June 2012

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THE DURABLE POWER OF ATTORNEY AS AN ALTERNATIVE TO THE IMPROPER USE OF CONSERVATORSHIP FOR HEALTH-CARE DECISIONMAKING

DALE L. MOORE*

Mentally competent adult individuals have the right to make decisions for themselves. Sometimes, however, an illness, accident, or other misfortune interferes with an individual’s capacity to exercise that right. In the event of such incapacity, the individual will need someone else to make decisions for him.

Decisionmaking on behalf of such incapacitated individuals has been the subject of legislation, court decisions, and legal commentary. Numerous forms of surrogate decisionmaking have been authorized; state statutes presently authorize several which are of relevance here: that which is performed by an attorney-in-fact under a durable power of attorney and that which is performed by other types of surrogates, such as conservators or guardians, who are appointed by courts under statutory authority. This article describes present law concerning the role of these surrogates in making health-care decisions for incapacitated individuals, contending that insufficient attention has been devoted to two issues. The first issue is the nature of the individual’s incapacity—whether it extends to the making of personal decisions, such as those involving health care. The second issue is the proper match between the individual’s incapacity and the surrogate to be chosen—whether a particular surrogate may appropriately make health-care decisions. Inattention to these questions in the past has resulted in inade-
quate protection of the rights of the incapacitated. Part I introduces two hypothetical situations that illustrate different types of surrogate decisionmaking needs. Looking to New York statutes as sources, part I then describes three forms of surrogate decisionmaking and explains their proper application in the hypothetical situations posed. Again using the New York scheme as a model, part II focuses on conservatorship, discussing its purpose and the conservator's proper role, and then explores the ways in which conservatorship is being used inappropriately in the health-care decisionmaking context. After concluding, in part III, that attorneys-in-fact are the ideal surrogates for the making of health-care decisions, the article in part IV analyzes the significant issues to be resolved before that particular form of surrogate decisionmaking is adopted as the answer to the dilemma of health-care decisionmaking for the incapacitated.

I. The Settings in Which the Need for a Surrogate Arises

A. Hypothetical Situations

A man in his mid-twenties is hospitalized following an automobile accident. He undergoes extensive treatment for his injuries, which include damage to his skull and brain. A lengthy period of rehabilitative therapy is contemplated, during which—his doctors hope—he will relearn how to manage the activities of daily living. That process will be painful for him, both psychologically and physically.

At present, however, this young man cannot perform many of the activities that ordinary daily living requires. In particular, he is unable to manage his finances, primarily because his injuries have left him with certain perceptual and motor impairments that render the writing of checks and the addition and subtraction of numbers impossible at this stage of his recuperative process. He is, however, not "incompetent":¹ he knows who and where he is, understands why he is there, and mourns for the loss of his friend.

¹ "Incompetence" is not readily defined, in part because it means different things to different people and in different circumstances. The test of competency may vary from one situation to another and from one type of decision to another. See, e.g., Meisel, The "Exceptions" to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking, 1979 Wis. L. Rev. 413, 439-42; Roth, Meisel & Lidz, Tests of Competency to Consent to Treatment, 134 Am. J. Psychiatry 279 (1977); see also infra notes 119-43 and accompanying text.
who was killed in the same accident that so severely injured him.

Because of this man's inability to manage his financial affairs, he is probably in need of, and would benefit from, surrogate management of his property until such time as he recovers sufficiently to be able to resume management himself. Such management could be assumed by his attorney-in-fact had he previously executed a durable power of attorney delegating that authority. In the absence of such delegation, a court-appointed surrogate could manage his financial affairs during the limited period of time that such surrogate management is likely to be necessary.

Contrast with the situation of that young man another, and perhaps more common, set of circumstances. A man is hospitalized after suffering a heart attack followed by a cardiac arrest. Resuscitation efforts met with sufficient success to allow him to survive, but he is still comatose and the prospects for his return to a cognitive, sapient state are poor. He too is in need of someone to manage his financial affairs. His need, however, is unfortunately not likely to be limited to a need for surrogate property management. Should he remain in his noncognitive state—which appears likely—he will also remain incapable of making more personal decisions, such as decisions concerning the health-care he will receive. It is in this sort of situation that the need to consider carefully both the nature of the incapacity and the appropriate surrogate is most acute.

**B. The Three Types of Surrogate Decisionmakers**

In the absence of incapacity, adult individuals have the right to make decisions for themselves. Although this article focuses on health-care decisions, the right of a competent adult extends to the making of all sorts of choices—educational, occupational, financial, associational, and recreational, among others. Sometimes, however, as in the two hypothetical situations outlined above, some degree of incapacity interferes with an individual's ability to make his own choices. State statutes provide for decisionmaking by a surrogate in the event such incapacity arises.

