THE GROWING IMPORTANCE OF ADVANCE MEDICAL DIRECTIVES

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All of this turmoil—political, judicial and emotional—could have been avoided or at least minimized if Terry Schiavo had left a living will or advanced directive stating her wishes about being kept alive, or not, on life support.[2]

I. Introduction

While the litigation in the Terri Schiavo case is an extreme example of what can go wrong in the health care decision-making process, it high-

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2. Bee Editorial Staff, *Editorial: The Schiavo Intrusion*, SACRAMENTO BEE, Oct. 25, 2003, *available at* http://www.sacbee.com/content/opinion/story/7664430p-8604453c.html. Terri Schiavo, who is thirty-nine years old, has been in a persistent vegetative state since 1990 after she "suffered severe brain damage after a heart stoppage." *Id.* Presently, she relies on a feeding tube and "can open her eyes and shows some facial expressions but doctors say those movements are involuntary." *Id.* For the past five years, her husband, "Michael Schiavo, has sought to have her feeding tube removed so she can die a natural death. Her parents fought him in court, but through a five-year legal battle, Florida courts consistently sided with her husband." *Id.*; *see, e.g.*, *In re* Schiavo, 800 So. 2d 640 (Fla. Dist. Ct. App. 2d Dist., 2001), *review denied*, *In re* Schindler, 816 So. 2d 127 (Fla. 2002), *remanded by*, *In re* Schiavo, 851 So. 2d 182 (Fla. Dist. Ct. App. 2d Dist., 2003) (holding that "the order of the guardianship court was affirmed. On remand, the guardianship court was to schedule another hearing solely for the purpose of entering a new order scheduling the removal of the nutrition and hydration tube"); *rehearing denied*, Schindler v. Schiavo, 2003 Fla. App. LEXIS 14167 (Fla. Dist. Ct. App. 2d Dist. July 9, 2003), *review denied*, Schindler v. Schiavo, 855 So. 2d 621, 2003 Fla. LEXIS 1493 (Fla. 2003). Terri's feeding tube was eventually removed in October 2003 for six days before the Florida legislature and Governor Jeb Bush enacted a new law to have it reinserted. *Id.*; *see* FLA. STAT. tit. XXX, ch. 415, § 105 (2003); HB 35-E, 2003 Leg., Spec. Sess. (Fla. 2003) (granting the governor "the authority to issue a one-time stay to prevent the withholding of nutrition and hydration" providing certain criteria are met).

lights the importance of advance medical directives (AMD) in helping to ensure patient autonomy during end-of-life medical treatment. Unfortunately, large segments of society, to include the military, are still unclear about the role of AMDs in patient care.[3] Thus, this article provides a broad overview of AMDs and their legal applications with a particular emphasis on expanding their use in the military community.[4]

II. Overview

This article begins with a discussion of living wills and durable powers of attorney (DPOAs), demonstrating how each one individually and or combined with the other form the component parts of an AMD. The second section of this article briefly explores the legal bases supporting AMDs. The third section provides a history of AMDs in the military followed by recommendations on how to better implement and craft AMDs; including proposed changes to the two Department of Defense (DOD)

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3. *See* Gina Kolata, *Documents Like Living Wills Are Rarely of Aid, Study Says,* N.Y. TIMES, Apr. 8, 1997, at A12. The reasons most frequently cited for the low percentage of patients having AMDs are:

> (1) Most physicians and health care providers believe that the patient is responsible for addressing the issue yet most patients perceive it as the doctor's responsibility;
> (2) Many physicians are uncomfortable discussing withholding or withdrawal of life-sustaining treatment;
> (3) Many young patients and their physicians believe that AMDs are only necessary for the elderly or chronically ill patients. This attitude is repeatedly reinforced by numerous publications that only address AMDs in the context of terminal illnesses; and
> (4) Education efforts about AMDs have been ineffective, inadequate and/or misdirected.

GENERAL ACCOUNTING OFFICE, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE REPORT, PATIENT SELF DETERMINATION ACT: PROVIDERS OFFER INFORMATION ON ADVANCE DIRECTIVES BUT EFFECTIVENESS UNCERTAIN, REPORT NO. GAO-95-135 (Aug. 1995); Anita K. Gordon, *Advance Directives Revisited: A Proposal to Amend Advance Directive Laws,* 28 J. HEALTH & HOSP. L. 73, 86 (1995).

4. For additional information regarding AMDs, *see* NANCY M. P. KING, MAKING SENSE OF ADVANCE DIRECTIVES (rev. ed. 1996); Alan Lieberson, *Advance Medical Directives—1998: A Medical View*, 12 QUINNIPIAC PROB. L.J. 305, (1998); U.S. ARMY MEDICAL COMMAND, OFFICE OF THE JUDGE ADVOCATE GENERAL, 1999 MEDICAL-LEGAL DESKBOOK 1-1 (Aug. 1999) [hereinafter MEDICAL LEGAL DESKBOOK, AMD].

Directives that address AMDs.[5] The article concludes with a model AMD.[6]

III. Component Parts

Generally speaking, an AMD is a written statement recognized under state law[7] intended to govern the health care[8] decisions of the patient, should he or she[9] lose decision-making capacity in the future. Although AMDs offer patients a measure of autonomy, they are by no means a panacea for those contemplating medical treatment decisions.[10] Advance medical directives can take the following three forms: a living will, DPOA, or combination thereof.[11]

Any adult[12] who has decision-making capacity[13] can make an AMD. All states and the District of Columbia have some type of documentary mechanism known collectively as an AMD.[14] Historically, most viewed AMDs as a way to refuse treatment in cases of terminal illness.[15] Now,

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5. *See* U.S. DEP'T OF DEFENSE, DIR. 1350.4, LEGAL ASSISTANCE MATTERS (28 Apr. 2001) [hereinafter DOD DIR. 1350.4]; U.S. DEP'T OF DEFENSE, DIR. 6000.14, PATIENT BILL OF RIGHTS AND RESPONSIBILITIES IN THE MILITARY HEALTH CARE SYSTEM (1998) (addressing the duty of the health care provider to discuss AMDs with the patient).

