textsuperscript{23} Storar was dying of bladder cancer and was receiving frequent transfusions to replace blood lost from an inoperable bladder lesion.\textsuperscript{24} His mother sought to stop the transfusions because Storar found them painful and disturbing, and because they would at best extend his life by three to six months.\textsuperscript{25} Although two lower courts supported the mother's decision,\textsuperscript{26} the Court of Appeals overruled them and ordered the transfusions to continue. It explained that John Storar, unlike Brother Fox, never chose to forgo life-sustaining treatment; indeed, he had never been capable of making such a decision.\textsuperscript{27} The Court acknowledged that the mother had Storar's best interests in mind, but said it could not "allow an incompetent patient to bleed to death because someone, even someone as close as a parent or sibling, feels that this is best for one with an incurable disease."\textsuperscript{28}

Viewed together, \textit{Eichner} and \textit{Storar} authorize the withdrawal or withholding of life-sustaining treatment from a patient who lacks capacity only if there is clear and convincing evidence that the patient would not want to receive life-sustaining treatment. When such evidence is not present, no one -- not the patient's family, physician, committee, conservator, guardian, not even a court -- can

\begin{enumerate}
\item Id. at 378-80, 420 N.E.2d at 72, 438 N.Y.S.2d at 274.
\item Id. at 378, 420 N.E.2d at 67, 438 N.Y.S.2d at 274.
\item \textit{Storar}, 52 N.Y.2d at 373, 420 N.E.2d at 68, 438 N.Y.S.2d at 270.
\item Id. at 373-74, 420 N.E.2d at 68-69, 438 N.Y.S.2d at 270-71.
\item Id. at 373-76, 420 N.E.2d at 72-74, 438 N.Y.S.2d at 270-72.
\item \textit{Storar}, 52 N.Y.2d at 380, 420 N.E.2d at 72-73, 438 N.Y.S.2d at 274-75.
\item Id. at 382, 420 N.E.2d at 72, 438 N.Y.S.2d at 275.
\end{enumerate}
authorize the discontinuance of life-sustaining treatment on the patient's behalf. In this respect, New York law differs from that of most other jurisdictions, which -- either by statute or court decision -- recognize the authority of a patient's family or others.

29. Eleven states have provisions in living will statutes that specifically empower family members to direct the withdrawal or withholding of life-sustaining treatment from patients under limited circumstances. ARK. STAT. ANN. § 19a-571 (West Supp. 1988); FLA. STAT. ANN. § 765.01 (West 1986); IOWA CODE ANN. § 144A.7 (West 1988); LA. REV. STAT. ANN. § 40:1299.58.5 (West Supp. 1989); N.M. STAT. ANN. § 24-7-8.1 (1986); N.C. GEN. STAT. § 90-320 (1985); OR. REV. STAT. § 970.83 (1985); TEX. REV. CIV. STAT. ANN. art. 4590h.4C (Vernon Supp. 1989); UTAH CODE ANN. § 75-2-1107 (Supp. 1988); VA. CODE § 54.1-2986 (1988). The District of Columbia recently enacted a surrogate decision-making statute that expressly empowers family members to decide about life-sustaining treatment. D.C. CODE ANN. §§ 21-2201 - 2213 (Supp. 1989). See also CALIFORNIA DEPARTMENT OF HEALTH SERVICES, GUIDELINES REGARDING THE WITHDRAWAL OR WITHHOLDING OF LIFE-SUSTAINING TREATMENTS IN LONG TERM CARE FACILITIES (Aug. 7, 1987) (Administrative regulations governing surrogate decision-making). Some of these laws expressly require the family member to make a decision in accordance with the patient's wishes, e.g., TEX. REV. CIV. STAT. ANN. art. 4590h.4C(b) (Vernon Supp. 1989) None, however, require clear and convincing evidence of a patient's wishes as a predicate for ending treatment. See generally Areen, The Legal Status of Consent Obtained From Families of Adult Patients to Withhold or Withdraw Treatment, 258 J. A.M.A. 229 (1987).

in at least some circumstances, to authorize the discontinuance of life-supports.\textsuperscript{31}

The clear and convincing evidence standard has proven an onerous and difficult standard for health care providers to apply.\textsuperscript{32} Instances arise in which the family believes that the patient would not want further treatment, the physician concludes that continued

The New York Court of Appeals' absolute rejection of surrogate decision-making also runs counter to predominant ethical and medical views. \textit{E.g., President's Commission For The Study Of Ethical Issues In Medicine And Biochemical And Behavioral Research, Deciding To Forego Life Sustaining Treatment} 121-70 (1983)\textsuperscript{[hereinafter Deciding To Forego Life-Sustaining Treatment]; The Hastings Center, Guidelines On The Termination Of Life-Sustaining Treatment And The Care Of The Dying} 22-26 (1987); Judicial Council Of The American Medical Association, Current Opinions Of The Council On Ethical And Judicial Affairs Of The American Medical Association § 2.18 (1986).

31. As a result of a statute enacted in 1987, decisions about entering Do Not Resuscitate (DNR) orders are excepted from the general rule against surrogate decision-making for life-sustaining treatment decisions. N.Y. Public Health Law §§ 2960 - 78 (McKinney Supp. 1989). A DNR order is a physician's instruction to the medical staff not to attempt cardiopulmonary resuscitation in the event the patient suffers cardiac or respiratory arrest. \textit{Id.} § 2961.13 (defining "order not to resuscitate"). The statute provides, with respect to patients who lack capacity, that a DNR order is lawful if the patient is in one of four specified medical conditions, provided an appropriate surrogate decision maker consents to the DNR order. \textit{Id.} § 2965. A statutory priority list identifies persons who may act as surrogate decision-maker for the purpose of the DNR decision. \textit{Id.} § 2965.4. Although the surrogate must make a decision based on the patient's known wishes or best interests, a decision to consent to a DNR order need not be supported by clear and convincing evidence. \textit{Id.} § 2965.5(a). The law also empowers an adult to select a person to make a decision about resuscitation in the event the adult loses the capacity to make that decision directly. \textit{Id.} § 2965.2 - .3. The designated individual would then have the highest priority if a surrogate decision is required. \textit{Id.} § 2965.4(a)(i). Recognition of an adult's right to designate the DNR decision-maker is novel and significant, but of limited utility: it does not enable an adult to appoint someone to make other life-sustaining treatment decisions for the adult.

treatment does not serve the patient's interest, yet there is insufficient proof to base the discontinuance of treatment on the patient's deliberate choice.\textsuperscript{33}

A recent New York Court of Appeals decision, \textit{Matter of O'Connor}, warns that the clear and convincing evidence standard is "rigorous" and "demanding," requiring proof "sufficient to persuade the trier of fact that the patient held a firm and settled commitment to the termination of life-supports under the circumstances like those presented."\textsuperscript{34} Moreover, to meet the standard, the patient's statements must refer to treatments and circumstances that are not "qualitatively different" from those actually confronted.\textsuperscript{35}

By insisting upon a high level of proof of the patient's wishes before life-sustaining treatment can be discontinued, \textit{Matter of O'Connor} draws the problem identified by the Task Force into even sharper focus: While the capable adult has a broad right to refuse treatment, once that adult loses capacity it is less likely than ever that his or her desire to refuse treatment will be honored.\textsuperscript{36} Hence


\textsuperscript{35} \textit{O'Connor}, 72 N.Y.S.2d at 533, 531 N.E.2d at 607, 618, 534 N.Y.S.2d at 893.

\textsuperscript{36} \textit{See} Annas, \textit{Preemptory Prediction and Mindless Mimicry: The Case of Mary O'Connor}, 18 \textit{HASTINGS CENTER REPORT} 31 (Dec. 1988) (contending that by requiring adults to predict how they will die and what medical interventions they want to forego, the O'Connor ruling "destroys personal autonomy and denies the rights of previously competent patients." \textit{Id.} at 32.) Two post \textit{O'Connor} decisions, Hayner v. Child's Nursing Home, No. 0188-015609, slip op. (Sup. Ct., Albany Co., Dec. 5, 1988) (McDermott, J.) and Elbaum v. Grace Plaza of Great Neck, Inc., N.Y.L.J. Mar. 16, 1989 at 26, col. 6 (Sup. Ct., Nassau Co.) (McCabe, J.) illustrate the increased difficulty patients may face in securing their right to decline treatment without an advance directive. In \textit{Hayner}, the court denied a petition to discontinue the artificial provision of nutrition and hydration for a 92 year old woman in a permanent vegetative state. \textit{Hayner}, No. 0180-015609, slip. op. at 5. Two witnesses testified that the patient, after seeing another nursing home patient have artificial nutrition supplied by a gastronomy tube, told them that she "did not want to live on a feeding tube." \textit{Id.} at 4. The court, relying on \textit{O'Connor}, held that the patient's statements were "a reaction to the unfortunate situation of another" and did not constitute clear and convincing evidence of the patient's wish to decline medical treatment. \textit{Id.}
the need for advance directives: documents created by an adult in advance of a loss of capacity to ensure that the person's wishes about health care are honored in the event of a subsequent loss of capacity. Two types of devices are used as advance directives: living wills and health care proxies.

II. LIVING WILLS

A living will is a well-known, straightforward device for conveying an adult's desire to refuse treatment. Typically, the document states that, in the event the adult is found to be terminally ill or permanently unconscious, and incapable of deciding about treatment directly, he or she directs that life-sustaining treatment be withdrawn or withheld. The document is signed, usually witnessed

Elbaum similarly involved a family's petition to have a gastrointestinal tube removed from a permanently unconscious woman. Elbaum, N.Y.L.J., Mar. 16, 1989 at 26, col. 6. The court held that, although Mrs. Elbaum had told others of her wish not to have her dying prolonged, and to die "with dignity," her statements were not sufficiently specific to meet the O'Connor standard. Id. at 27, col. 2. Notably, the court expressed its dismay at the "unworkable" rule imposed by O'Connor, and called for legislative change. Id. at 27, col. 2.

37. See generally CONCERN FOR DYING, THE LIVING WILL AND OTHER ADVANCE DIRECTIVES (1986); BLACK'S LAW DICTIONARY 1434 (5th ed. 1985).

38. The two leading organizations that promote the use of living wills are Concern for Dying, 250 W. 57th Street, NY, NY 10107 and Society for the Right to Die, 250 W. 57th Street, NY, NY 10107. A form widely distributed by Concern for Dying states, in part: "If at such time the situation should arise in which there is no reasonable expectation of my recovery from extreme physical or mental disability, I direct that I be allowed to die and not be kept alive by medications, artificial means or heroic measures."

A form widely distributed by Society for the Right to Die states, in part:

If I should be in an incurable or irreversible mental or physical condition with no reasonable expectation of recovery, I direct my attending physician to withhold or withdraw treatment that merely prolongs my dying . . . .