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New York statutes presently authorize three types of surrogate decisionmakers of relevance to the issue of health-care decisionmaking. Two of these kinds of surrogates are court appointed (conservators and committees); to the judge appointing such a surrogate, the nature and degree of the individual's incapacity are, at least theoretically, of paramount significance. Such considerations will also be quite important to the individual who, prior to incapacity, plans for his own surrogate decisionmaking by executing a durable power of attorney—the third type of delegation authorized by New York law.

These three types of surrogate decisionmakers are described in greater detail below. They are considered in the order of their intrusiveness into individual power and autonomy; careful attention to the powers conferred on each type of surrogate is important. Committees, discussed first, are court-appointed surrogates for individuals whose incapacity has reached the level of incompetence. Conservators, discussed next, are court-appointed surrogates for those whose incapacity falls short of incompetence. Attorneys-in-fact are surrogates designated by individuals prior to their own incapacity.

1. Committees

In the event that a person becomes "incompetent to manage himself or his affairs," the New York courts have the authority, under section 78.01 of the Mental Hygiene Law, to appoint a "committee of the person or a committee of the property, who may be the same or different individuals." In most other jurisdictions such a custodian of the person or property of an incompetent would be referred to as a guardian. Serious consequences flow from a declaration of incompetence — among them the loss of certain civil rights, such as the right to vote; accordingly, such a declaration is not lightly made.

Courts appointing committees to manage the affairs of incom-

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3 N.Y. MENTAL HYG. LAW § 78.01 (McKinney Supp. 1987).
petent individuals may appoint committees to manage property, or personal affairs, or both; such powers may be delegated to one or more persons. Court decisions subsequent to the enactment of the committee statute, however, make clear that a committee appointed to manage only the property of an incompetent individual has no power over that individual’s personal choices and that the committee of the person is the party responsible for “taking care of the physical needs of the incompetent . . . furnishing him with such medical and other care and treatment as is required, and looking after his health and general welfare.” It bears emphasizing here that committees of the person are the surrogates who have power over the personal matters of incapacitated individuals. More recently enacted statutes seem to assume that a committee of the person may have some role in making health-care decisions, and some state agencies make similar assumptions; courts, however, have retained their role in major health-care decisions.

2. Conservators

Some individuals, who may find it difficult or even impossible to manage their financial affairs, may not be sufficiently incapacitated to justify an adjudication of incompetence. To facilitate needed surrogate property management for such individuals, the New York Legislature in 1972 amended the Mental Hygiene Law to include conservatorship provisions. The Legislature emphasized, in the memoranda accompanying those amendments, that it was responding to the need to “preserve the property” of those unable to manage their own affairs.

A conservator—an individual or institution appointed by the

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6 N.Y. MENTAL HYG. LAW § 78.01 (McKinney Supp. 1987).
8 Webber, 187 Misc. at 677, 64 N.Y.S.2d at 285.
9 See infra notes 80-91 and accompanying text.
10 See, e.g., New York State Commission on Quality of Care for the Mentally Disabled, QUALITY OF CARE, Jan.-Feb. 1986, at 3.
12 See infra note 27 and accompanying text.
13 Memorandum of Joint Legislative Committee on Mental and Physical Handicap, reprinted in [1972] N.Y. Laws 3277, 3290 (McKinney) [hereinafter Legislative Memoranda].
14 See N.Y. MENTAL HYG. LAW § 77.03(e) (McKinney Supp. 1987). “Any relative or friend of the proposed conservatee, including a corporate body, social services official, or
court—therefore, is under a statutory duty to preserve, maintain, and care for the property of an individual (the "conservatee") who "has suffered substantial impairment of his ability to care for his own property..." The conservator's power is described as including "all of the powers... granted to... a committee of the property of an incompetent." Of significance here is the absence of any requirement that an individual be declared incompetent before a conservator may be appointed.

3. Attorneys-in-fact

The third form of surrogate decisionmaking is the durable power of attorney, which "allows any competent person to desig-
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nate another person as his or her attorney-in-fact." It differs from the other forms in two significant respects. First, the individual—and not the court—chooses the surrogate. Second, although the attorney-in-fact may be authorized to exercise one or more of a number of powers on behalf of the principal, most involving financial, business, and property transactions, the principal chooses the specific powers to be delegated. The individual who executes a durable power of attorney, therefore, loses much less control over his own affairs than one whose surrogate is court appointed—and perhaps even a stranger. The delegation to his attorney-in-fact survives the principal’s incapacity to make the relevant decisions himself, and exercise of the powers is “expeditious.” The durable power of attorney is therefore an excellent property management device and has been referred to as “a cornerstone of long-range planning for the older client.”