6. This AMD is based on the one currently in use at Walter Reed Army Medical Center. On 1 October 2000, Drafting Libraries (DL) Wills became the Army Standard Software for drafting estate-planning documents. Lieutenant Colonel Curtis A. Parker, Deputy Chief, Legal Assistance Policy Division, OTJAG (14 Sept. 2000). The DL Wills users may prepare state-specific living wills and advance medical directives. Presently, "DL Wills Software is available without charge to all Army Legal Assistance (LA) providers (active and reserve components) including those outside of LA who have a LA-related mission to prepare important estate planning documents (e.g., wills, advance medical directives)." Information Paper, Miles Smutz, Development Project Services, subject: Downloading & Registering Drafting Libraries (DL) Wills Software via JAGCNET (24 Jan. 2002).

7. T.P. Gallanis, *Write and Wrong: Rethinking the Way We Communicate Health Care Decisions*, 31 CONN. L. REV. 1015, 1025-1026 (1999).

8. This includes mental health care. Currently, five states have statutes recognizing mental health AMDs. Lieberson, *supra* note 4, at 312; *see also* Roberto Cuca, *Ulysses in Minnesota: First Steps Toward a Self-Binding Psychiatric Advance Medical Directive Statute*, 78 CORNELL L. REV. 1152 n.146 (1993); Elizabeth M. Gallagher, *Advance Instruments for Mental Health Treatment: Advance Directives for Psychiatric Care: A Theoretical and Practical Overview for Legal Professionals*, 4 PSYCHOL. PUB. POL'Y. & L. 746 (1998).

however, many view an AMD as a tool to allow incapacitated patients the possibility of dignity and control at the end of life.[16]

A. Living Will

The first component of an AMD is the living will or instructive directive.[17] The living will is a written document informing health care providers about particular types of medical care the patient wants provided or withheld. First introduced in 1969 by attorney Luis Kutner, the living will was an early attempt to grant the patient increased treatment autonomy.[18] Mr. Kutner argued that, although the common law prohibited euthanasia, patients could withhold their consent to necessary future medical treatment.[19] Mr. Kutner proposed that the law permits competent patients to

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9. Thirty-four states include pregnancy exemptions in their AMD statutes. Of the thirty-four states, seventeen automatically disregard the AMD throughout the entire pregnancy, while many of the remaining seventeen offers lesser forms of restrictions. It is the author's opinion that pursuant to the Supremacy Clause, an AMD created under 10 U.S.C. § 1044 (2000) would override any state statute, which prohibited the enforcement of a military AMD because the declarant was pregnant. *See* Supremacy Clause, ("Laws of the United States which shall be made in Pursuance thereof . . . under the Authority of the United States, shall be the supreme Law of the Land . . ."). For a more complete discussion on AMD pregnancy statutes, *see* Timothy J. Burch, *Incubator or Individual?: The Legal Policy Deficiencies of Pregnancy Clauses in Living Will and Advance Health Care Directive Statutes,* 54 MD. L. REV. 528 (1995); Amy Lynn Jerdee, *Breaking Through the Silence: Minnesota's Pregnancy Presumption and the Right to Refuse Medical Treatment*, 84 MINN. L. REV. 971 (2000); Anne D. Lederman, *A Womb of My Own: A Moral Evaluation of Ohio's Treatment of Pregnant Patients with Living Wills*, 45 CASE W. RES. L. REV. 351 (1994); Janice MacAvoy-Snitzer, *Pregnancy Clauses in Living Will Statutes*, 87 COLUM. L. REV. 1280 (1987).

10. *See* Vicki Joiner Bowers, *Elder Law Symposium: Comment: Advance Directives: Peace of Mind or False Security*, 26 STETSON L. REV. 677 (1996); Rebecca Dresser, *Relitigating Life and Death*, 51 OHIO ST. L.J. 425, 431 (1990) (discussing some of the limits of AMDs); Gordon, *supra* note 3, at 85; Lieberson*, supra* note 4; Jon L. Spargur, Jr., *Are Living Wills Dead in North Carolina?*, 32 WAKE FOREST L. REV. 591 (1997); Joan M. Tenno et al., *Do Advance Directives Provide Instructions That Direct Care?*, 45 J. AM. GERIATRICS SOC'Y 508 (1997).

11. Thaddeus Mason Pope, *The Maladaptation of Miranda to Advance Directives: A Critique of the Implementation of the Patient Self Determination Act*, 9 HEALTH MATRIX 139, 149 (1999).

12. *See* Jennifer Rosato, *The Ultimate Test of Autonomy: Should Minors Have a Right to Make Decisions Regarding Life Sustaining Treatment*, 49 RUTGERS L. REV. 1 (1996) (discussing the rights of minors and AMDs).

13. AR 40-3, *infra* note 77, sec. II, Terms ("A patient with decision-making capacity is an adult who has the ability to communicate and understand information and the ability to reason and deliberate sufficiently well about the choices involved.").

execute documents explaining their future health care wishes.[20] Over the past thirty years, Kutner's idea has evolved into a document widely