I especially do not want _______________ [the form offers examples of treatments the declarant might want to specifically refuse, e.g., cardiac resuscitation].
and sometimes notarized, depending on the requirements of the jurisdiction.\(^{39}\)

Living wills may vary from the description above in numerous respects. They may, for example, contain a broader statement of the medical conditions in which the adult would want treatment discontinued; they may set forth a list of specific treatments that are to be withheld or withdrawn; they may expressly release health care professionals from liability for honoring the document. Moreover, there is no reason in theory why an adult might not use the document to convey his or her wish to receive life-sustaining treatment or specific measures, though evidently few persons create a living will for that purpose.\(^{40}\)

Thirty-nine states and the District of Columbia have living will statutes, sometimes called "Natural Death Acts," that recognize the validity of living wills and establish procedural and substantive protections concerning their use.\(^{41}\) Such statutes facilitate reliance upon living wills by declaring their legality and bestowing immunity upon health care providers who honor them. The statutes may also serve an important educational function.

New York is among the minority of states that has no living will statute,\(^{42}\) notwithstanding the frequent introduction of related bills in the State Legislature.\(^{43}\) The Task Force, while supportive of the

\(^{39}\) In states, like New York, that do not have living will legislation, there are no specific execution requirements. Nonetheless, the weight later given to the document by health care providers or a court may depend, in part, on the formalities employed in creating the document. Thus both Concern for Dying and Society for the Right to Die provide places for two witness signatures in their nonstatutory living will forms.

\(^{40}\) Indiana's living will statute is unique in prescribing a "Life Prolonging Procedures Declaration," whereby a declarant may request the provision of treatment. IND. CODE ANN. §§ 16-8-11-12(c) (Burns Supp. 1988).


\(^{42}\) Cf. N.Y. PUB. HEALTH LAW § 2964.2(b) (McKinney 1985, 1988 Supp.) (authorizing advance directives to forgo resuscitation).

\(^{43}\) APPOINTING A HEALTH CARE AGENT, supra note 1, at 76. See also Note, To Die or Not to Die: The New York Legislature Ponders a Natural Death Act, 13 FORDHAM URB. L.J. 639 (1985).
use of advance directives, chose not to recommend enactment of living will legislation. It explained that a living will statute, unless part of a comprehensive scheme for decision-making for all incapable patients, can actually impede a patient's or family's desire for treatment to be withdrawn. For example, by identifying procedures that must be followed to refuse treatment in compliance with the statute, living will laws may increase the reluctance of health care providers to carry out wishes of patients that are expressed in noncomplying ways, e.g., orally, or in a procedurally defective writing. Moreover, living will statutes tend to narrowly define the categories of treatments that may be withdrawn, and the medical conditions under which they may be withdrawn.

The Task Force also emphasized that New York law already "provides strong support for reliance on living wills" because the document can provide clear and convincing evidence of the patient's

44. APPOINTING A HEALTH CARE AGENT, supra note 1, at 80-83.
45. Id. at 82.
46. Id. See also DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT, supra note 22, at 144-45. This attitude, though real, ordinarily is not justifiable since living laws expressly or implicitly provide a non-exclusive means for an individual to assert his or her right to refuse treatment. E.g., IND. CODE ANN. § 16-8-11-18(e), 19 (Burns Supp. 1988); TEX. REV. CIV. STAT. ANN. ART. 4590h(11) (Vernon Supp. 1989).
47. APPOINTING A HEALTH CARE AGENT, supra note 1, at 82; Heintz, Legislative Hazard: Keeping Patients Living Against Their Will, 14 J. MED. ETHICS 82 (1988). For example, the Missouri statute authorizes the withdrawal of a "death-prolonging procedure" when a patient is in a "terminal condition." MO. ANN. STAT. §§ 459.010 - .055 (Vernon Supp. 1987). "Death-prolonging procedure" is defined to exclude the provision nutrition and hydration. Id. § 459.010(3). "Terminal condition" is defined as "an incurable or irreversible condition which, in the opinion of the attending physician, is such that death will occur within a short time regardless of the application of medical procedures." Id. § 459.010(6). Under those strictures, an adult could not direct the withdrawal of nutrition and hydration in the event of permanent unconsciousness -- at least pursuant to the statute. The Missouri statute, like many others, states that it is not to be interpreted to impair other rights the person has to direct the withdrawal of treatment. Id. § 459.055(2). Indeed, to the extent those rights are constitutionally protected, a living will statute could not impair them, even if it purported to do so. See, e.g., Corbett v. D'Alessandro, 487 So. 2d 368 (Fla. Dist. Ct. App. 1986), review denied, 492 So.2d 1331 (Fla. Sup. Ct. 1986) (Florida living will law cannot constitutionally impair patient's right to refuse artificial nutrition and hydration). Nonetheless, health care providers may perceive such laws as establishing the outer limits of the patient's right to refuse treatment, or at least the safe harbor in which they are willing to honor those rights without a court order.
It urged professional and public education to counter reluctance to honor living wills, and called upon health care facilities to develop procedures to promote creation and reliance on the documents.

The 1988 O'Connor decision confirmed the Task Force's view of the legal support for living wills. In discussing the type of proof that would meet the clear and convincing evidence standard, the court of appeals stated that "[t]he ideal situation is one in which the patient's wishes were expressed in some form of a writing, perhaps a 'living will,' while he or she was still competent." It explained that the existence of a writing indicates that the person is both likely to be serious about those wishes, and likely to make sure to express any "subsequent changes of heart."

Thus, while there is no statute in New York that establishes the validity of living wills, health care providers may with confidence withdraw or withhold treatment based on a patient's wishes expressed in a living will, provided there is no reason to doubt the document's authenticity or believe it to have been repudiated, and

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48. APPOINTING A HEALTH CARE AGENT, supra note 1, at 82.
49. Id. at 83.
51. Id. at 531, 531 N.E.2d 618, 534 N.Y.S.2d at 892.
52. Id. at 531, 531 N.E.2d 618, 534 N.Y.S. at 892-93.

In fact, when adult's objection to treatment is clear, as may be the case if there is a living will, health care professionals risk liability for imposing that procedure on the patient. See, e.g., Estate of Leach v. Shapiro, 13 Ohio App. 3d 393, 469 N.E.2d 1047 (1984) (upholding cause of action for wrongfully placing patient on life-support system); McVey v. Englewood Hosp. Ass'n, 216 N.J. Super. 502, 524 A.2d 450 (1987) (affirming dismissal of claim that hospital failed to honor patient's undocumented request to forgo treatment.) See generally, Comment, Damage Actions for Nonconsensual Life-Sustaining Treatment, 30 ST. LOUIS U.L.J. 895 (1986); Oddi, The Tort of Interference With the Right to Die: The Wrongful Living Cause of Action, 75 GEO. L.J. 625 (1986); Myers, Health Care Provider Civil Liability for Denying the Patient's Right to Refuse Life-Sustaining (Death Deferring) Medical Treatment, 38 FED'N INS. & CORP. COUNS. Q. 263 (1988).
provided the document adequately speaks to the treatment decisions that are actually confronted.

That final proviso touches upon the most significant problem inherent in the use of living wills: the difficulty of anticipating and providing for the treatment decisions that will be confronted. Some adults may already suffer from a known deteriorating condition, and are thus able to predict with great confidence the treatment choice that will arise after they lose capacity. Most adults, however, have little or no idea what illness or injury may befall them, and what medical treatment decision may later arise. For the latter, a living will provide a way to avoid a specific prospect they find abhorrent, e.g., being permanently unconscious and attached indefinitely to a respirator. Or it may provide a means to convey a more general sense of their wish to limit treatment toward the end of their life, to die peacefully and with dignity. In either case, because an individual can rarely foresee and provide specifically for future treatment decisions, his or her living will may fail to squarely address the treatment issue that actually arises. It may leave others asking, "when she wrote that, did she mean this?"

III. APPOINTING A HEALTH CARE AGENT

The Task Force concluded that the appointment of a health care agent "is the best vehicle to protect a person's rights and interests following the loss of decision-making capacity."


55. APPOINTING A HEALTH CARE AGENT, supra note 1, at 81.
ment of an agent can accomplish the same objective as a living will, that is, securing an adult's wish to die "with dignity" by forgoing procedures that prolong the dying process. Moreover, the agency approach offers several advantages in achieving that objective, and is valuable for other objectives as well.

First and foremost, use of a health care agent facilitates resolution of interpretation problems that afflict the use of living wills. Drawing on his or her instructions and knowledge of the principal, the agent can ascertain the principal's wishes and apply them to the life-sustaining treatment decision. Health care professionals can rely on the agent's reasonable interpretation with greater confidence, both that they are honoring the patient's wishes, and that they are acting lawfully.

Indeed, the agent's interpretive role can prove valuable even when the patient's wishes on the central life-sustaining treatment decision are clear. The agent can answer numerous collateral decisions that may arise, such as whether an invasive diagnostic procedure should be undertaken, or whether pain medication or other comfort measure should be provided even though it may shorten the patient's life.

The Task Force also recognized the value of a health care agent beyond the life-sustaining treatment context as a means to provide consent to treatment the patient would want and expect. While health care providers customarily seek and accept substitute consent from the patient's spouse or next-of-kin, there are several circumstances in which that practice is inadequate or problematic.

56. Id. at 78. See also Note, Appointing an Agent to Make Medical Treatment Choices, 84 COLUM. L. REV. 985, 1005 (1984); Peters, Advance Medical Directives: The Case for the Durable Power of Attorney for Health Care, 8 J. LEGAL MED. 437 (1987).

57. This assumes that the jurisdiction is one that permits the delegation of life-sustaining treatment decisions to an agent.

58. APPOINTING A HEALTH CARE AGENT, supra note 1, at 78.

The patient may have no family, or no relative available, willing, and capable of deciding. Family members may disagree about the course of treatment, raising the question of who has the authority to decide. Or the patient may have a closer relationship with a non-related person than with his or her family.

While some states have general substitute consent statutes that list the persons who can provide consent for an incapable adult, New York does not. There are some statutory procedures in New York for empowering a health care decision-maker or obtaining a health care decision on behalf of an incapable adult. However, these generally require judicial involvement, either to appoint the decision-maker or to rule on the treatment question directly. Extra-judicial surrogate decision-making is expressly authorized only in limited circumstances, primarily relating to patients in mental


62. See infra note 69.


64. N.Y. PUB. HEALTH LAW § 2504.2 (McKinney 1985) prescribes who may consent to treatment on behalf of a minor, but not for an incapacitated adult.