C. Choice of Decisionmaker in the Hypothetical Situations

Consider the appropriateness of each of these types of surrogate decisionmaking for the hypothetical situations posed above. The first fact pattern involves a man who requires surrogate property management only. Had he executed a durable power of attorney, his attorney-in-fact could fill his decisionmaking needs. Although he would also be a proper candidate for the appointment of a conservator, a conservatorship is not the ideal solution for him. A problem with all conservatorships (a problem identified and discussed at length elsewhere) concerns the cost and “cumbersome-ness” of a conservatorship proceeding, which “vests control of a person’s property in a conservator who is not necessarily the person the incapacitated property-owner would have chosen.” To some extent, the costs, delays, and other problems associated with

1 Strauss & Wolf, supra note 20, at 17, col. 1. The powers that may be delegated to, and exercised by, the attorney-in-fact involve, for example, real estate transactions, banking transactions, insurance transactions, claims, and litigation. Id. See N.Y. GEN. OBLIG. LAW §§ 5-1501, 5-1502A to 5-1502L (McKinney 1978 & Supp. 1987).
2 See Strauss & Wolf, supra note 20, at 17, col. 5.
3 Id. Shortcomings of the durable power of attorney are discussed in Callahan, supra note 20, at 424-25.
4 See, e.g., sources cited supra note 20.
5 See Strauss & Wolf, supra note 20, at 1, col. 1.
conservatorship proceedings may be avoided through the use of a
durable power of attorney executed prior to incapacity.

Although appointment of a conservator may not be preferable
to use of an attorney-in-fact, conservatorship is nonetheless an ac-
ceptable method for providing surrogate decisionmaking in the
first hypothetical situation. The patient is not incompetent; ap-
pointment of a committee, therefore, would not be appropriate.

The second fact pattern highlights more difficult issues. Even
if this man had executed a durable power of attorney, his decision-
making requirements would not be fully met. His needs, as noted,
are not limited to a necessity for surrogate property management.
Moreover, he is comatose and therefore clearly not competent. It
would seem, then, that the appropriate solution is a declaration of
incompetence and the appointment of a committee of the person
and property. This article contends, however, that 1) present law is
being applied in such a way as to result in outcomes different from
those that appear appropriate and 2) present law, by allowing for
these inappropriate outcomes, is misguided—it fails to protect the
rights of incapacitated individuals to the extent that it could and
should. In order to comprehend how such inappropriate outcomes
can occur, it is necessary to explore the principles of the conserva-
torship law and their application.

II. CONSERVATORSHIP

A. Purpose

The purpose of the New York conservatorship statute, which
was enacted in 1972, is to reduce the obstacles surrounding the ap-
pointments of surrogate managers of the property of those who
cannot, for whatever reason, manage their own property. The legis-

tative history emphasizes the need for such property management
in many cases, and for a “flexible means” of providing it. Prior to
1972, such surrogate property managers could be appointed only if
the rigorous requirements of the committee statute were met.

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26 See infra text following note 42.
27 See Legislative Note, Legislation-The New York Conservator Law, 22 BUFFALO L.
Rev. 487, 488-89 (1973); see generally In re Estate of Bauer, 96 Misc. 2d 40, 40-44, 408
N.Y.S.2d 649, 650-52 (Sup. Ct. N.Y. County 1978) (discussing and applying statute and its
amendments); In re Huffard, 85 Misc. 2d 399, 400-03, 381 N.Y.S.2d 198, 197-98 (Sup. Ct.
N.Y. County 1976) (same).
28 Legislative Memoranda, supra note 13, at 3290.
Among these, as noted above, is the necessity for a judicial declaration of incompetence on the part of the individual sought to be protected.