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14. *See* T.P. Gallanis, *Write and Wrong: Rethinking the Way We Communicate Health Care Decisions*, 31 CONN. L. REV. 1015, 1028 (1999) (citing ALA. CODE § 22-8A-5(a)(2) (1997); ALASKA STAT. § 18.12.020 (Michie 1997); ARIZ. REV. STAT. § 36-3202 (1997); ARK. CODE ANN. § 20-17-204(a) (Michie 1997); CAL. HEALTH & SAFETY CODE § 7188 (Deering 1998); COLO. REV. STAT. § 15-18-109 (1997); CONN. GEN. STAT. § 19a-579a (1997); DEL. CODE ANN. tit. 16, § 2504(a)(1) (1997); D.C. CODE ANN. § 6-2424(2) (1997); FLA. STAT. ch. 765.104(1)(a) (1997); GA. CODE ANN. § 31-32-5(a)(2) (1997); HAW. REV. STAT. § 327D-12(2) (1997); IDAHO CODE § 39-4506(1)(b) (1997); 755 ILL. COMP. STAT. 35/5(a)(2) (West 1997); IND. CODE § 16-36-4-12(a)(1) (1998); IOWA CODE § 144A.4(1) (1997); KAN. STAT. ANN. § 65-28,105(a)(2) (1997); KY. REV. STAT. ANN. § 311.627(1)(a) (Michie 1996); LA. REV. STAT. ANN. § 40:1299.58.4(A)(2)(a) (West 1998); MASS. ANN. LAWS ch. 201D, §5 (1997); ME. REV. STAT. ANN. tit. 18-A, § 5-803(b) (West 1997); MD. CODE ANN., HEALTH-GEN. I § 5-604 (1997); MICH. COMP. LAWS § 700.496(11)(d) (1997); MINN. STAT. § 145B.09(1) (1997); MISS. CODE ANN. § 41-41-109(1) (1997); MO. REV. STAT. § 459.020(1) (1997); MONT. CODE ANN. § 50-9-104(1) (1997); NEB. REV. STAT. § 20-406(1) (1997); NEV. REV. STAT. § 449.620(1) (1997); N.H. REV. STAT. ANN. § 137-H:7(1)(c) (1997); N.J. STAT. ANN. § 26:2H-57(b) (West 1997); N.M. STAT. ANN. § 24-7A-3(B) (Michie 1997); N.Y. PUB. HEALTH LAW §§ 2969(1), 2985(1)(a) (McKinney 1998); N.C. GEN. STAT. § 90-321(e) (1997); N.D. CENT. CODE § 23-06.4-05(1)(a) (1997); OHIO REV. CODE ANN. § 2133.04 (Anderson 1998); OKLA. STAT. tit. 63, § 3101.6(A) (1997); OR. REV. STAT. § 127.545(1)(b) (1997); 20 PA. CONS. STAT. § 5406 (1997); R.I. GEN. LAWS § 23.4.11-4(a)(1) (1997); S.C. CODE ANN. § 44-77-80(2) (Law. Co-op. 1997); S.D. CODIFIED LAWS § 34-12D-8 (Michie 1998); TENN. CODE ANN. § 32-11-106(1) (1997); TEX. HEALTH & SAFETY CODE ANN. § 672.012(2) (West 1998); UTAH CODE ANN. § 75-2-1111(1)(b) (1997); VA. CODE ANN. § 54.1-2985(i) (Michie 1997); VT. STAT. ANN. tit. 18, § 5257 (1997); WASH. REV. CODE § 70.122.040(1)(b) (1997); W. VA. CODE § 16-30-4(a)(2) (1997); WIS. STAT. § 154.05(1)(b) (1997); WYO. STAT. ANN. § 35-22-103(a)(ii) (Michie 1997)). For an overview of select statutes, *see* Bretton J. Horttor, *A Survey of Living Will and Advance Health Care Directives*, 74 N.D. L. REV. 233 (1998) (discussing selected state statutes).

15. DAVID JOHN DOUKAS & WILLIAM REICHEL, PLANNING FOR UNCERTAINTY: A GUIDE TO LIVING WILLS AND OTHER ADVANCE DIRECTIVES FOR HEALTH CARE 53 (1993). The use of the "right-to-die" label and its association with death may explain why the general public has not used AMDs more widely. Perhaps more people would have signed AMDs if they were associated with the right to choose medical treatment, rather than the right to die.

16. KING, *supra* note 4, at 2. Even though AMDs embody a broad range of possible medical treatment areas, most are written for the refusal of life-sustaining treatment. *Id.*

17. *See* Ardath A. Hamann, *Family Surrogate Laws: A Necessary Supplement to Living Wills and Durable Powers of Attorney*, 38 VILL. L. REV. 103 (1993). "Living will" is the term generally used by the public although only a few statutes use the term. *See, e.g.*, TENN. CODE ANN. § 32-11-103(4) (Supp. 1992) (defining "living will" as a "written declaration" of a person's preferences for medical treatment). Most statutes use the terms "declaration" or "directive" to describe a living will. *See, e.g.*, ALA. CODE § 22-8A-4 (1990) (defining declaration as a written document directing "withdrawal of life-sustaining procedures in a terminal condition"); OR. REV. STAT. § 127.610 (1990) (defining directive as written document expressing individual's wish to withhold or withdraw life-sustaining procedures).

accepted and recognized in all fifty states to include the District of Columbia—the living will.[21] This is not to say, however, that living wills are as well known by the average individual, as they should be.[22] Even today, many people are still unfamiliar with living wills and even mistakenly refer to them as testamentary wills.[23]

Procedurally speaking, living wills become effective when (1) the declarant (patient)[24] is no longer capable of making medical care decisions; (2) the declarant is in a condition covered by the living will; and (3) a decision covered by the living will is called for.[25] The principal advantage of the living will is the unparalleled capacity to memorialize the subjective intent of the declarant.[26] Also, the living will avoids potential conflicts[27] of interest that may arise in the case of substitute decision-makers and removes a huge burden from those same decision-makers who are normally a relative or close family friend.[28] The obvious inherent weakness of the living will is its inability to cover every potential contingency. Yet, even if one could draft a living will in such a way as to cover every unforeseen event, such broad coverage would render it impotent, as the

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18. Luis Kutner, *Due Process of Euthanasia: The Living Will, A Proposal,* 44 IND. L.J. 539 (1968-1969); Luis Kutner, *The Living Will: Coping with the Historical Event of Death,* 27 BAYLOR L. REV. 39 (1975). Mr. Kutner had formulated this concept years earlier during the 1950s while working with the Euthanasia Society. Horttor, *supra* note 14, at 233.

19. *Id.*

20. *Id.*

21. Gallanis, s*upra* note 14 at 1028.

22. Kolata, *supra* note 3, at A12.

23. While these two legal documents share a similar purpose, that is, both attempts to speak after their maker is unable to do so, they are entirely different instruments. Testamentary wills dispose of property at death. Living wills direct medical treatment. The living will, unlike the testamentary will, is not governed by the law of the maker's domicile but by the law of the state where the AMD is exercised. *See* Leslie Francis, *The Evanescence of Living Wills*, 24 REAL PROP., PROB. & TR. J. 141 (1989) (comparing AMDs and testamentary wills); Therese A. Bruno, *The Deployment Will*, 47 A.F. L. REV. 211 (1999) (discussing testamentary wills in the military).