65. E.g., N.Y. MENTAL HYG. LAW, §§ 77.01-.41 (McKinney 1988) (conservator); N.Y. MENTAL HYG. LAW, §§ 78.01-.31 (committee); N.Y. SURR. CT. PROC. ACT §§ 1750-55 (McKinney Supp. 1989) (guardians of mentally retarded persons). While the New York Mental Hygiene Law enables an adult to select someone as his or her Article 78 committee, a court must still approve the appointment. N.Y. MENTAL HYG. LAW § 78.05 (McKinney 1988). There is a current debate about whether an Article 77 conservator can make health care decisions. See Elbaum v. Grace Plaza of Great Neck, Inc., No. 8892-88, slip op. (Sup Ct., Nassau Co., Sept. 9, 1988) (McCabe, J.) (conservator can represent patient in health care decisions); N.Y. PUB. HEALTH § 2803-c(j) (McKinney 1985) (patient's rights may be exercised by "appointed committee or conservator in representative capacity"); Moore, The Durable Power of Attorney as an Alternative to the Improper Use of Conservatorship for Health Care Decision-Making, 60 ST. JOHN'S L. REV. 631, 634 (1986)(contending that conservators lack statutory authority to make health care decisions).
health facilities. As the Task Force observed, commencing a judicial proceeding to obtain consent is a "costly, cumbersome process" that can delay the provision of even "routine surgical procedures that are clearly beneficial for the patient."

Appointment of an agent thus affords obvious advantages for both patient and provider. For instance, an adult who has no close relatives can appoint a more distant relative, a friend, or other trusted person to consent for him or her in the event of a loss of capacity. The availability of an agent enables providers to avoid either the undue burden of obtaining a court order or the legal uncertainty of treating without consent.

Moreover, some adults who have relatives might want someone else to make health care decisions for them. Indeed, a Harris poll demonstrated that a significant minority of adults would prefer a friend, doctor, or lawyer to speak for them. While the designation of a non-relative might reflect distrust or estrangement, it could also stem from noble, or at least benign, concerns. For instance, a man may wish to spare his wife the grief and emotional distress of making the decision he would want made. He could use a health care proxy to document that preference, and that would enable health care providers to honor his decision.


67. APPOINTING A HEALTH CARE AGENT, supra note 1, at 16.

68. President's Commission for the Study of Ethical Issues in Medicine and Biochemical and Behavioral Research, 2 Making Health Care Decisions 240 (1982) [hereinafter Making Health Care Decisions]. The poll asked 1251 adults who they want to make an important medical decision if they were too sick to make the decision. Fifty-seven percent chose "a family member," 31% chose their doctor, 6% chose their doctor together with a family member or friend, and 2% chose their lawyer. Id. See also The Citizen's Committee on Biomedical Ethics, Inc., Your Health, Your Choices, Whose Decision, Final Report 20-21 (1988) (Survey of New Jersey citizens containing similar inquiry).

69. Homosexual patients, particularly those with Acquired Immune Deficiency Syndrome (AIDS), are another category of persons who are apt to prefer a nonrelated decisionmaker. Steinbrook, Lo, Moulton, Saika, Hollander, Volberding, Preferences of Homosexual Men with
The Task Force also considered it important that the agent’s consent to treatment, or to the withdrawal of treatment, should be informed. That is, it should be based on current information about the risks and benefits of, and alternatives to, the proposed treatment or nontreatment. In this sense, a health care agent’s decision more nearly approximates the patient’s informed consent than an instruction in a living will.

Similarly, an agent—unlike a document—can discuss matters with the physician and family members, and can engage in a collaborative approach to ascertain the patient’s wishes and interests under the circumstances. Indeed, the Task Force’s report acknowledges the continuing role that non-appointed family members and the physician have in providing information and advice, and in scrutinizing the agent’s decision. However, the appointment establishes that the agent—not a non-appointed family member, not the physician, not the hospital, not a court—has the initial and primary responsibility for applying the patient’s wishes to the specific circumstances.

The agency approach may also be more effective in that it encourages a specific person, the health care agent, to strive to implement the patient’s wishes and interests. This in turn induces the health care professionals to honor those wishes: a person holding a document and speaking for the patient is apt to be more effective in securing the patient’s wishes than a document speaking alone.

Finally, it warrants emphasis that the appointment of an agent is purely a procedural approach. It merely identifies the surrogate decision-maker and is not inherently weighted in favor of any

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70. APPOINTING A HEALTH CARE AGENT, supra note 1, at 78.

71. Id. at 92-93, 119-20.

72. However, the principal could require the concurrence of a physician or another person as a limitation on the agent’s authority.
outcome in treatment decisions. Persons who fear that their dying will be prolonged by extraordinary measures can direct their agent to protect them from that event. Those who are concerned about treatment being discontinued prematurely, or who oppose the withdrawal of certain measures such as artificial nutrition and hydration, can instruct their agent to insist upon the provision of such measures. Even those who have no specific concern in mind might wish to appoint an agent to ensure that someone whose judgment they trust will have the authority to protect their interests when health care decisions must be made.

There are, of course, risks associated with the appointment of an agent.\footnote{See Buchanen, \textit{Principal-Agent Theory and Decisionmaking in Health Care}, 2 \textit{Bioethics} 317, 324 (1988) (discussing "agency risk" due to divergence of interest and asymmetry of information between principal and agent).} An agent may act negligently, irrationally, or in bad faith. But this danger, which is inherent in any surrogate decision, is less likely to occur when one personally selects his or her representative than when one does not. Moreover, important substantive and procedural protections can be attached to decisions by agents, as illustrated by the Health Care Proxy proposal.\footnote{See infra 38-47.}

There are other inherent limitations of the health care proxy approach. For instance, not every individual knows someone whom they trust enough to make health care decisions for him or her, or who is willing and capable to do so. Many persons, for example, have no close relatives, or place no special trust in their family members. Of course, the health care proxy enables an individual to expand the universe of persons who may act on the person's behalf. Thus, a person who does not have a family could, with a proxy, appoint a friend, neighbor, or colleague to make decisions for him or her. But there will be persons who cannot identify, or choose not to designate, someone to exercise such authority. The Task Force suggested that, for such persons, a living will remains the best means to protect their wishes with respect to life-sustaining treatment.\footnote{APPOINTING A HEALTH CARE AGENT, \textit{supra} note 1, at 83.}
More important, even for adults who have someone to appoint, the proxy approach offers no advantage unless they actually appoint that person. Without significant educational efforts and, indeed, cultural change, it is unlikely that great numbers of adults will have the foresight to create health care proxies. Thus, the recognition of health care proxies by no means obviates the need to address the broader issue: surrogate decision-making for patients who lack capacity and who did not appoint an agent.  

The concept of health care proxies has attracted strong national support from interested commissions and organizations in addition to the New York State Task Force on Life and the Law. The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, in its widely regarded 1981 report, *Deciding to Forego Life-Sustaining Treatment*, provided the first major endorsement of the use of health care proxies for life-sustaining treatment decisions. The U.S. Office of Technology Assessment, which advises Congress on scientific affairs, emphasized the usefulness of proxy appointments in its 1988 report on life-sustaining treatment protocols. The Hastings Center, a leading center for the study of bioethics, encouraged the use of health care proxies in its 1987 Guidelines.

The American Medical Association, in 1986, endorsed and began to distribute a Durable Power of Attorney for Health Care Act. The American Hospital Association also encouraged the use of durable powers to designate surrogate decision-makers. Com-

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76. The Task Force is currently devising policy recommendations on surrogate decision-making for persons who do not appoint a health care agent.

77. *DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT*, supra note 30, at 146-47.


79. *THE HASTINGS CENTER*, supra note 30, at 78.


mentators in numerous medical and bioethical journals express support for the proxy approach to surrogate decision-making.  

The legal community has also promoted the concept. In 1982, the National Commissioners for Uniform Laws adopted a Model Health Care Consent Act, which would expressly authorize the appointment of a "health care representative." In 1988 they held proceedings to add a proxy provision to the Uniform Rights of the Terminally Ill Act. The American Bar Association Commission on Legal Problems of the Elderly recently issued a paper explaining the status and advantages of using durable powers.

National patient advocacy organizations, such as Concern for Dying and Society for the Right to Die support the use of health care proxies, as an alternative or a supplement to a living will.

82. E.g., Bok, supra note 54; Relman, supra note 54; Lanzer, Adelstein, Cranford, Federman, Hook, Moertel, Safar, Stone, Taussig, van Eys, The Physician's Responsibility Toward Hopelessly Ill Patients, 310 N. ENG. J. MED. 955, 956 (1986); Buchanen, supra note 73; Letter to the editor by JoAnne Lynn, MD, Availability of Durable Power of Attorney for Health Care, 312 NEW ENG. J. MED. 248 (1985).


85. Telephone conversation with John McCabe, Legislative Director/Legal Counsel of the Uniform Law Commissioners (Jan. 12, 1989).


87. Concern For Dying, supra note 37, at 32-33; The Latest Advice for Living Will Protection: Concern's Three Prong Strategy to Make Sure All of Your Treatment Decisions Are Honored, 12 Concern for Dying Newsletter 2 (Winter 1986). Concern for Dying's model living will form contains a proxy provision.

88. Society For The Right To Die, supra note 41, 9-10 (1987). Society for the Right to Die's model living will form contains a proxy designation clause. The Society also distributes forms for creating a durable power of attorney for health care.
Modern Maturity, the magazine of the American Association of Retired Persons (AARP), recently carried an article urging AARP members to create durable powers for health care as well as living wills. 89

IV. LEGAL STATUS OF APPOINTING A HEALTH CARE AGENT

Currently, twenty-six states have statutes that expressly support an adult’s right to appoint an agent to make some or all health care decisions. 90 Those statutes fall primarily into three categories:

(1) durable power of attorney statutes, 91
(2) living will statutes with proxy provisions; and

(3) health care proxy statutes.

Even in the remaining states, where there is no explicit authority for delegating health care decisions, there is strong support for doing so pursuant to durable power of attorney statutes.

A. Power of Attorney Statutes

1. Durable and springing powers -- generally

A power of attorney is an instrument authorizing another to act as one's agent, or "attorney-in-fact," for some specified purpose or range of purposes. The device is best known as a way to convey authority for the transaction of business or property matters. Thus, a "principal" will give an attorney-in-fact a power of attorney to enable the latter to purchase property for the principal or to write checks against the principal's bank account. Several states, including


94. See infra notes 127-35 and accompanying text.

95. See Blacks Law Dictionary 1055 (5th ed. 1985); 2 N.Y. Jur. 2d Agency § 62 (1979). It is not necessary to execute a power of attorney to create an agency relationship. See Restatement (Second) Of Agency §§ 1, 15 (1957)(nature and creation of agency). The agency relationship may be created by conduct, oral agreement, or written instrument. Heine v. Papp, 97 A.D.2d 929, 471 N.Y.S.2d 18 (3d Dep't 1983). Indeed, strictly understood, the purpose of the power of attorney is not to define the agent's authority, but "to evidence the authority of the agent to third parties with whom the agent deals." In re Anyon's Estate, 137 Misc. 582, 585, 244 N.Y.S. 244, 248 (Sur. Ct. 1930) (quoting Keyes v. Metropolitan Trust Co., 220 N.Y. 237, 242, 115 N.E. 455, 456 (1917)).
New York, offer specific statutory language and procedures that may be used to create a power of attorney. When such language is used and procedures followed, the document conveys powers that are defined in the statute.