Attachment of the designation "incompetent" to any individual is costly: in time, in judicial resources, in dollars, and perhaps most of all, in personal rights and reputation. Note, however, that the requirement of an adjudication of incompetence also protects the incapacitated individual, in that certain civil rights cannot be lost absent a finding of incompetence. Nonetheless, reduction of the frequency with which this label is attached to incapacitated individuals to those cases in which it is truly necessary is a laudable goal, one which the New York Legislature sought to achieve by creating a less intrusive alternative to the committee procedure. Sound policy supported the Legislature's actions; in many situations there is no need to declare an individual incompetent solely for the purpose of ruling on the appropriateness of appointing a surrogate manager for the individual's property. This is particularly true when the need for surrogate management is expected to be short-lived, as in the first hypothetical situation posed at the beginning of this article. For those whose incomes and assets are relatively small, reduction of the costs associated with appointment of a surrogate is preferable, further supporting the idea of conservatorship. The Legislature's view that conservators are preferred is reflected in its 1974 enactment of section 78.02 of the Mental Hygiene Law, which provides that

[p]rior to the appointment of a committee . . . it shall be the duty of the court to consider whether the interests sought to be protected could best be served by the appointment of a conservator. The court shall not make a finding that a person is incompetent . . . unless the court first determines that it would not be in such

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person's best interests to treat him as suffering substantial impairment under [the conservatorship statute].

This preference for conservatorships is justified by their "'lesser intrusion into the rights of the individual . . . .'" Often the appointment of a conservator, which avoids the stigma and loss of civil rights associated with a declaration of incompetence, is to be preferred. The thesis of this article, however, is that this statutory "preference" favoring the appointment of conservators has spawned results that are potentially—and actually—far more intrusive of individual rights than has been recognized. Moreover, these results have occurred alongside contemporaneous developments in New York law governing health-care decisionmaking with which they are at best inconsistent.

B. Problems

One criticism levelled at the conservatorship proceeding is mentioned above—its cost and cumbersomeness. The problems to be addressed here, however, are different. They arise out of two sections of the Mental Hygiene Law: that which outlines the powers and duties of the conservators and that which creates the statutory preference for conservators over committees. Section 77.19, which sets forth a conservator's powers and duties, provides that the "court order appointing a conservator shall set forth . . . the court approved plan for the preservation, maintenance, and care of the conservatee's income, assets and personal well-being . . . ." Under the authority of this ambiguous statutory reference

31 N.Y. MENTAL HYG. LAW § 78.02 (McKinney 1978). See also id. at § 77.04 (allowing court to treat petition for declaration of incompetency and appointment of committee as petition for appointment of conservator); In re Seronde, 99 Misc. 2d 485, 496, 416 N.Y.S.2d 716, 723 (Sup. Ct. Westchester County 1979) ("preference for conservatorship . . . should be used in all cases").
32 Seronde, 99 Misc. 2d at 496, 416 N.Y.S.2d at 723-24 (quoting J. ZUSMAN & W. CARNAHAN, MENTAL HEALTH: NEW YORK LAW & PRACTICE § 17.01 (1976)).
33 See infra notes 51-77 and accompanying text.
34 See infra notes 94-101 and accompanying text.
35 See N.Y. MENTAL HYG. LAW § 77.19 (McKinney 1978); supra note 15.
36 See N.Y. MENTAL HYG. LAW § 78.02 (Mckinney 1978); supra text accompanying note 31.
37 N.Y. MENTAL HYG. LAW § 77.19 (McKinney 1978) (emphasis added). The words "personal well-being" were added to the statute in 1974, but were left undefined. The legislative history accompanying the 1974 amendments, however, continued to emphasize the property-management aspects of conservatorship and distinguished carefully between the roles of committees and conservators. See Memorandum of State Executive Department, re-
to "personal well-being," to what extent may health-care and other "nonproperty" decisions be made on behalf of conservatees by their conservators?

Consider the situation of the man whose condition is described in the first hypothetical fact pattern. His inability may well be limited to a temporary incapacity to manage his financial affairs. But he is alert, oriented, and certainly capable of making other, more personal decisions—such as health-care decisions—for himself. In the absence of a showing that he is incapable of making health-care decisions, his right to make those decisions himself is clearly protected by law: a long and well-established principle is that a competent adult "has a right to determine what shall be done with his own body . . . ."38 That right is not likely to be disregarded, as the New York Court of Appeals has recently reaffirmed in Rivers v. Katz,39 making clear that even mental illness sufficient to justify involuntary commitment does not of itself signify incapacity to make treatment decisions.40 Nonetheless, once this man becomes a

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38 In re Storar, 52 N.Y.2d 363, 376, 420 N.E.2d 64, 70, 438 N.Y.S.2d 266, 272, cert. denied, 454 U.S. 958 (1981); Schloendorf v. Society of New York Hosp., 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914). In Schloendorf, the court stated that every person "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. at 129-30, 105 N.E. at 93.