24. For the purposes of this article "declarant" and "patient" are used interchangeably as are "agent" and "proxy."

25. KING, *supra* note 4, at 126-127.

26. Gallagher, *supra* note 8, at 750.

27. *See generally* Wendland v. Wendland, 28 P.3d 151 (Cal. 2001); Lynda M. Tarantino, *Withdrawal of Life Support: Conflict Among Patient Wishes, Family, Physicians, Courts and Statutes, and the Law*, 42 BUFF. L. REV. 623 (1994) (discussing such conflicts); Katy Hillenmeyer, *End-of-Life Care A Dilemma; Families*, *Patients Wrestle With Medical Advances, Hard Choices*, ASHEVILLE CITIZEN-TIMES, Sept. 5, 2000, at A1, n.2.

28. Lieberson, *supra* note 4, at 328.

numerous contingencies would drown out the specific intent of the declarant.[29]

B. Durable Power of Attorney[30]

The second component part of the AMD is the DPOA[31] or "health care power of attorney." Durable powers of attorney trace their roots back to agency law, which allows "a person [principal] to do through an agent whatever he is empowered to do for his own person."[32] Unlike regular powers of attorney, however, incapacity of the principal does not extinguish a DPOA.[33] To the contrary, the principal creates a DPOA with the intent that he will soon become incapacitated and unable to make decisions.[34] Because DPOAs survive incapacity, revocation becomes of prime importance. Fortunately, the common-law rule of agency—that a principal may revoke the authority of the agent at will[35]—applies to the DPOA.[36]

Procedurally speaking, the DPOA comes in two different forms, "springing" and "current."[37] A "springing" DPOA is effective only when a specific event occurs, such as incapacity of the principal.[38] A "current" DPOA is effective upon execution of the document. Of the two, the "springing" DPOA is more burdensome to use when creating an AMD, as the third party, the health care provider, may not be convinced that the

29. Gallagher, *supra* note 8, at 750.

30. The following phrases are examples of language used in DPOAs: "This power of attorney shall not be affected by subsequent disability or incapacity of the principal" or "This power of attorney shall become effective upon the disability or incapacity of the principal." UNIFORM PROB. CODE § 5-501, 8 U.L.A 513 (1989); UNIF. DURABLE POWER OF ATT'Y ACT § 1, 8A U.L.A. 278 (1987).

31. *See generally* Mark Fowler, *Appointing an Agent to Make Medical Treatment Choices*, 84 COLUM. L. REV. 985, 1008-20 (1984).

32. First Nat'l Bank of Alex. v. Southland Prod. Co., 112 P.2d 1087, 1092 (Okla. 1941).

33. Major Michael N. Schmitt & Captain Steven A. Hatfield, *Durable Power of Attorney: Applications and Limitations*, 132 MIL. L. REV. 203, 205 (1991).

34. Jill Hollander, *Health Care Proxies: New York's Attempt to Resolve the Right to Die Dilemma,* 57 BROOK. L. REV. 145, 148-149 (1991).

35. This may not be true for mental health AMDs. *See* Roberto Cuca, *Ulysses in Minnesota: First Steps Toward a Self-Binding Psychiatric Advance Medical Directive Statute*, 78 CORNELL L. REV. 1152, 1153 (1993).

36. Schmitt & Hatfield, *supra* note 33, at 203.

37. Faculty, The Judge Advocate General's School, TJAGSA Practice Note: *Estate Planning Note*, ARMY LAW., Nov. 2000, at 38.

38. *Id.*

"springing" condition triggering the DPOA has actually occurred.[39] Also, as with regular powers of attorney, a third party generally is not obligated to honor the DPOA.[40]

For most, the advantages of the DPOA over the living will are obvious.[41] Living wills always need interpretation and, regardless of skillful craftsmanship, cannot cover all healthcare contingencies. The agent or proxy in a DPOA, however, knows the patient's values intimately and can respond to unexpected events.[42] In addition, the agent can ask questions, assess risks and costs, speak to relatives and friends of the patient, consider a variety of therapeutic options, seek the opinions of other physicians, and evaluate the patient's condition and prospects of recovery; in short, engage in the same complex decision-making process that the patient would undertake if able to do so.[43] The DPOA, however, is not without its faults. For example, many patients do not want to burden their relatives or close friends with the job of proxy thereby requiring them to make the "tough choices."[44] In addition, there is no guarantee that the proxy will be able to carry out the patient's desired intent or that the proxy will be in a rational state when forced to make a decision.[45]

C. The Hybrid

The hybrid, which has become the standard format[46] for most AMDs to include those used in the military, employs a living will and a DPOA. Several reasons exist as to why one should have both a living will and a DPOA.[47] First, proxy decision makers do not want the full responsibility of making life-altering decisions without some form of guidance.[48] A living will provides a framework within which the proxy can make his or her

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39. Captain Kent R. Meyer, *Continuing Powers of Attorney,* 112 MIL. L. REV. 257 (1986). The model military AMD offered at the end of this article offers both a current and springing POA.

40. Schmitt & Hatfield, *supra* note 33, at 211. However, see *infra* note 55.

41. David A. Peters, *Advance Medical Directives: The Case for the Durable Power of Attorney for Health Care,* 8 J. LEGAL MED. 437 (1987).

42. *See* Lieutenant Colonel William A. Woodruff, *Letting Life Run Its Course: Do Not-Resuscitate Orders and the Withdrawal of Life-Sustaining Treatment*, ARMY LAW., Apr. 1989, at 13 (providing information on selecting an agent or proxy).

43. Fowler, *supra* note 31, at 1001.

44. *Id.*

45. Lieberson, *supra* note 4, at 327.

46. *See, e.g.*, IDAHO CODE § 39-4505 (1998).

47. Pope, *supra* note 11, at 183-184.

decisions.[49] Second, a health care provider is more likely to follow a hybrid as it increases the chances that the patient and his proxy have discussed in-depth the patient's healthcare wishes.[50] The hybrid, however, like any legal instrument, is not without its complications. For example, if a patient has both a living will[51] and a DPOA,[52] some states have created a pecking order[53] between the two, while other states have mandated that the last instrument executed is controlling.[54]

D. AMDs and Liability[55]

All state living will and DPOA statutes confer some type of immunity from civil and or criminal liability on health care providers who in good faith comply with a properly executed AMD in accordance with the patient's wishes or in the patient's best interest.[56] Conversely, only a small number of states provide enforcement provisions against health care providers who fail to follow an AMD.[57] Those states recognizing enforcement provisions place them in three broad categories: professional sanctions, civil liability, and criminal charges.[58] While the potential exists for a patient or his estate to pursue one or all of these actions, they rarely

48. Steven R. Stieber, *Right to Die: Public Balks at Deciding for Others*, HOSPS. 72 (Mar. 5, 1982) (stating that only forty-six percent of Americans would be willing to disconnect life-support).