Under common law principles, the authority created by a power of attorney expires if the principal becomes disabled or incompetent. In response to this inadequacy of the device, all fifty states have enacted legislation authorizing the creation of "durable powers of attorney," which remain effective even after the principal becomes incompetent.

Under such statutes, a power of attorney will be considered "durable" if it contains language, often specified in the statute, that establishes the principal's intent for the power to remain effective despite his or her disability or incapacity.

For certain purposes, a principal may not wish the attorney-in-fact to have authority unless and until a particular event occurs, most commonly the principal's loss of the ability to exercise the authority personally. For example, an elderly woman may want to empower her son to make withdrawals from her bank account, but only if and when she becomes unable to do so herself. To permit this, some state statutes expressly authorize a "springing" power of attorney, so-called because the power springs into existence upon principal's incapacitation or other contingency.


97. The New York statutory short form is permissive not mandatory. New York General Obligations Law § 5-1501 states "No provision of this article shall be construed to bar the use of any other or different form of power of attorney desired by the parties concerned." N.Y. GEN. OBLIG. LAW § 5-1501.1 (McKinney 1978).

98. RESTATEMENT (SECOND) OF AGENCY §§ 122, 133 (1957).


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

2. Availability of durable or springing power to delegate health care decisions

While powers of attorney have traditionally been used to delegate authority over property matters, the usefulness of durable and springing powers for delegating decisions more personal in nature is also well-recognized. Indeed, durable power statutes were promoted as a means to appoint an agent to fulfill many of the personal functions handled by a court-appointed committee of the person, such as managing the principal's personal finances, and performing acts necessary to maintain the lifestyle of the principal and his or her family. 102

Nonetheless, statutes and caselaw in New York and elsewhere establish that certain acts are too personal to be performed by an attorney-in-fact, even when there is an attempted delegation of such authority. Examples of personal activities often considered nondelegable are marrying, 103 divorcing, 104 voting in a public election, 105 changing an insurance beneficiary, 106 exercising a right of election against a decedent's estate, 107 and swearing an oath. 108

It has been suggested that health care decisions are among those matters that are too personal to be delegated to an agent. 109

102. See DRAFTING THE DURABLE POWER, supra note 83, at 6-7 ("The original drafters of the Durable Power of Attorney, in its proposed statutory form, intended it to apply to matters relating to the care and custody of persons as well as the management of property.")


106. E.g., In re Wainman, 121 Misc. 318, 320, 200 N.Y.S. 893 (Sup. Ct. 1923).


That view, however, is increasingly recognized as unpersuasive. Every day, health care decisions are made by third persons for incapacitated patients. Indeed, such decisions must be made, one way or another, for the incapable patient. Surgery must be performed or withheld; antibiotics must be administered or not. Unlike marriage, divorce, or oath-taking, there is no evading the decision. The presence of substitute consent statutes and guardianship statutes attest to the general recognition that, when patients lack capacity, others must decide on their behalf. Thus, the critical question is not whether someone else will make a decision, but who should do so and on what basis.

Indeed, there is significant and growing authority for the proposition that adults may delegate medical decisions, including decisions about life-sustaining treatment, pursuant to existing durable power of attorney statutes. To begin with, the power of attorney statutes of five states, Alaska, Colorado, Maine, North Carolina, and Pennsylvania, explicitly permit or contemplate the delegation of medical decisions. For example, Alaska's power of attorney statute was amended in 1988 to expressly enable a principal to confer upon an attorney-in-fact the authority to make health care decisions. The statute sets forth a checklist of various matters, including "health care services," and states that the attorney-in-fact will have all the powers listed except for categories the principal crosses out and initials. By statute, "health care services" includes the power to "consent or refuse to consent to medical care or relief for the

110. E.g., Note, supra note 56, at 1009-12; DRAFTING THE DURABLE POWER, supra note 83, at 31-34; Moore, supra note 65, at 654-55. See also, In re O'Connor, 72 N.Y.2d 517, 528, n.2., 531 N.E.2d at 612, n.2., 534 N.Y.S.2d at 891, n.2 (1988) (view that powers of attorney are limited to financial powers as opposed to personal decisions "has been eroded.").

111. See e.g., N.Y. MENTAL HYG. LAW, § 77.01-41 (McKinney 1988) (conservatorship); N.Y. MENTAL HYG. LAW, § 78.01-31 (McKinney 1988) (appointment of committee); and N.Y. MENTAL HYG. LAW, § 80.01-13 (McKinney 1988) (Surrogate Health Care Decisionmaking). See also supra notes 63-66 and accompanying text.


principal from pain, but the agent may not authorize the termination of life-sustaining procedures.\footnote{115} However, the attorney-in-fact does have the authority to "take all steps necessary to enforce a properly executed declaration" under Alaska's living will law.\footnote{116}

The Maine durable power statute is similarly explicit, and broader than Alaska's law.\footnote{117} It permits the principal to confer on the attorney-in-fact any power which the principal has, "including . . . the power to consent to, withhold consent to or approve on behalf of the principal any medical or other professional care, counsel, treatment or service . . . ."\footnote{118} The legislature also provided Maine residents with a suggested form that an adult could use to appoint an attorney-in-fact with instructions to refuse life-sustaining treatment on behalf of the principal.

The right to delegate health care decisions pursuant to durable power laws also has support in Hawaii, Iowa, Maryland, and Washington by virtue of reference in other statutes.\footnote{119} For example, Maryland and Washington have general substitute consent statutes that accord a role to the patient's attorney-in-fact when the patient is unable to make decisions.

To date, only two court decisions, Evans v. Bellevue\footnote{120} in New York and Matter of Peter\footnote{121} in New Jersey, actually consider attempted uses of a power of attorney for health care decisions. In Matter of Peter, the New Jersey Supreme Court granted the application of the attorney-in-fact and close friend of an elderly nursing home patient, to withdraw a feeding tube that was keeping her alive in a permanent vegetative state.\footnote{122} The court held that

\footnotesize
\begin{enumerate}
\item\footnote{115} Id. § 13.26.344(l)(2) (Supp. 1988).
\item\footnote{116} Id. § 13.26.344(l)(3) (Supp. 1988).
\item\footnote{117} ME. REV. STAT. ANN. tit. 18, 18-A § 5-501 (Supp. 1988).
\item\footnote{118} Id.
\item\footnote{121} In re Peter, 108 N.J. 365, 529 A.2d 419 (1987).
\item\footnote{122} Id.
\end{enumerate}
"although [New Jersey's durable power] statute does not specifically authorize conveyance of durable authority to make medical decisions, it should be interpreted that way."\textsuperscript{123} In Mrs. Peter's case, the court found that the durable power, along with other evidence, constituted clear and convincing proof of her wish to forgo tube feeding.\textsuperscript{124} However, it emphasized that, with regard to permanently unconscious nursing home patients, a designated decision-maker may direct the withdrawal of treatment based on a substituted judgment, without clear and convincing proof of the patient's wishes.\textsuperscript{125}

State courts in Arizona and Colorado and a federal district court in Texas also suggest, in dicta, that a power of attorney could establish a patient's intent to decline life-sustaining treatment.\textsuperscript{126}

Even in those states where durable power statutes do not expressly address health care decisions, where other laws do not suggest such powers, and where courts have not spoken, there are significant grounds for concluding that such powers may be delegated. Almost all state durable power statutes are based on either the Uniform Durable Power of Attorney Act (UDPAA),\textsuperscript{127} its predecessor, Article V of the Uniform Probate Code,\textsuperscript{128} or the

\textsuperscript{123} Id. at 378, 529 A.2d at 426.
\textsuperscript{124} Id.
\textsuperscript{125} Id. at 385, 529 A.2d at 429.
\textsuperscript{128} UNIF. PROBATE CODE Article V, 8 U.L.A. 511 (West 1983). States with durable power laws based on the Uniform Probate Code include: Alaska, Arizona, Hawaii, Iowa, Maine, Maryland, Michigan, Minnesota, Nevada, New Mexico, New York, Rhode Island, South Carolina, Texas, Utah, Vermont, Virginia, and Washington. See Note, supra note 56, at 1012, n.175. Five of those states, Alaska, Maine, Nevada, Rhode Island, and Vermont, have statutes or provisions authorizing and governing the delegation of health care decisions, obviating reliance on the Uniform Probate Code for such authority. See infra 37-40.
Model Special Power of Attorney for Small Property Interests Act (MSPA-SPIA). The Uniform Law Commissioners, in their comments to a model act concerning health care decisions, stated that the UDPAA already enables a principal to give an attorney-in-fact the power to make health care decisions. Since the pertinent language in the UDPAA is identical to language in Article V of the Uniform Probate Code, the Commissioners' analysis applies with equal force to all UDPAA and UPC states with that provision. Finally, the MASPA-SPIA expressly approves the creation of a durable power "to provide for the care of the principal's person.

Commentators familiar with the development of durable power of attorney laws maintain that such statutes have always been broad enough to support the delegation of authority over health care decisions to an attorney-in-fact. As one leading treatise concludes, "durable power statutes, even those that do not expressly refer to


130. MODEL HEALTH-CARE CONSENT ACT, 9 U.L.A. Part I, 457, 465 (Comment to section 6) (1988). Section 6 of the Model Health Care Consent Act recognizes an individual's right "to appoint another as a health care representative." Id. at 464, § 6(a). The Law Commissioner's comment to that section states:

Section 6 is consistent with the Uniform Durable Power of Attorney Act. The appointment made under this section would be given effect without this Act in a jurisdiction which has enacted the Durable Power of Attorney Act. By incorporating this section into the Act, the power of appointment will be brought to the attention of persons who may not be aware of the Durable Power Act. Id. at 466.


133. See supra note 129.

134. E.g., DRAFTING THE DURABLE POWER, supra note 83, at 6; Collin, supra note 83; SOCIETY FOR THE RIGHT TO DIE, supra note 41; Note, supra note 58, at 1016-20; ROBERTSON, THE RIGHTS OF THE CRITICALLY ILL 111 (1983); MAKING HEALTH CARE DECISIONS, supra note 68, at 159; Lynn, supra note 82; MYERS, supra note 84.
HEALTH CARE AGENTS

health care, are sufficient to delegate health care powers to an agent."

3. The law in New York

In 1984, the State Health Commissioner requested the State Attorney General to issue a formal opinion on whether, under New York's durable power of attorney statute, a principal may designate another person to make health care decisions in the event he or she becomes incompetent. The Attorney General responded that a durable power "cannot with prudence be used to delegate generally to an agent the authority to make health care decisions on behalf of an incompetent principal." However, it "may be used to delegate specifically to an agent the responsibility to communicate the principal's decision to decline medical treatment under defined circumstances." 