40 Id. at 484-87, 485 N.Y.S.2d at 342-44, 504 N.Y.S.2d at 77-81.
“conservatee,” the likelihood is greater that he may improperly be viewed as incapacitated with respect to health-care decisions, and that those decisions may be assigned to his conservator.

Contrast with his situation that of the man described in the second fact pattern. He too is in need of someone to manage his financial affairs, and for that purpose the appointment of a conservator would be appropriate. Given the statutory preference for the appointment of conservators over the appointment of committees, it is quite likely that a court would appoint a conservator should such an appointment be sought. This man’s need, however, is unfortunately not likely to be limited to a need for surrogate property management. Should he remain in his noncognitive state—which appears likely—he will also remain incapable of making more personal decisions, such as decisions concerning the health-care he will receive. Thus, unlike the first situation, a true decisionmaking void exists if the conservator’s authority is limited, as it should be, to property-management decisions.

C. Filling the Decisionmaking Void

The conservator’s statutory obligation to provide for the conservatee’s “personal well-being,” was created in 1974 but left undefined by the statute or its legislative history. That obligation, coupled with the statutory presumption favoring the appointment of conservators and an understandable reluctance on the part of the judges to stigmatize individuals with the label “incompetent” when such a label may be avoided, has produced a situation in which personal, and not purely “property,” decisions are being made by conservators for individuals who remain unprotected by any adjudication of their incapacity to make such decisions for themselves. This insidious development is particularly ironic in view

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41 See infra notes 65-71 and accompanying text.
42 See infra notes 51-64 and accompanying text.
44 That such a separate adjudication is indeed required by law is supported by the New York Court of Appeals’ recent decision in Rivers v. Katz, 67 N.Y.2d 485, 494, 497, 495 N.E.2d 337, 341-42, 344, 504 N.Y.S.2d 74, 78-79, 81 (1986), which held that “neither the fact that appellants are mentally ill nor that they have been involuntarily committed, without more, constitutes a sufficient basis to conclude that they lack the mental capacity to comprehend the consequences of their decision to refuse medication . . .” and requiring, in cases in which the state’s parens patriae power is invoked as the basis for forcing treatment with antipsychotic drugs, a separate “judicial determination of whether the patient has the
of the debate, prior to the enactment of the 1974 amendments, over whether the words “of the property” following the word “conservator” should be retained or deleted from the statute. Following the advice of numerous individuals and groups who feared that deletion would blur, if not eradicate, any distinctions between conservators and committees, the Legislature retained the “property” limitations inherent in conservatorship as originally enacted.\(^4\)

capacity to make a reasoned decision with respect to proposed treatment . . . .” The New York Court of Appeals thus disagreed with the analysis of the United States Court of Appeals for the Second Circuit in Project Release v. Prevost, 722 F.2d 960, 977-81 (2d Cir. 1983), which had found constitutionally adequate the New York regulations governing the right of involuntarily committed patients to refuse antipsychotic medication despite their failure to provide judicial review for such forced treatment decisions. The New York court thus joins the Supreme Judicial Court of Massachusetts in requiring more than mere intra-institutional review of decisions to force treatment on involuntarily committed patients “for their own good.” \(^4\) See Rogers v. Comm’r of Dep’t of Mental Health, 390 Mass. 489, 458 N.E.2d 308 (1983) (requiring, under state common law and statutes, a judicial declaration of incompetence prior to the forced administration of antipsychotic drugs). See also Note, The Right to Refuse Antipsychotic Drug Treatment: Substantive Rights and Procedural Guidelines in Massachusetts, 7 W. New Eng. L. Rev. 125 (1985).

See, e.g., Memorandum from Department of Mental Hygiene, May 16, 1974, reprinted in Bill Jacket to [1974] New York Session Laws, ch. 624, at 9 (deletion of words “of the property” would be “undesirable since it might give some conservators the impression that they could run the lives of their conservatees”); Testimony from Karen Shatkzin, Special Projects Coordinator of the New York City Office for the Aging, before the Assembly Subcommittee on Mental Hygiene, Hearing on Conservatorship, April 3, 1974, reprinted in Bill Jacket to [1974] New York Session Laws, ch. 624, at 5-7 (“By not explicitly stating that the conservatorship is still one of the property exclusively, it may be implicitly construed to grant authority over the person of the conservatee as well . . . . We must safeguard against a conservator who considers it within his authority to place the conservatee in a nursing home—for the sake of the conservatee’s personal well-being, but against his wishes. Without the phrase ‘of the property’ the boundaries of the conservator’s authority in such matters are ambivalent . . . . If a person requires a more complete guardianship, then a petition should be brought for a committee, not a conservatorship”) (emphasis added); Memorandum from New York Department of Social Services, May 14, 1974, reprinted in Bill Jacket to [1974] New York Session Laws, ch. 623, at 5 (objecting to deletion of words “of the property” and noting that power over the person should not be granted absent declaration of incompetency); Statement on Conservatorship Presented to the Subcommittee on Mental Hygiene of the Assembly Standing Committee on Health by Community Service Society of New York, Department of Public Affairs, Committee on Health and Committee on Aging, April 3, 1974, reprinted in Bill Jacket to [1974] New York Session Laws, ch. 623, at 29 (noting Society’s strong opposition “to giving a conservator unlimited power over the person of a conservatee, and [urging] that the limitation in the current law be maintained”).