49. Pope, *supra* note 47, at 183.

50. Lieberson, *supra* note 4, at 329.

51. *Id.* The living will is controlling in Connecticut, Hawaii, Ohio and Arizona.

52. *Id.* The DPOA is controlling in Georgia, New Hampshire and Utah.

53. The model AMD offered at the end of this article demonstrates how to avoid a potential conflict between the DPOA and living will.

54. *Id.* (including Texas, Rhode Island, North Dakota, and South Dakota).

55. *See generally* M. Rose Gasner, *Financial Penalties for Failing to Honor Patient Wishes to Refuse Treatment*, 11 ST. LOUIS U. PUB. L. REV. 499 (1992); Adam A. Milani, *Better off Dead than Disabled?: Should Courts Recognize a "Wrongful Living" Cause of Action When Doctors Fail to Honor Patient's Advance Directives*, 54 WASH & LEE L. REV. 149 (1997); Philip G. Peters, *The Illusion of Autonomy at the End of Life: Unconsented Life Support and the Wrongful Life Analogy*, 45 U.C.L.A. L. REV. 673 (1998); Maggie J. Randall Robb, *Living Wills: The Right to Refuse Life Sustaining Medical Treatment A Right Without a Remedy,* 23 DAYTON L. REV. 169 (1997); Mark Strasser, *A Jurisprudence in Disarray: On Battery, Wrongful Living, and the Right to Bodily Integrity*, 36 SAN DIEGO L. REV. 997 (1999); S. Elizabeth Wilborn, *The Right to Refuse Medical Treatment Where There Is a Right, There Ought To Be A Remedy*, 25 N. KY. L. REV. 649 (1998).

56. Wilborn, *supra* note 55, at 658 n.47.

57. Robb, *supra* note 55, at 173.

58. *Id.*

do.[59] This potential is even more remote in the military as many patients are prevented from bringing legal action against the federal government pursuant to the *Feres*[60] doctrine, and those who are not must follow the restrictive requirements of the Federal Tort Claims Act.[61] Both military and non-military patients, however, should be aware that, while states have attempted to limit the liability of both hospitals and health care providers, the potential for provider liability still exists.[62]

IV. Legal Bases for Recognizing AMDs

While AMDs are relatively new, the legal framework supporting them has been around for over a hundred years.[63] The legal basis for recognizing AMDs rests with the patient's right of autonomy and self-determination regarding medical treatment.[64] This right can be found in both the common law[65] and the U.S. Constitution.[66] At common law,[67] the touching of one person by another—regardless of whether committed by a health care provider—without consent or legal justification constitutes an assault.[68] The natural corollary of the common law consent doctrine is the right not to consent; that is, the right to refuse medical treatment.[69]

In *Cruzan v. Director, Missouri Department of Health*, the Supreme Court, in a 5-4 decision,[70] found the right to refuse medical treatment constitutionally protected.[71] The Court, while acknowledging that some states

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59. *Id.*

60. Feres v. United States, 340 U.S. 135 (1950).

61. 28 U.S.C. 1346 (2000).

62. Gragg v. Calandra, 297 Ill. App. 3d 639 (Ill. 1998); *see also* Osgood v. Genesys Reg. Med. Ctr., No. 94-26731-NH (Genesee County Mich. Cir. Ct. Feb. 16, 1996) (awarding $16.6 million to a plaintiff after her husband was provided life support against his will).

63. *See* Union Pac. R. Co. v. Botsford, 141 U.S. 250, 251 (1891).

64. Cruzan v. Dir., Missouri Dep't of Health Dir., 497 U.S. 261, 269 (1990).

65. *Id.*

66. U.S. CONST. amend. XIV.

67. Schloendorff v. Soc'y of New York Hosp., 211 N.Y. 125, 129 (1914). Justice Cardozo stated, "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault; for which he is liable in damages." *Id.*

68. *See* W. KEETON, D. DOBBS, R. KEETON, & D. OWEN, PROSSER & KEETON ON LAW OF TORTS § 9, at 39-42 (5th ed. 1984). Obtaining consent is not always required when treating service members. U.S. DEP'T OF ARMY, REG. 600-20, ARMY COMMAND POLICY para. 5-4 (15 July 1999) [hereinafter AR 600-20].

69. *Cruzan*, 497 U.S. at 269.

70. *Id.*

reviewed this right pursuant to the Fourteenth Amendment's "right to privacy,"[72] held that "this issue is more properly analyzed in terms of a Fourteenth Amendment liberty interest."[73] Also, the Supreme Court made it patently clear that AMDs are "a valuable additional safeguard of the patient's interest in directing his medical care."[74]

Patient Self-Determination Act (PSDA)[75]

In addition to the *Cruzan* decision, passage of the PSDA in 1991 further enhanced the legal recognition and use of AMDs. This act required hospitals receiving Medicare and Medicaid monies to inform their patients about relevant state laws regarding AMDs.[76] While the PSDA is not applicable to military medical treatment facilities, both military and Joint Commission on Health Care Organization (JCAHO) regulations mandate that military treatment facilities follow similar standards.[77] The PSDA signified the first major federal legislation concerning the use of AMDs and was ushered through Congress to help reduce the number of difficult ethical and legal issues presented during medical treatment decisions.[78] The ulti-

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71. *Id. at* 279.

72. Prior to *Cruzan*, several state courts viewed the right to refuse medical treatment as a Fourteenth Amendment fundamental Right to Privacy issue. *See, e.g.*, *In re Quinlan*, 355 A.2d 647, 663 (1976).

73. *Cruzan*, 497 U.S. at 278. Applying a "liberty interest" results in somewhat less protection for the individual. By analyzing this issue pursuant to a "liberty interest," the Court must balance the individual's "liberty interest" against the relevant state interest to determine if a constitutional infringement has occurred. If the Court, however, had analyzed this issue within a "Right to Privacy" framework, the state would have had to demonstrate a compelling state interest prior to infringing upon the individual's rights. *Id.*

74. *Id.*

75. Edward J. Larson & Thomas A. Eaton, *The Limits of Advance Directives: A History and Assessment of the Patient Self-Determination Act*, 32 WAKE FOREST L. REV. 249 (1997).