Under this analysis, it is the principal's instructions, not the delegation of decision-making powers, that has legal effect. As the Task Force observed, "[t]his limitation, however, makes the power equivalent to a living will and eliminates its real value: appointment of an agent with authority to make decisions in the myriad of circumstances that cannot be anticipated."

A subsequent lower court decision, Evans v. Bellevue, took a similarly narrow view of the role of durable powers of attorney for

135. DRAFTING THE DURABLE POWER, supra note 83, at 34. The authors also provide valuable model forms for drafting durable powers to convey health care decisions. One of the authors, Collin, provides further assistance to the drafter. See Collin, supra note 83.


137. Id. at 64-65.

138. Id. at 65.

139. In fact, the appointed person would more precisely be described as a "messenger" than an "agent." As N.Y. Jur. 2D explains:

There is a clear distinction between a messenger and an agent. A messenger is simply a medium of communication; he exercises no judgment of his own, he merely repeats what is told him. An agent on the other hand, acts on his own judgment, though of course within the limits of his instructions.


140. APPOINTING A HEALTH CARE AGENT, supra note 1, at 80.
health care. In that case, the friend of an unconscious AIDS patient, armed with both a living will and durable power of attorney from the patient, sought to have physicians withhold medication and other treatment. The court found that, under the circumstances of the case, the living will did not provide clear and convincing evidence of the patient's wish to forgo treatment. It further held that the power of attorney gave the agent no special authority to interpret the agent's wishes.

In October 1988, a footnote in the court of appeals decision in Matter of O'Connor added new weight to the argument for delegating health care decisions by a power of attorney. In that note, the court explained that the recent enactment of a statute authorizing "springing" powers of attorney has "broadened" the durable power of attorney. After a brief discussion, it concluded that "there is therefore no longer any reason in principle why those wishing to appoint another to express their specific or general desires with respect to medical treatment, in the event they become incompetent, may not do so formally through a power of attorney."

The central question raised by the court's discussion is whether a principal may use a springing power of attorney to confer upon an attorney-in-fact the authority to make health care decisions, including the decision to direct the discontinuance of life-sustaining treatment, even when there is less than clear and convincing evidence of the principal's wish to forgo treatment. The court's remarks, while ambiguous and not dispositive of this issue, at least suggest a greater role for durable powers in health care than that envisioned by the Attorney General.

142. Id.
143. Id.
144. Id.
147. O'Connor, 72 N.Y.2d at 528, n.2., 531 N.E.2d at 612, n.2., 534 N.Y.S.2d at 891, n.2.
4. Agency principles governing use of powers of attorney

Except as modified by statute, the common law of agency generally governs the respective rights and obligations of principals, attorneys-in-fact, and the third persons who deal with them. These principles were forged in cases involving property management and, in the absence of any caselaw, it is not certain to what extent courts will draw upon them when deciding cases involving the delegation of health care decisions. Yet, as shown below, agency principles provide guidance and safeguards that are relevant and valuable, but not entirely adequate, for the delegation of health care decisions.

In general, any person who has the capacity to perform a delegable act may authorize an agent to perform that act, and any person can be appointed agent. The agent's authority terminates if either the principal or agent revokes or renounces the agency, and in other circumstances as well.

"An agent is a fiduciary with respect to matters within the scope of [the] agency." Consequently, the agent "must act in utmost good faith and undivided loyalty towards the principal, and must act in accordance with the highest principles of morality, fidelity, loyalty


152. See Restatement (Second) Of Agency § 105 (lapse of time), § 117 (mutual consent), § 121 (death of agent), § 122 (loss of capacity of principal or agent) (1957).

and fair dealing." The agent may be held liable to the principal for breaching this fiduciary obligation.

With respect to the scope of the agent's authority, the Restatement (Second) of Agency provides as follows: "An agent is authorized to do, and to do only, what it is reasonable for him to infer that the principal desires him to do in the light of the principal's manifestations and the facts as he knows or should know them at the time he acts." This standard closely resembles the substituted judgment standard generally applied to surrogates in making decisions about health care, including life-sustaining treatment.

Settled principles also apply to the interpretation of agency agreements, including powers of attorney. As a general rule, the agreement is construed in accordance with the rules that govern the interpretation of contracts. Thus, words are given their plain and natural meaning in light of the principal's object and purpose. A delegation of authority to perform particular acts includes authority to perform acts that are incidental to it. However, a specific delegation suggests that more general authority was not intended.


156. Restatement (Second) of Agency § 33 (1957).

157. Under the substituted judgment standard a surrogate must "attempt to reach the decision that the incapacitated person would make if he or she were able to choose." Deciding To Forego Life-Sustaining Treatment, supra note 30, at 132. To do so, the surrogate should look for reliable evidence of the person's wishes, preferably prior expressions, but also the person's general values, goals and desires. Id. at 133-34.

158. Restatement (Second) of Agency § 32 (1958). Similarly, powers of attorney are to be construed in accordance with the rules for interpreting written instruments generally. 3 Am. Jur. 2d Agency § 30 (1986). However, statutes may prescribe a particular meaning for powers of attorney clauses that meet statutory requirements. See e.g., N.Y. Gen. Oblig. Law §§ 5-1501(A)-(K) (McKinney 1978 and Supp. 1989).


160. Restatement (Second) of Agency § 35 (1957).

An agent can be held liable to the principal for any loss sustained as a result of the failure to follow the principal's instructions. However, if the instructions are ambiguous, the agent will not be liable for adopting in good faith a reasonable construction.

It is often held that third persons, in relying upon an agent's claim of authority, have a duty to ascertain the agent's powers. Where there is a power of attorney, that duty involves inspecting the document and abiding by the limitations in it. However, a New York appellate court recently held that "the duty of reasonable inquiry is owed by the third person to himself, not to the putative principal." The court thus rejected the contention that a third party may be held liable to the principal for failing to ascertain that the agent was acting in excess of authority.

In general, a power of attorney is a device to enable, not to require, those who deal with the principal to do so through an agent. However, in some instances states have acted to compel third persons to honor powers of attorney that meet certain requirements.

As the foregoing discussion reveals, agency principles meaningfully apply to the use of powers of attorney to delegate health care

163. Id. § 519.; See also Miles Mfg. Co. v. North German Lloyd S.S. Co., 89 Misc. 376, 151 N.Y.S. 881, 883 (Sup. Ct. 1915).
167. Id.
168. See Bos, The Durable Power of Attorney, 64 Mich. B.J., 690, 690-91 (July 1985) ("The power is effective only to the extent that the agent can persuade third persons to permit him or her to transact business or make personal care decisions on behalf of the principal." Id.); 2A C.J.S. AGENCY § 168 (1955) ("It has been held that no one is bound to deal with an agent." Id.). See also Strauss & Wolf, Durable Power of Attorney: New York Applications, N.Y.L.J. June 3, 1985, at 17, col. 4 (noting that banks, the IRS and insurance companies often refuse to honor valid powers of attorney).
decisions. However, there are special problems relating to the
degregation of health care decisions that are not adequately addressed
by existing agency principles, a point developed in the analysis of the
New York State Task Force's Health Care Proxy proposal.170

B. Living Will Proxy Provisions

Another approach to authorizing the delegation of health care
decisions, taken by nine state legislatures, is to include in their living
will statute provisions that empower an adult to designate a person
to refuse treatment on the adult's behalf. The living will statutes of
Arkansas, Delaware, Florida, Iowa, Louisiana, Texas, Utah, Virginia,
and Wyoming take this approach.171

These nine living will statutes vary in the attention they accord
to the proxy provisions. Arkansas' statute, for example, addresses
the matter relatively thoroughly. It defines "health care proxy," sets
forth a suggested appointment form, and provides for the proxy's
authority to commence when the patient, "in the opinion of the
attending physician, is permanently unconscious, incompetent or
otherwise mentally or physically incapable of communication."172 The
Texas living will statute, adopting a more abbreviated approach,
simply states that a living will "may include other directions,
including a designation of another person to make a treatment
decision in accordance with . . . this Act for the declarant if the
declarant is comatose, incompetent or otherwise mentally or
physically incapable of communication."173

170. See infra 38-47.
(1983); Fla. Stat. Ann. §§ 765.05(2), 765.07 (West 1986); Iowa Code Ann. § 144A.7 (West
Minnesota living will statutes arguably could be included in this list. Idaho Code § 39-4505
(Supp. 1988); Act of Mar. 3, 1989 Minn. Laws 3. However, those statutes contain provisions
that are sufficiently comprehensive to warrant inclusion in the "health care proxy statute"
category. See infra, note 173.
One common attribute of proxy provisions in living will statutes is that they only relate to decisions about life-sustaining treatment. In Florida for instance, the living will statute gives no direct support for appointing a health care agent to make more routine health care decisions.174 Ironically, then, citizens of some states have a clearer right to delegate the power to consent to remove life-supports than the power to consent to remove an inflamed appendix.

C. Health Care Proxy Legislation

In 1983, California became the first state to expressly authorize the appointment of a health care agent by means of a comprehensive statute devoted to the issue, the Durable Power of Attorney for Health Care Act.175 By early 1989, nine jurisdictions -- California, District of Columbia, Idaho, Illinois, Indiana, Minnesota, Nevada, Rhode Island, and Vermont had enacted comprehensive health care proxy legislation.176

The District of Columbia statute also authorizes surrogate decision-making for patients who did not appoint an agent. The Indiana statute is based on the Model Health Care Consent Act, Model Health-Care Consent ACT, 9 U.L.A. Part I, 453 (1988), and governs matters other than the appointment of an agent. The Vermont statute is modeled, in large part, after the Health Care Proxy proposal advanced by the New York State Task Force On Life and the Law. See infra 40-49.  
In 1988, bills to authorize the delegation of health care decisions were proposed in Alabama, Kansas, Massachusetts, Michigan, Missouri, New York, and Ohio. See Society For The Right To Die, 1988 Proposed Health Care Proxy Acts Of Amendments Which Concern Life Sustaining Treatment (Oct. 26, 1988). As of mid-February 1989, health care proxy bills have been introduced in Connecticut, Kansas, Michigan, Missouri, New Hampshire, Ohio, Oregon, and Wyoming. See Society For The Right To Die, 1989 Proposed Health
The nine statutes recognize an individual's right to appoint an agent to make health care decisions by creating a special document, for present purposes, a "health care proxy." Illinois' statute states that it is not exclusive of other means of delegating such authority to an agent.\textsuperscript{177} California's statute, purports to set forth exclusive requirements for appointing a health care agent.\textsuperscript{178}

All nine statutes prescribe execution requirements for the health care proxy. California's requirements are the most restrictive and complex: it imposes numerous limitations on witness eligibility for all proxies, and requires a state-designated patient advocate or ombudsman to witness proxies created by nursing home residents.\textsuperscript{179} Illinois' law, in contrast, simply requires the principal's notarized signature.\textsuperscript{180} In all states\textsuperscript{181} but Indiana and Minnesota,\textsuperscript{182} the health care provider is ineligible to be named as the health care agent.