See Ch. 623, §§ 77.01, 77.03, [1974] N.Y. Laws 921, 922 (McKinney). On May 30, 1974, the legislature enacted Chapter 623, which deleted the words “of the property” from the statute and added the words “personal well-being” to it. \(^4\) On the same day, the legislature enacted Chapter 624, which restored the words “of the property” without deleting the phrase “personal well-being,” see Ch. 624, §§ 77.01, 77.03, [1974] N.Y. Laws 925, 926 (McKinney), thus enhancing the ambiguity of that phrase.
Nevertheless, the distinctions have been blurred. Two different problems have arisen. One, illustrated by the first hypothetical fact pattern, involves the potential for delegation of health-care decisionmaking power in situations in which delegation may be neither necessary nor appropriate. Another, illustrated by the second hypothetical fact pattern, involves delegation of personal decisionmaking power to a conservator under the authority of a statute designed solely to authorize surrogate property-management.

Courts, litigants, and lawyers seem to be assuming the appropriateness of conservators making other decisions—i.e., with respect to health-care—for their conservatees. To some extent this may seem unavoidable: one of the money-spending decisions a conservator must make may concern payment for health-care for the conservatee. The problem is that even a decision concerning the purchase of or payment for health-care may be difficult to distinguish from a more personal decision: the selection of a health-care provider, choices between available health-care options, or, indeed, the decision to accept or refuse treatment.

Underlying the conservatorship scheme is a belief that the incapacity of some individuals extends solely to an inability to manage their property, and that this incapacity may be remedied without displacing their right to make personal decisions. An inability to manage property, after all, does not necessarily signify "incompetence"; therefore, the appointment of surrogate property managers need not be predicated upon declarations of incompetence. As applied to some situations, this view is sound. The misuse of conservatorship in other situations, however, creates concern that a statutory scheme designed to implement laudable goals can be subverted into something that in fact invades the interests it was designed to protect.

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47 For an excellent illustration of the blurring, see Hall, Appointment of a Conservator: A Useful Tool, 58 N.Y. St. B.J. 29, 29 (1986) (replete with references to "conservatee" as "incompetent" and describing conservatorship as "special judicial proceeding to deal with incompetency cases in a dignified and less offensive manner").

48 See infra notes 65-92 and accompanying text.

49 See infra note 56.

50 See, e.g., the hypothetical fact pattern set forth supra at text accompanying note 1.
D. Evidence of "Misuse"

1. Inappropriate Appointments by Courts

The purpose of the conservatorship statute is to authorize "the appointment of a person to manage the property and provide for the maintenance and support of someone unable to provide for himself because of advanced age, illness, or infirmity, but who [is] not so unable to manage his affairs to cause a declaration of his incompetency." If incapacity has reached the level of incompetence, the appropriate court-appointed surrogate is a committee, as was recognized by the trial court in the case of Brother Fox, an eighty-three year old Roman Catholic Marianist brother who suffered a cardiorespiratory arrest during surgery and never regained consciousness. The court in that case properly found that the appointment of a conservator rather than a committee would not be in the best interests of Brother Fox, who was not suffering merely from "a general weakening of his capacities by virtue of advanced age." Rather, his "cognitive powers [had] been destroyed," leading the court to conclude that there could be "no question but that Brother Fox [was] incompetent."