76. 42 U.S.C. § 1395cc(f)(1) (A)(ii) (2000).

77. U.S. DEP'T OF ARMY, REG. 40-3, MEDICAL, DENTAL AND VETERINARY CARE para. 2-1 (11 Dec. 2002); U.S. DEP'T OF AIR FORCE, INSTR. 51-504, LEGAL ASSISTANCE, NOTARY, AND PREVENTIVE LAW PROGRAMS para. 1.3.1 (1 May 1996) [hereinafter AFI 51-504]; U.S DEP'T OF NAVY, JUDGE ADVOCATE GENERAL INSTR. (JAGINST) 5801-2 (11 Apr. 97) [hereinafter JAGINST 5801-2]; U.S. DEP'T OF TRANSP., U.S. COAST GUARD, COMMANDANT INSTR. 5801.4C, LEGAL ASSISTANCE PROGRAM (30 July 99) [hereinafter COAST GUARD, COMMANDANT INSTR. 5801.4C].

78. *The Patient Self-Determination Act: Health Care's Own Miranda*, 8 J. CONTEMP. HEALTH L. & POL'Y 455 (1992) (Commentary by Senator William V. Roth Jr.) (citing 136 CONG. REC. E2, 190 (June 28, 1990)) (statement of Representative, now Senator, Levin).

mate goal of the PSDA was to heighten public awareness of AMDs and empower the patient in making health care decisions.[79]

V. Part III: Evolution of AMDs in the Military

In the military, AMDs followed a similar pattern of acceptance and use as in the civilian community. Initially, in 1978, Army policy did not allow either DNRs[80] or withdrawal-of-life-support orders.[81] This policy remained in effect until 1985, when subsequent to the publication of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical Research,[82] the Army formally started to recognize DNR Orders.[83] Prior to 1985, many military medical treatment facilities like civilian hospitals found themselves creating "slow codes" or "notify MOD [medical officer of the day] before coding" instructions.[84] Medical staff, patients and patient's families at military medical treatment facilities used these informal agreements to get around the prohibition against withdrawal of life support and DNR orders.[85] By 1990, after much staffing, the

79. *Id.*

80. Do not resuscitate (DNR) orders are technically, but not legally, a type of AMD. Do not resuscitate orders are medical orders left on the patient's chart by an attending physician instructing other health care providers not to order therapy collectively referred to as cardio-pulmonary resuscitation. COMMITTEE ON CARE AT THE END OF LIFE, APPROACHING DEATH: IMPROVING CARE AT THE END OF LIFE, INST. OF MED. 98-99 (1997).

81. Woodruff, *supra* note 42, at 7-8.

82. *Id.* at 8 (citing President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatment: Ethical, Medical, and Legal Issues in Treatment Decisions 248-55 (1983)).

83. The Army, however, did not rescind its prohibition against the withdrawal of life support until the decision in *Tune v. Walter Reed Army Hosp.*, 602 F. Supp. 1452, 1453, (D.D.C 1985). An earlier case regarding the withdrawal of care at a military treatment facility, *Newman v. United States*, No. EP-86-CA-276 LEXIS (W.D. Tex. 1986), was dismissed as the patient died before adjudication.

84. Woodruff, *supra* note 42, at 8.

85. *Id*. These informal arrangements were necessary because the Judge Advocate General at the time determined that "it was at least possible that a physician withdrawing life support or failing to order resuscitation could face criminal prosecution in some circumstances." *Id.*

Army finally permitted living wills in the inpatient and outpatient records of its patients.[86]

A. Growing Pains

As AMDs continued to gain acceptance and popularity after the Cruzan decision and the passage of the PSDA,[87] the Army began to include AMD implementation guidelines in its regulations.[88] Judge advocates tasked with advising personnel about AMDs quickly realized that, due to the transient lifestyle of military personnel, a strong possibility existed that some states would not recognize AMDs created for service members in other states.[89] Soldiers could not be sure if an AMD created pursuant to the local state requirements would be valid in another state that had different standards.[90] Fortunately, 10 U.S.C. § 1044c removed this uncertainty.[91]

B. 10 U.S.C. § 1044c

This statute exempts "an advance medical directive executed by a person eligible for legal assistance . . . from any requirement of form, substance, formality, or recording."[92] The statute permits federal recognition of AMDs created for individuals eligible for military legal assistance. Therefore, if an AMD is created at Fort Bragg, it is valid in every state recognizing AMDs regardless of that state's particular procedural requirements.[93] This legislation is significant for several reasons. First, the need for judge advocates to be familiar with AMD laws of other states is greatly

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86. Major Stephen M. Parke, *Death and Dying in Army Hospitals: The Past and Future Roles of Advance Medical Directives*, ARMY LAW., Aug. 1994, at 6. Memorandum, to Commanders, U.S. Army Health Services Command, subject: Placement of Living Wills in Outpatient Treatment Records, and In Patient Records 3 (9 Nov. 1990).

87. Michael A. Salatka, *Commentaries: The Patient Self-Determination Act of 1990*, 1 J. PHARMACY & L. 155, 156 (1992).

88. Currently, all four services plus the Coast Guard offer military AMDs. AR 40-3, *supra* note 77, para. 2-1; AFI 51-504, *supra* note 77, para. 1.3.1; JAGINST 5801-2, *supra* note 77; U.S. COAST GUARD, COMMANDANT INSTR. 5801.4C, *supra* note 77. In addition, some local military medical treatment facilities have their own implementation regulations, U.S. DEP'T OF ARMY, WALTER REED ARMY MED. CENTER REG. 40-8, IMPLEMENTATION OF ADVANCE DIRECTIVES (2 Apr. 99) [WALTER REED ARMY MED. CENTER REG. 40-8].

89. Colonel Alfred R. Arquilla et al., *Army Legal Assistance: Update, Initiatives, and Future Challenges,* ARMY LAW., Dec. 1995, at 14-15.