Another feature common to all the statutes is a proxy form that either may\textsuperscript{183} or must\textsuperscript{184} be used. All the statutory forms contain a description or warning about the breadth of power an agent can exercise.\textsuperscript{185} In Illinois, Nevada, and Vermont, the forms provide examples of language that a principal might wish to, or must substantially, use to forgo or insist upon life-sustaining treatment.\textsuperscript{186}

\textsuperscript{177} CARE PROXY ACTS (Feb. 15, 1989).
\textsuperscript{178} ILL. ANN. STAT. ch. 110 1/2, paras. 804-1, 804-10 (Smith-Hurd Supp. 1988).
\textsuperscript{179} Id. §§ 2432(d)-(f) (West Supp. 1989).
\textsuperscript{180} ILL. ANN. STAT. ch. 110 1/2, para. 804-10 (Smith-Hurd Supp. 1988).
\textsuperscript{183} E.g., IDAHO CODE § 39-4505 (Supp. 1988); ILL. ANN. STAT. ch. 110 1/2, para. 804-10(a) (Smith-Hurd Supp. 1988).
\textsuperscript{186} ILL. ANN. STAT. ch. 110 1/2, para. 804-10(a) (Smith-Hurd Supp. 1988); NEV. REV. STAT. § 449.830 (1987); VT. STAT. ANN. tit. 14, § 3466 (Supp. 1988).
Other states simply provide a blank space for individualized instructions.187

In general, the statutes enable the agent to make any health care decision the principal lawfully could have made, subject to any limitations or instructions by the principal.188 Thus, under all nine statutes, the agent has the authority to consent to the withdrawal or withholding of life-sustaining treatment on behalf of the principal, unless such power is excluded. California and Illinois even empower the agent to make decisions about a deceased patient, including whether organs will be donated, whether an autopsy will be performed, and what method will be used in disposing of the body.189

There are, however, some exceptions to the rule that the agent's powers are equivalent to the principal's. California and Nevada expressly preclude the agent from consenting to the commitment of the principal in a mental health facility, convulsive treatments, psycho-surgery, sterilization, and abortion.190 Illinois makes the agent's authority "subject to the provider's right to administer treatment for the patient's comfort care or alleviation of pain."191 Moreover, some of the statutes expressly require adherence to the substituted judgment/best interests standard.192 Thus, California provides that the agent is obligated "to act consistent with the desires of the principal . . . or, if the principal's desires are unknown, to act in the best interests of the principal."193

Most of the health care proxy statutes provide that the agent's authority is effective only when the principal is incapable of making

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191. ILL. ANN. STAT. ch. 110 1/2, para. 804-7(b) (Smith-Hurd Supp. 1988).
health care decisions. California's law, for instance, states that the agent cannot make any decision "if the principal is able to give informed consent with respect to that decision." Illinois, in contrast, affords the principal a full range of options, from empowering the agent to act immediately, to specifying the event or time when the agency begins.

Other clauses found in most or all of the health care proxy laws address the revocation or expiration of the proxy, the agent's access to health care information and records, the appointment of alternate agents, the immunity of health care providers and agents, and criminal penalties for violations such as forging or destroying a patient's proxy. In addition, Illinois, Minnesota, and Vermont expressly allow a health care provider who objects to the agent's decisions to transfer the care of the patient to another provider.

V. THE NEW YORK HEALTH CARE PROXY PROPOSAL

In July 1987, the New York State Task Force on Life and the Law recommended the enactment of "Health Care Proxy Legislation" to clearly establish the right of an adult to appoint a health care

A bill embodying the Task Force’s recommendations was introduced in the 1988 session of the State Legislature by Senator Mary Goodhue and Assemblyman Richard Gottfried.205 The bill contained a number of modifications and additions to the Task Force proposal suggested by interested individuals, organizations and agencies, to the Task Force proposal.206

While no action was taken on the proposed legislation in 1988, a health care proxy bill will be considered by the Legislature in the forthcoming 1989 session. As of this writing, however, a 1989 bill has not yet been introduced. Because discussions about the 1989 Health Care Proxy bill are still taking place, this chapter analyzes the original Task Force proposal.

The Task Force’s Health Care Proxy Proposal is set forth in the appendix to this article.207

A. Summary And Analysis

1. Requirements for appointing health care agent

The proposal recognizes that a competent adult has the right to appoint a health care agent by creating a health care proxy.208 No special form is required, but the writing must contain specified elements to be valid.209 For example, it must identify the principal and agent and indicate that the principal intends the agent to have

206. For example, the 1988 bill contained provisions regarding: appointing an alternate agent, id. § 2981.6; witnessing requirements for patients with mental illnesses or developmental disabilities, id. §§ 2981.2(b), (c); determining the incapacity of patients with mental illnesses or developmental disabilities, id. §§ 2983.1(b), (c); confirming a patient’s incapacity for subsequent treatment decisions, id. § 2983.5; the effect of other written instructions by the principal id. § 2985.1(d); the lack of effect of the statute on other rights, id. § 2989; and court proceedings. Id. § 2992.
207. See infra Appendix 49-61 [hereinafter Appendix].
208. Id. § 2.1(a).
209. Id. § 5.
authority to make health care decisions on the principal's behalf.\textsuperscript{210} The Task Force proposed a model form which could be used as a health care proxy.\textsuperscript{211}

The proxy must be signed by the principal before two adult witnesses.\textsuperscript{212} The person who is to be the health care agent is not eligible to witness the principal's signature.\textsuperscript{213} The witness requirement adds greater assurance about the authenticity of the document and seriousness of the principal than those afforded by a power of attorney. At the same time, the proposal eschews the complex, unduly restrictive approach of some living will and health care proxy statutes.\textsuperscript{214} In this, as in other provisions, the proposal strives to achieve a balance between the need for procedural protections and the need to make the health care proxy device simple, accessible, and free of traps for the unwary.

The principal has broad discretion in appointing a health care agent. However, if the principal is hospitalized when creating the proxy, he or she may not appoint an operator, administrator, or employee of the hospital as health care agent.\textsuperscript{215} Empowering the person who provides treatment to decide unilaterally whether the patient accepts it raises significant concerns. A provider-agent could be subject to institutional pressures or professional perspectives which can impair the agent's ability to assert the patient's wishes or interests. For similar reasons, a physician may not simultaneously be both the principal's agent and attending physician.\textsuperscript{216}

In a sense, the principal's family members also have conflicts of interest: they may bear part or all of the expense of treatment or

\textsuperscript{210} Id.
\textsuperscript{211} Id. at 61 (Health Care Proxy Form).
\textsuperscript{212} Id. § 2.2.
\textsuperscript{213} Id.
\textsuperscript{215} See infra Appendix § 2.3(a). Although the proposal does not permit the health care provider to be appointed agent, it would not impair or otherwise affect the legality of providing care to an incapable patient who does not have an agent. Thus, existing exceptions to the informed consent requirement (e.g., emergency, waiver) would continue to apply. See N.Y. PUB. HEALTH LAW § 2805-d (McKinney 1985). See generally Meisel, supra note 51.
\textsuperscript{216} See infra Appendix § 2.3(c).
stand to inherit from the principal’s estate. They are also more likely to be influenced by emotional or personal considerations in their treatment decisions. Nevertheless, the proxy proposal does not render family members ineligible from being health care agents: these are people who, for social and cultural reasons, are usually expected to make decisions for an incapable patient, and whom most persons would want to make such decisions for them. 217 Indeed, one benefit of the health care proxy proposal is that it enables those adults who want to select someone from outside the family unit to do so. 218

2. Commencement of agent’s authority

Under the health care proxy proposal, the agent’s authority commences when the attending physician determines that the patient lacks capacity to make health care decisions. 219 Thus, the proposal authorizes only a "springing power"; it does not allow an agent to make decisions while the principal is decision-capable.

This seemingly simple issue of the commencement of the agent’s authority was the subject of considerable debate within the Task Force, and resulted in a four person dissenting opinion in their report. 220 The minority believed that an adult should have the option of making their proxy effective upon execution. 221 They argued that the option would enable frail patients to obtain decision-making assistance in advance of a loss of capacity. 222 They further contended that the option would enable an agent to act without a cumbersome and degrading determination of the patient’s incapacity. 223 Significantly, the minority did not propose enabling the principal to

218. See note 68-69 and accompanying discussion.
219. See infra Appendix § 2.4.
220. APPOINTING A HEALTH CARE AGENT, supra note 1, at 141-45.
221. Id. at 141.
222. Id.
223. Id. at 142.
avoid all participation in treatment decisions. Instead, under the minority proposal, the health care provider would still have to seek treatment decisions from the principal, so long as the principal has capacity. Only if the principal then indicates a desire not to make the decision can the provider turn to the agent.

The majority endorsed only the springing power approach. They contended that allowing an agent to make decisions for a capable patient would erode patient autonomy and disrupt and encumber the physician-patient relationship. Moreover, since the alternative proposal requires consultation with the patient only as long the patient has capacity, it does not avoid the central problem of determining incapacity. Finally, they pointed out that the capable patient already has adequate authority under law to "waive" his or her right to decide.

The health care proxy bill's exclusive reliance on a springing power distinguishes it from general powers of attorney, which can be made effective immediately or can spring upon a contingency specified by the principal.

3. Determination of incapacity

Under the Health Care Proxy proposal, a patient's incapacity, and consequently the agent's authority, is established by the attending physician to a reasonable degree of medical certainty. For patients with mental illnesses or developmental disabilities, the physician must have or consult with a physician who has specialized training or experience. Notice of the determination of incapacity must then be given to the principal, orally and in writing, but only

224. Id. at 145.
225. Id. at 145.
226. Id. at 95-100. See also Rizzo, The Living Will: Does It Protect the Rights of the Terminally Ill?, N.Y.S. J. MED. 72, 78 (Feb. 1989).
227. N.Y. PUB. HEALTH LAW § 2805-d.4(b) (McKinney 1985) (waiver is a statutory defense to an action for treatment without informed consent).
228. See N.Y. GEN. OBLIG. LAW §§ 5.1601-02 (McKinney 1989).
229. See infra Appendix § 4.1(a).
230. Id. § 4.1(b).
if there is any indication of the patient's ability to comprehend the notice. This is a basic protection to ensure that the health care agency is used to secure the patient's health care choices, not to avoid them. Notice also must be given to the agent and, if the patient is in or from a mental hygiene facility, to the facility director.