Unfortunately, however, not all courts in New York State have reached appropriate conclusions concerning the choice between a conservator and a committee; accordingly, they have appointed conservators for those whose disabilities are far greater than those for whom conservatorship was intended. In such cases, the suggestion that the proposed conservatee's need for a surrogate is limited to property management is unrealistic. One such case is In re

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53 Eichner, 102 Misc. 2d at 195, 423 N.Y.S.2d at 588.
54 Id. at 195, 423 N.Y.S.2d at 588.
55 Id.
56 In 1966, the New York Law Revision Commission, in recommending the enactment of a conservatorship statute in New York State, explained the purposes of such statutes:
[T]o preserve and care for the property of persons of sound mind who for some cause (usually one other than mental illness) are unable to look after their property themselves. In providing for the appointment of a "conservator" to perform this function they meet a very real need in our society. It frequently happens that an individual requires assistance in the management of his property and business affairs while being quite capable of taking care of himself. Ordinarily a conservator, unlike a guardian, has nothing to do with the care of the person.
Salz, in which the court labelled the need for the appointment of a conservator “undisputed” and went on to address what it saw as the real issue in the case—the identity of the proposed conservator. The court accepted that Sam Salz, the 86-year-old proposed conservatee, was in a “vegetative state”; the medical testimony described him as having “no capacity to talk, no capacity to in any visible way appear that he understands commands or can respond to the most elemental social circumstances, and his level of function approaches what we have officially or medically termed essentially vegetative.” Moreover, there was “no medical precedent for his recovery” from that state. Yet the question whether a conservatorship proceeding was the more appropriate one in this case never arose. That the need for surrogate property management should have been “undisputed” in this case is not remarkable; that the need was seen as limited to surrogate property management is remarkable. It seems likely that an individual in an “essentially vegetative” state is not only incapable of making decisions concerning his property but also lacks decisionmaking capacity with respect to other more personal decisions—such as the choice of medical care, made necessary by that vegetative state, that he will receive.

Although one could assert that such considerations are irrelevant to the decision whether surrogate property management is needed, in reality they are not. For a person whose incapacity arises out of ill health, the need for health care is on-going, and decisions must be made with respect to that care. Once a conservator has been appointed, the possibility arises that the conservator

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88 Salz, 80 App. Div. 2d at 769, 436 N.Y.S.2d at 714.
89 Id.
90 Id.
92 The irony here is that the court, prior to appointing a committee, has the duty to “consider whether the interests sought to be protected could best be served by the appointment of a conservator.” N.Y. MENTAL HYG. LAW § 78.02 (McKinney 1978). No corresponding obligation to raise the issue of the appropriateness of a conservatorship proceeding exists.
93 Cf. In re Von Bulow, 122 Misc. 2d 129, 131, 470 N.Y.S.2d 72, 74 (Sup. Ct. N. Y. County 1983) (discussing declaration of incompetency and appointment of committee for “person in an apparently permanent vegetative state” as “an extreme case, one which might justify summary disposition [on the question of incompetency] if any case can”).
will be consulted concerning, and will make decisions with regard to, the care that the conservatee receives. This is particularly likely because of the evidence that judges, legislators, and litigants and their lawyers are assuming the existence of a conservator’s authority to make such decisions.

2. Improper Delegation of Health Care Decisionmaking Power

The decisionmaking void left by the appointment of a conservator in cases in which the conservatee is also unable to make more personal decisions is a void that must be filled. The need to make health-care decisions, for example, cannot be ignored when health care is needed. Unfortunately, evidence exists that such decisions have been or are being made by conservators, and that such decisionmaking has been viewed as appropriate by courts and by the parties to the litigation.

For example, in In re Grant, a proceeding for judicial settlement of the account of the former conservator of Mary Grant, the lower court disallowed claims for medical services rendered to Ms. Grant at the request of her mother, who was not her conservator. In ruling that the case should be remanded for a hearing on the disallowed claims, the court stated:

It was the duty of Chase, as conservator, to provide for the maintenance, support and personal well-being of the conservatee to the extent of the net estate available. However, Chase’s testimony that he regarded all hospital and medical care as a “family matter” and left such decisions to the conservatee’s mother, indicates that Chase, in fact, delegated his statutory duty to the mother.

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64 See infra notes 65-89 and accompanying text. In In re Ramos, 111 Misc. 2d 1078, 445 N.Y.S.2d 891 (Sup. Ct. Bronx County 1981), the question was whether the court should appoint a conservator following a medical malpractice action in which an infant was awarded a large judgment. The court found no dispute that “the child is hopelessly and irreversibly retarded and otherwise multiply handicapped by virtue of other physical and medical injuries sustained.” Id. at 1078, 445 N.Y.S.2d at 892. The court found guardianship inappropriate because it would terminate when the child reached legal age; yet upon reaching legal age the child would still be unable, because of his injuries, to care for himself or his property. Id. at 1078-79, 445 N.Y.S.2d at 892. It therefore found conservatorship “vital” to the protection of the child’s interests. Id. at 1079, 445 N.Y.S.2d at 892. This case, like Salz and Von Bulow, is one in which the need for surrogate decisionmaking is not, and surely will never be, limited to property management.