90. Parke, *supra* note 86, at 9.

diminished.[94] Second, Congress did not mandate a required AMD format, thus giving drafters wide-latitude in deciding what language to include in the AMD.[95] Third, the statute did not require an attorney (military or civil-

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91. *Arquilla*, *supra* note 89, at 14-15. Lieutenant Colonel George L., Hancock, Jr. then the Chief, Administrative and Civil Law Division, The Judge Advocate General's School, U.S. Army, first proposed the concept and initial draft for this legislation. The law is as follows:

> (a) Instruments To Be Given Legal Effect Without Regard to State Law. An advance medical directive executed by a person eligible for legal assistance—
> (1) is exempt from any requirement of form, substance formality, or recording that is provided for advance medical directives under the laws of a State; and
> (2) shall be given the same legal effect as an advance medical directive prepared and executed in accordance with the laws of the State concerned.
> (b) Advance Medical Directives. For purposes of this section, an advance medical directive is any written declaration that-
> (1) sets forth directions regarding the provision, withdrawal, or withholding of life-prolonging procedures, including hydration and sustenance, for the declarant whenever the declarant has a terminal physical condition or is in a vegetative state; or
> (2) authorizes another person to make health care decisions for the declarant, under circumstances stated in the declaration, whenever the declarant is incapable of making informed health care decisions.
> (c) Statement To Be Included.
> (1) Under regulations prescribed by the Secretary concerned, an advance medical directive prepared by an attorney authorized to provide legal assistance shall contain a statement that sets forth the provisions of subsection (a).
> (2) Paragraph (1) shall not construed to make inapplicable the provisions of subsection (a) to an advance medical directive in a State that does not otherwise recognize and enforce advance medical directives under the laws of the State.
> (d) Definitions. In this section:
> (1) The term "State" includes the District of Columbia, the Commonwealth of Puerto Rico, and a possession of the United States.
> (2) The term "person eligible for legal assistance: means a person who is eligible for legal assistance under section 1044 of this title.
> (3) The term "legal assistance" means legal services authorized under section 1044 of this title.

10 U.S.C. § 1044c (2000).

92. *Id.*

93. Currently, all fifty states and Washington, D.C. recognize some form of an AMD. *See supra* note 14.

94. MEDICAL LEGAL DESKBOOK, AMD, *supra* note 4, at 1-7.

ian) to draft the AMD, thereby making the AMD more easily accessible to those who need it.[96]

VI. Part IV: Current Status and Recommendations

A. *DOD Directive 1350.4*

Unfortunately, some individuals, to include attorneys, may mistakenly believe that an AMD created pursuant to 10 U.S.C. § 1044c is only effective in the state in which it was created or that an attorney must draft it for it to be valid. While the former issue is solved by increased publication and discussion of 10 U.S.C. § 1044c, the latter requires an alteration to DOD Directive 1350.4. The Directive states in para. 4.2.2, "A military testamentary instrument shall: Be executed in the presence of a military legal assistance counsel acting as presiding attorney," and goes on in para. 4.4. to state, "If prepared, such documents will include a statement or preamble in form and content substantially as outlined at enclosure 4," which reads as follows:

> This is a military advance medical directive prepared pursuant to section 1044c of title 10, United States Code. *It was prepared by an attorney authorized to provide legal assistance for an individual eligible to receive legal assistance under section 1044 of title 10, United States Code.* Federal law exempts this advance medical directive from any requirement of form, substance, formality or recording that is provided for advance medical directive under the laws of a State. Federal law specifies that this advance medical directive shall be given the same legal effect as an advance medical directive prepared and executed in accordance with the laws of the State concerned.[97]

The directive as currently written improperly interprets 10 U.S.C. § 1044c.[98] The DOD should modify the Directive[99] by removing both para

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95. *Arquilla*, *supra* note 89, at 14-15.

96. *Id.*

97. *See* DOD DIR. 1350.4, *supra* note 5, at 9 (emphasis added).

98. Arquilla et al., *supra* note 89, at 14-15.

99. This modification would allow the Directive to reflect the recommendations originally offered by *Parke, supra note 86, app. B.*

4.2.2 ("Be executed in the presence of at military legal assistance counsel as presiding attorney") and the italicized language listed above.[100]

To receive the protections of 10 U.S.C. §1044c, an attorney need not draft the declarant's AMD. Instead, the declarant need only be eligible for military legal assistance.[101] The significant point is not "by whom" the AMD is prepared but "for whom" it is prepared.[102] In the opinion of this author, such additional formalities imposed by *DOD Directive 1350.4* are contrary to the purpose of both the PSDA and 10 U.S.C. § 1044c. Mandating that only attorneys draft AMDs both overstates the importance of attorneys[103] in the AMD process and creates unnecessary impediments not generally found in the civilian community.[104] Notwithstanding the fact that AMDs can be drafted without assistance from counsel, judge advocates need to stay current with AMD developments and be available to those who need or want additional information or assistance in completing them. Also, judge advocates should be proactive in educating the military community about the benefits of AMDs by offering timely information papers, presentations and other educational materials.

B. Soldier Readiness Processing (SRP)[105]

Besides modifying *DOD Directive 1350.4*, the military should take steps to offer AMDs to its personnel prior to hospitalization, ideally during initial in-processing or mobilization briefings. Currently, military regulations require hospital personnel to brief service members on AMDs upon

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100. *See* DOD DIR. 1350.4, *supra* note 5, para. 3.4, 4.2.2.

101. 10 U.S.C. § 1044c (2000).

102. Arquilla et al., *supra* note 89, at 14-15.

103. John F. Fader, *Trends in Health Care Decisionmaking: The Precarious Role of the Courts: Surrogate Health Care Decisionmaking*, 53 MD. L. REV. 1193 (1994). Judge Fader argues that permitting non-attorneys to draft AMDs "will help keep life and death medical decisions out of the courtrooms and will allow more of these decisions to remain with the individual patient and his family and friends, where they belong." *Id.* at 1219.

104. Many non-profit organizations have created a universal AMD valid in most states. "Each state has an approved living will document that has an approved living will document that is downloadable and free on the website of the not-for profit partnership-forcaring.org." Jean Chatzky, *A Will For the Living,* TIME MAG., Nov. 3, 2003, at 18.