4. Agent's authority and obligations

The Health Care Proxy proposal enables an adult to delegate up to the full measure of his or her health care decision-making authority to an agent. It states "[s]ubject to any express limitations in the health care proxy, an agent shall have the authority to make any and all health care decisions on the principal's behalf, that the principal could make, including decisions about life-sustaining treatment."

The rationale for this principle is straightforward and compelling: the object of preserving patient self-determination beyond the loss of capacity can be achieved only if the agent can exercise those powers the patient could have exercised if decision-capable. To the extent the agent is restrained by law from making decisions the patient could have, and would have, made, the patient's treatment wishes cannot be secured.

While the agent's authority is broad, it is by no means limitless or unreviewable. First, the agent cannot make any decision the principal could not have made. Thus, in those circumstances where the principal, if capable, could not have refused treatment, the agent cannot refuse treatment on the principal's behalf. Moreover, the principal may attach specific limitations or instructions to the

231. Id. § 4.2.
232. Id.
233. Id. § 3.1. This principle is embodied in most health care proxy statutes, although some exclude the delegation of reproductive and mental health procedures. See supra note 174.
234. See APPOINTING A HEALTH CARE AGENT, supra note 1, at 89-90.
235. See infra Appendix § 3.1.
proxy. For instance, the principal may provide that the agent may under no circumstances direct the withdrawal of artificial nutrition and hydration. The agent would be bound by such limitations, and the health care provider could decline to carry out decisions that exceed those limitations.

Furthermore the agent is expressly bound by the substituted judgment/best interests standard. That is, in making any health care decisions, the agent must first strive to decide in accordance the principal's wishes, including the principal's religious or moral beliefs. If the principal's wishes are unknown and cannot with reasonable diligence be ascertained, the agent is required to choose the course that serves the principal's best interests. The patient's family or provider could, if need be, commence suit to oust an agent or override an agent's decision for failure to adhere to these standards.

The health care agent has priority over any other decision-maker except the principal himself. Thus the agent's decision, by virtue of his or her formal selection by the patient, has precedence over a decision by the patient's relatives, or even a court-appointed committee. The principal, however, retains the right to override an agent's decision, even though he may have been found to lack capacity by a physician. As the New York Court of Appeals decision, Rivers v. Katz, establishes, a nonjudicial determination of incapacity is not a constitutionally sufficient basis to override a patient's medical treatment decisions.

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236. *Id.* §§ 2.5(a)(iii), 5.2.
237. See, e.g., *Id.* § 5.2 (provider has duty to honor agent's decision "subject to any limitations in the health care proxy" *Id.*).
238. *Id.* § 3.2.
239. *Appointing A Health Care Agent*, supra note 1, at 120.
240. See infra Appendix § 3.4.
241. *Id.* § 4.4.
5. Provider's obligations

The proposal would require health care providers to "comply with health care decisions made by an agent . . . to the same extent as if such decisions had been made by the principal" subject to whatever limitations the principal specified and the principal's own priority. This clarifies that providers cannot decline to recognize a patient's duly appointed health care agent. The term "health care provider" is defined broadly and includes individuals and facilities licensed to treat patients. Thus, the agent can act in any setting in which a provider treats a patient, not just institutional settings.

6. Immunity

The proxy proposal would confer explicit immunity on health care providers for carrying out in good faith a decision by an agent. The immunity clause is necessary to make patient's choices interests, rather than liability concerns, the primary consideration in treatment decisions. Thus, the provider who, with the consent of the health care agent, withdraws life-sustaining treatment from a terminally ill and unconscious patient need no longer fear the legendary "long-lost son from California" who might show up later and sue. The immunity clause also protects the provider from administrative sanctions and criminal prosecution. It would not, however, shield a health care professional who is negligent in the provision of medical care.

Health care providers in New York who rely on a decision by an attorney-in-fact under a springing power of attorney do not have the benefit of a statutory immunity clause. Of course, the absence of statutory immunity does not mean that honoring an

243. See infra Appendix § 5.2.
244. See supra note 153.
245. See infra Appendix § 1.5.
246. Id. § 7.1.
247. Appointing a Health Care Agent, supra note 1, at 122.
attorney-in-fact's decision always entails a significant risk of liability or other legal repercussion. But because there is uncertainty about relying on health care decisions by an attorney-in-fact, more so than in honoring a living will, explicit recognition of immunity is a reasonable step to encourage professionals to honor agent's decisions.

7. Other features

The Health Care Proxy proposal contains several other features that are not present in the delegation of health care decisions by a springing power of attorney. The proposal requires residential health care facilities and mental hygiene facilities to establish special procedures to ensure that residents who create health care proxies do so knowingly and voluntarily. It empowers the Commissioner of Health to promulgate regulations relating to health care proxies. The proposal requires a statement of patient's rights under the statute to be posted in hospitals and distributed to patients and staff. However, the proposal prohibits anyone from requiring (or prohibiting) the execution of a health care proxy as a condition for receiving health care services. The statutory objective is to enable, not require, adults to appoint agents.

B. Need for the Health Care Proxy Bill

The O'Connor footnote suggests that one may already be able to delegate health care decisions to an attorney-in-fact by using a springing power of attorney. Even so, enactment of the health care proxy proposal is enormously important for New Yorkers. First, it establishes unequivocally that an adult has the right to appoint a

248. See infra Appendix § 11.
249. Id. § 12.
250. Id. § 13.
251. Id. § 9.
health care agent who can make any decision, including decisions about life-sustaining treatment, the adult could have made. Enactment would end any uncertainty on this question.

Even more important, the proxy proposal governs the appointment of health care agents in a more careful, responsible manner than general agency principles. There are special issues raised by designating another to make health care decisions, issues that are not well-addressed by agency principles. Who can act as health care agent? When should the agent's authority commence? What obligations and liability protection should health care professionals have? These issues and others are addressed directly and appropriately by the proxy proposal.

The bill based on the proxy proposal has received widespread support in New York from various interested communities and individuals. Governor Cuomo called for enactment of the bill in his 1988 and 1989 State of the State Addresses. The bill has also received editorial support from the New York Times, Newsday, the Albany Knickerbocker News, and the Gannett Westchester Newspaper.

VI. CONCLUSION

In New York, decision-capable adults have a broad right to accept or refuse medical care. However, once an adult loses the

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253. The President's Commission also acknowledged that special statutory provisions may be needed in connection with proxy appointments. MAKING HEALTH CARE DECISIONS, supra note 68, at 160-66.


capacity to make decisions directly, he or she has little assurance that his wishes will be honored or interests protected, particularly for decisions about life-sustaining treatment.

As a general rule in New York, life-sustaining treatment can be withheld or discontinued from an incapable patient if there is clear and convincing evidence that the patient would want to forgo treatment under the circumstances. Yet it is difficult for individuals to predict future health care decisions and provide instructions that are sufficient to satisfy the clear and convincing standard.

The best way to enable an adult to protect his or her wishes and interests in the event of a subsequent loss of capacity is to recognize the right to delegate to a trusted family member or friend the authority to speak for the adult when he or she loses the ability to make health care decisions directly. The appointed "health care agent" must then strive to make decisions in accordance with the adult's wishes or interests, but can extrapolate the adult's decision in unforeseen circumstances. Numerous states already enable their citizens to appoint a decision-maker, either through their durable power of attorney statutes, living will statutes, or special health care proxy statutes.

The Health Care Proxy proposal, developed by the New York State Task Force on Life and the Law, responds directly to the perceived and real inadequacies of current law. It unequivocally recognizes the right of an adult to appoint a health care agent, and obligates health care providers to honor that right and protects them for doing so. Moreover, the proposal governs the use of health care proxies in more careful, responsible manner than agency principles govern the use of durable powers of attorney for health care decisions.
Appendix

Health Care Proxy
Proposed Legislation

Section

1. Definitions.
2. Appointment of Health Care Agent; Health Care Proxy.
3. Rights and Duties of Agent.
5. Provider's Obligation.
6. Revocation.
8. Liability for Health Care Costs.
9. Requiring or Prohibiting Execution of a Health Care Proxy.
10. Proxies Executed in Other States.
11. Creation and Use of Proxies in Residential Health Care and Mental Hygiene Facilities.
12. Regulations.
13. Rights to be Publicized.

§ 1. Definitions.

1. "Attending physician" means the physician, selected by or assigned to a patient, who has primary responsibility for the treatment and care of the patient.

2. "Capacity to make health care decisions" means the ability to understand and appreciate the nature and consequences of health care decisions, including the benefits and risks of and alternatives to any proposed health care, and to reach an informed decision.

3. "Health care" means any treatment, service or procedure to diagnose or treat an individual's physical or mental condition.

4. "Health care agent" or "agent" means an adult to whom authority to make health care decisions is delegated under a health care proxy.

5. "Health care provider" means an individual or facility licensed, certified, or otherwise authorized or permitted by law to administer health care in the ordinary course of business or professional practice.

6. "Health care proxy" means a document delegating to an agent the authority to make health care decisions, executed in accordance with the requirements of this article.

7. "Hospital" means a hospital and a residential health care facility as defined in section 2801 of the Public Health Law, and a mental hygiene facility as defined in paragraph (8) of this section.

8. "Mental hygiene facility" means a facility operated or licensed by the Office of Mental Health or the Office of Mental Retardation and Developmental Disabilities.

9. "Principal" means a person who has executed a health care proxy.

10. "Residential health care facility" means a residential health care facility as defined in section 2801.3 of the Public Health Law.

§ 2. Appointment of Health Care Agent; Health Care Proxy.

1. Right to appoint agent; presumption of competence.

(a) A competent adult has the right to appoint a health care agent.
(b) For the purpose of this section, every adult shall be presumed competent unless determined otherwise pursuant to court order.

2. Health care proxy; execution; witnesses. A competent adult may appoint a health care agent by a health care proxy, signed by or at the direction of the adult in the presence of two subscribing adult witnesses. The witnesses shall affirm that the principal appeared to be of sound mind and free from duress. The person appointed as agent shall not act as witness to execution of the health care proxy.

3. Restrictions on who may be appointed agent.

(a) An operator, administrator or employee of a hospital may not be appointed as health care agent by any person who, at the time of the appointment, is a patient or resident of, or has applied for admission to, such hospital.

(b) The restriction in paragraph (a) of this subdivision shall not apply to:

(i) an operator, administrator or employee of a mental hygiene facility, provided the person appointed agent gives notice of the appointment to Mental Hygiene Legal Service promptly after learning of the appointment and before acting as agent;

(ii) an operator, administrator or employee of a hospital who is related to the principal by blood, marriage or adoption;

(iii) a physician, subject to the limitation set forth in paragraph (c) of this subdivision.

(c) If a physician is appointed agent, the physician shall not act as the patient’s attending physician after the authority under the health care proxy commences, unless the physician declines the appointment as agent at or before such time.
4. **Commencement of agent's authority.** The agent’s authority shall commence upon a determination, made pursuant to section 4 of this article, that the principal lacks capacity to make health care decisions.