105. U.S. DEP'T OF ARMY, REG. 600-8-101, PERSONNEL PROCESSING (IN-AND OUT AND MOBILIZATION PROCESSING) (1 Mar. 1997). The SRPs serve to prepare soldiers for deployment by updating their medical and dental records, life insurance policies, identification cards, family care plans, testamentary wills and power of attorneys. Generally speaking, units conduct bi-annual SRPs.

admission to a medical treatment facility.[106] Studies demonstrate that this is normally not the best time for patients to start thinking about AMDs.[107] Providing AMDs prior to hospitalization[108] allows service members more time to contemplate the AMD without the immediacy of pain, discomfort, fears or the press of time.[109] In addition, prior to hospitalization, the service member has more time to seek further counsel from friends, family, counsel, clergy or other health care providers.

The SRP is just one example of an opportunity the Army has to expose a captive audience to the benefits of an AMD. While commanders cannot require personnel to complete an AMD, they can at least ensure that the service member is educated about its opportunities. Through the SRP, the Army can encourage service members to plan for future medical treatment or at least to start thinking about it. In fact, the DOD policy mandates, "Although not every person needs a will or military testamentary instrument, all military personnel shall consider the advisability of making either."[110]

VII. Conclusion

While no amount of prior planning or documentation exists to ensure patient treatment autonomy when a person is incapacitated, AMDs help ensure that the patient's desires are followed. The recommendations provided in this article will, if implemented, ensure that service members are offered greater opportunities to complete or at least become aware of AMDs, and thus become more active participants in their own medical care treatment.

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106. Parke, *supra* note 86 at 7; *see also* Captain Michael J. Roy & Itzhak Jacoby, *The Patient Self-Determination Act: Is It All It Can Be?*, 158 MIL. MED. 1128-1129 (1993). In addition, some local military medical treatment facilities have their own implementation regulations, WALTER REED ARMY MED. CENTER REG. 40-8, *supra* note 77, at Sec. 5a.

107. Pope, *supra* note 11, at 141.

108. Parke, *supra* note 86 at 10.

109. The American Medical Association does not believe that the hospital is the most appropriate place, nor admission to a facility the most appropriate time, for a patient to consider the issues of an AMD. *Hearings Before the Subcomm. on Medicare and Long-Term Care Senate Committee on Finance*, 101st Cong. 1-3 (1990) (statement of Nancy W. Dickey, M.D. Board of Trustees, American Medical Association); Parke, *supra* note 86, at 10.

110. DOD DIR. 1350.4, *supra* note 5, para. 4.1.1.

Appendix A

Proposed Model Advance Medical Directive

This is a military advance medical directive prepared pursuant to section 1044c of title 10, United States Code. Federal law exempts this advance medical directive from any requirement of form, substance, formality or recording that is provided for an advance medical directive under the laws of a State. Federal law specifies that this advance medical directive shall be given the same legal effect as an advance medical directive prepared and executed in accordance with the laws of the State concerned. This military advance medical directive consists of five sections: (I) Durable Power of Attorney; (II) Living Will; (III) Other Wishes; (IV) Signatures; and (V) Revocation.

Part I. Durable Power of Attorney

A Durable Power of Attorney authorizes your agent broad discretion regarding your medical treatment. You should speak with an attorney if you wish to limit this authorization. Choose someone who knows you very well, cares about you, and who can make difficult decisions.

____I designate the following individual to act as my agent to make health care decisions for me when I cannot make those decisions myself___ or starting at the present time___:

Name:_____

Telephone (home)_____(work)_____

Address:_____

e-mail address:_____

____If the person above cannot or will not make decisions for me, I appoint the following person.

Name:_____

Telephone (home) _____(work)_____

Address:_____

e-mail address:_____

___I have not appointed anyone to make health care decisions for me in this or any other document.

Part II. Living Will

A Living Will is used to determine what medical treatment you would or would not want in the event that you are unable to make decisions for yourself.

____I do not want life-sustaining treatments started. If life-sustaining treatments are started I want them stopped.

____I want life-sustaining treatments that my health care providers think are best for me.

___Additional information _____

1. Comfort Care

___I want to be as comfortable and free of pain as possible, even if such care prolongs or shortens my life.

___Additional Information:_____

2. Artificial Nutrition and Hydration

___I do not want artificial nutrition and hydration started if it would be the main treatment keeping me alive. If artificial nutrition and hydration are started, I want them stopped.

___I want artificial nutrition and hydration even if it is the main treatment keeping me alive.

___Additional information:_____

3. These are my desires if I am ever in a persistent vegetative state:

___I do not want life-sustaining treatments started. If life-sustaining treatments are started, I want them stopped.

___I want life-sustaining treatments that my health care providers think are best for me.

___Additional information:_____

Part III. Other Wishes

4. Expiration Date

___If you want to limit the duration of this AMD provide an expiration date_____

5. Military Benefits

__If I am a member of the armed services, the medical choices made by my agent or any health care provider shall take into consideration the completion of all procedures necessary to obtain potential medical and/or retirement benefits.

6. Pregnancy

__If I am pregnant my AMD is null and void___unchanged___or modified___, if modified list those changes _____

7. Conflict

___If a conflict arises between my Durable Power of Attorney and my Living Will, I want the health care providers to rely on my Living Will ___Durable Power of Attorney___

8. Organ Donation

___I do not wish to donate any of my organs or tissues.

___I want to donate all of my organs and tissues.

___I want to donate only these organs and tissues.
_____

9. Autopsy

___I do not want an autopsy.

___I agree to an autopsy if my doctors or family wish it.

___Additional information.
_____

10. Witness Statement

I, declare under penalty of perjury; (1) that the individual who signed or acknowledged this military advance medical directive is personally known to me, or that the individual's identity was proven to me by convincing evidence; (2) that the individual signed or acknowledged this military advance medical directive in my presence; (3) that the individual appears to be of sound mind and under no duress, fraud or undue influence; (4) that I am not a person appointed as agent by this military advance medical directive; and (5) I am not the individual's health care provider.

First Witness

Name:_____Date_____

Telephone (h)_____(w)_____

Address:_____e-mail address:_____

Signature of witness_____Date_____

Second Witness

Name:_____Date_____

Telephone(h)_____(w)_____

Address:_____e-mail address:_____

Signature of witness_____Date_____

Part V. Revocation

___I understand that I may revoke this military advance medical directive at any time.