5. **Contents and form of health care proxy.**

(a) The health care proxy shall:

(i) identify the principal and agent;

(ii) indicate that the principal intends the agent to have authority to make health care decisions on the principal’s behalf;

(iii) describe the limitations, if any, that the principal intends to impose upon the agent’s authority; and

(iv) indicate that the agent’s authority shall become effective if the principal subsequently loses capacity to make health care decisions.

(b) The health care proxy shall be executed in accordance with the requirements of section 2.2 and may, but need not, be in the form set forth in the Appendix to this article.

§ 3. **Rights and Duties of Agent.**

1. **Scope of authority.** Subject to any express limitations in the health care proxy, an agent shall have the authority to make any and all health care decisions on the principal’s behalf that the principal could make, including decisions about life-sustaining treatment.

2. **Decision-making standard.** After consultation with health care providers, the agent shall make health care decisions: (a) in accordance with the agent’s assessment of the principal’s wishes, including the principal’s religious and moral beliefs, or (b) if the
principal's wishes are unknown, in accordance with the agent's assessment of the principal's best interests.

3. **Right to receive information.** Notwithstanding any law to the contrary, the agent shall have the right to receive medical information necessary to make informed decisions regarding the principal's health care.

4. **Priority over other surrogates.** Health care decisions by an agent on a principal's behalf shall have priority over decisions by any other person, except as otherwise provided in the health care proxy or in section 4.4 of this article.


1. **Determination by attending physician.**

   (a) A determination that a principal lacks capacity to make health care decisions shall be made by the attending physician to a reasonable degree of medical certainty. The determination shall be stated in writing and shall contain the attending physician's opinion regarding the cause and nature of the principal's incapacity as well as its extent and probable duration.

   (b) If the attending physician determines that a patient lacks capacity because of mental illness or developmental disability, the attending physician who makes the determination must have, or must consult with a health care professional who has, specialized training or experience in diagnosing or treating mental illnesses or developmental disabilities of the same or similar nature.

   (c) A physician who has been appointed as a patient's agent shall not make the determination of the patient's capacity to make health care decisions.
2. **Notice of determination.** Notice of a determination that a principal lacks capacity to make health care decisions shall promptly be given: (a) to the principal, orally and in writing, where there is any indication of the principal's ability to comprehend such notice; (b) to the agent; and (c) if the patient is in or is transferred from a mental hygiene facility, to the facility director.

3. **Limited purpose of determination.** A determination made pursuant to this section that a principal lacks capacity to make health care decisions is solely for the purpose of empowering an agent to make health care decisions pursuant to a health care proxy.

4. **Priority of principal's decision.** Notwithstanding a determination pursuant to this section that the principal lacks capacity to make health care decisions, where a principal objects to a health care decision made by an agent, the principal's decision shall prevail unless the principal is determined to lack capacity to make health care decisions by court order.

5. **Effect of recovery of capacity.** In the event the attending physician determines that the principal has regained capacity:

   (a) the authority of the agent shall cease, but shall recommence if the principal subsequently loses capacity; and

   (b) the principal's consent for treatment shall be required.

§ 5. **Provider's Obligation.**

1. **Duty to insert proxy in medical record.** A physician who is provided with a health care proxy shall arrange for the proxy or a copy thereof to be inserted in the principal's medical record.

2. **Duty to honor agent's decision.** A health care provider shall comply with health care decisions made by an agent under a health care proxy to the same extent as if such decisions had been made
by the principal, subject to any limitations in the health care proxy and to the provisions of section 4.4 of this article.

§ 6. Revocation.

1. Means of revoking proxy.

(a) A competent adult may revoke a health care proxy by notifying the agent or a health care provider orally or in writing or by any other act evidencing a specific intent to revoke the proxy.

(b) For the purpose of this section, every adult shall be presumed competent unless determined otherwise pursuant to court order.

(c) A health care proxy shall also be revoked upon:

   (i) execution by the principal of a subsequent health care proxy; or

   (ii) the divorce or legal separation of the principal and spouse, where the spouse is the principal's agent under a health care proxy.

2. Duty to record revocation. A physician who is informed of or provided with a revocation of a health care proxy shall immediately: (i) record the revocation in the principal's medical record and (ii) notify the agent and the medical staff responsible for the principal's care of the revocation. Any member of the nursing staff informed of or provided with a revocation of a health care proxy pursuant to this section shall immediately notify a physician of such revocation.

1. Provider immunity. No health care provider or employee thereof shall be subjected to criminal or civil liability, or be deemed to have engaged in unprofessional conduct, for carrying out in good faith a health care decision by an agent pursuant to this article.

2. Agent immunity. No person acting as agent pursuant to a health care proxy shall be subjected to criminal or civil liability for making a health care decision in good faith pursuant to this article.

§ 8. Liability for Health Care Costs.

Liability for the cost of health care provided pursuant to an agent's decision shall be the same as if the health care were provided pursuant to the principal's decision.

§ 9. Requiring or Prohibiting Execution of Health Care Proxy.

A person may not require or prohibit the execution of a health care proxy by an individual as a condition for providing health care services or insurance to such individual.

§ 10. Proxies Executed in Other States.

Nothing herein shall limit the enforceability of a health care proxy or similar instrument executed in another state or jurisdiction in compliance with the law of that state or jurisdiction.

§ 11. Creation and Use of Proxies in Residential Health Care and Mental Hygiene Facilities.

Residential health care facilities and mental hygiene facilities shall establish procedures:
(a) to provide information to residents about their right to create a health care proxy under this article;

(b) to educate residents about the authority delegated under a health care proxy and how a proxy is created; and

(c) to ensure that each resident who creates a proxy while residing at the facility: (i) does so voluntarily; and (ii) understands the health care proxy, including the scope of authority that may be delegated, the benefits and risks of creating the proxy, and the opportunity to provide specific instructions to the agent in the proxy.

Such procedures shall be established in accordance with regulations issued by the Commissioners of Health, Mental Health, and Mental Retardation and Developmental Disabilities for facilities subject to their respective regulatory authorities.

§ 12. Regulations

The Commissioner of Health shall establish such regulations as may be necessary for the implementation of this article, subject to section 11 of this article.

§ 13. Rights to be Publicized

The Commissioner of Health shall prepare a statement summarizing the rights, duties and requirements of this article and shall require that a copy of such statement (a) is furnished to patients or their families at or prior to the time of admission to a hospital, and to each member of the hospital's staff; and (b) is posted in a public place in each hospital. The statement of rights required by this section may be included in any other statement of patients' rights required by other provisions of the Public Health Law.
Information about the Health Care Proxy

This is an important legal document. Before signing this document, it is vital for you to understand the following facts:

This document gives the person you name as your agent the authority to make any and all health care decisions for you, except to the extent you state otherwise in this document. "Health care" means any treatment, service or procedure to diagnose or treat your physical or mental condition. Your agent therefore can have the power to make a broad range of health care decisions for you, including decisions about withdrawing or withholding life-sustaining treatment.

Your agent's authority will begin when your physician determines that you lack capacity to make health care decisions. You will be informed of this determination when it is made and will have an opportunity to object and assert your right to make health care decisions on your own behalf.

You may state in this document any treatment that you do not desire and/or those that you want to make sure you receive. Your agent will be obligated to follow your instructions when making decisions on your behalf.

Examples of medical treatments about which you may wish to give your agent special instructions are:

- artificial respiration
- artificial nutrition and hydration (nourishment provided by feeding tube)
- cardiopulmonary resuscitation (CPR)
- antibiotics
• dialysis
• transplantation
• blood transfusions
• abortion
• sterilization
• antipsychotic medication
• electroconvulsive therapy
• psychosurgery
• other treatments

Unless you state otherwise, your agent will have the same authority to make decisions about these treatments as you would have had. This is not, however, a complete list of the treatments about which you may leave instructions. Nor does the list mean that you, and consequently your agent, can legally refuse these treatments under all circumstances. It is important that you discuss this document with your physician or another health care professional before you sign it to make sure that you understand the nature and range of decisions that may be made on your behalf. You may also wish to give your physician a signed copy. You do not need a lawyer's assistance to complete this document.

The person you appoint as agent must be over eighteen years old. If you appoint a physician as your agent, he or she may have to choose between acting as your agent or as your attending physician; the law does not permit a physician to do both at the same time. Also, if you are a patient or resident of a hospital, nursing home or mental hygiene facility, there are special restrictions on appointing a person who works for that facility as your agent. You should ask the administrator or other personnel at the facility to explain those restrictions.

You should inform the person you appoint that he or she will be your health care agent. You should discuss this document with your agent and give him or her a signed copy. Your agent will not be liable for health care decisions made in good faith on your behalf.
Even after you have signed this document, you have the right to make health care decisions for yourself as long as you are able to do so, and treatment cannot be given to you or stopped over your objection. You have the right to revoke the authority granted to your agent by informing him or her or your health care provider orally or in writing.

**Instructions for Completing the Health Care Proxy**

Item (1): Insert your name (i.e., the name of person who is appointing a health care agent) and the name, home address and telephone number of the agent.

Item (2): If you have special instructions for your agent, you should state them here. Also, if you wish to limit your agent’s authority in any way, you should state so here. If you do not state any limitations, your agent will have authority to make any and all health care decisions on your behalf that you could have made, including the authority to consent to or refuse life-sustaining treatment.

Item (3): You may, if you wish, insert the name, home address and telephone number of an alternate agent.

Item (4): You must date and sign the proxy. If you are unable to sign yourself, you may direct someone else to sign in your presence. Be sure to include your address.

Item (5): Two witnesses 18 years of age or older must sign your proxy. The person who is appointed agent cannot act as a witness.
Health Care Proxy Form

(1) I, ____________________________, hereby appoint ____________________________, as my health care agent to make any
and all health care decisions for me, except to the extent I provide otherwise in this document.

This health care proxy shall take effect in the event I become unable to make my own health care decisions, as determined by the physician who has primary responsibility for my treatment.

(2) I direct my agent to make health care decisions in accordance with my wishes as stated below or as otherwise known to him or her:

Statement of wishes concerning health care:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

IMPORTANT: For examples of medical treatments that you may wish to give your agent instructions about, see "Information about the Health Care Proxy," at the beginning of this form.

(3) In the event the person I appoint above is unable, unwilling or unavailable to act as my health care agent, I hereby appoint

__________________________________________________
Name of alternate agent

Home address and telephone

as my health care agent.

(4) Signed this _______ day of _______, ______.

Signature: ____________________________

Address: ____________________________

(5) I declare that the person who signed or asked another to sign this document is personally known to me, that he or she signed or asked another to sign this document in my presence, and that he or she appears to be of sound mind and under no duress, fraud, or undue influence. I am not the person appointed as agent by this document.

First Witness: ____________________________

Address: ____________________________

Second Witness: ____________________________

Address: ____________________________