65 98 App. Div. 2d 747, 469 N.Y.S.2d 455 (2d Dep’t 1983) (mem.).

66 Id. at 748, 469 N.Y.S.2d at 456.

67 Id., 469 N.Y.S.2d at 457 (citations omitted).
That the court considered the making of health-care decisions within the scope of the powers granted to conservators by the statute is apparent from its reference to the conservator’s “delegation” of his statutory duty.

A similar assumption concerning the powers of a conservator is revealed by the court’s language in *In re Lyon*, a case in which the conservatee’s son appealed the appointment of a non-relative as his mother’s conservator. In denying relief to the son, the court declared:

> Although appellant is willing to waive compensation and to condition his appointment on his being precluded from changing his mother’s medical care without prior court approval, it is clear that he considers her present care to be “squandering” in view of her condition.

It is equally clear that the court shared the son’s assumption that, in the absence of such a condition, the son, as conservator, would be empowered to make health-care decisions for his mother. The same view is reflected in the opinion of the dissenting justice, who believed that the son should have been named conservator. Yet the question whether her incapacity was limited to an inability to manage her property, or extended to an incapacity to make health-care decisions, was not addressed.

Litigants as well as judges view the making of health-care decisions as being within the conservator’s powers. In *In re Salz*, the case in which the identity of the conservator was at issue, both the son and the wife of the proposed conservatee, each of whom wished to be appointed conservator, made such an assumption. The son, in his affidavit, stated:

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69 Id.
70 Id. at 848, 382 N.Y.S.2d at 833.
71 See id. at 849, 382 N.Y.S.2d at 835 (Shapiro, J., dissenting in part).
72 While the son is not depicted as a model of what a son should be, he is the sole beneficiary of the estate and has stipulated not to change his mother’s medical care or place of confinement without prior approval by the court, and to waive any compensation for his services. With those appropriate limitations, he should be appointed as conservator in place of the respondent.
73 Id. (emphasis added, citation omitted).
74 80 App. Div. 2d 769, 436 N.Y.S.2d 713 (1st Dep’t 1981) (mem.).
75 Record on Appeal at 34-35, Salz.
76 Record on Appeal at 11, Salz.
I believe that my father is now receiving competent and appropriate treatment and I would be guided by the recommendations of his physicians.

Of course, my stepmother should be consulted in the care and treatment of my father, and were I appointed conservator her wishes in this regard would be accorded the highest consideration. I will cooperate to the fullest extent with my stepmother concerning my father's course of treatment.\textsuperscript{76}

The wife, who apparently shared the son's view concerning the conservator's powers, stated in her petition: "I intend to continue this care in accordance with the recommendation of Dr. Plum and my husband's other attending physicians."\textsuperscript{76}

These casual assumptions concerning the appropriateness of surrogate health-care decisionmaking, coupled with a failure to address the issue of the individual's incapacity to make the relevant decisions himself, are inconsistent with principles of autonomy and self-determination. Moreover, such assumptions are particularly ironic in light of In re Storar,\textsuperscript{77} in which the New York Court of Appeals declared that treatment choices\textsuperscript{78} should not be made for an incapacitated individual in the absence of clear and convincing evidence that such choices conform to the individual's own wishes as expressed prior to incapacity.\textsuperscript{79}

3. Legislative Reinforcement of the "Misuse"

At the urging of the Law Revision Commission,\textsuperscript{80} the New York Legislature in 1981 undertook to amend well over 100 statutory provisions,\textsuperscript{81} which previously had contained references to the committees of incompetents, so as to "include reference to the ad-

\textsuperscript{76} Record on Appeal at 34-35, Salz (affadavit of Andre Salz).
\textsuperscript{77} Record on Appeal at 11, Salz (petition of Janet Salz).
\textsuperscript{79} See id. at 379, 420 N.E.2d at 72, 438 N.Y.S.2d at 274.
ditional and newer concept of conservators and conservatees." Many of these amendments are unobjectionable; indeed, most are required to recognize the powers of a conservator which are not specifically set forth in an applicable statute. This process of wholesale amendment of at least 70% of the statutes in which the words "committee" or "incompetent" formerly appeared, however, unfortunately resulted in the inappropriate amendment of one section of the Public Health Law. This amendment has served to reinforce the notion that conservators may make health-care decisions.

The amended provision of the Public Health Law, section 2803-c(3), sets forth the rights and responsibilities of patients in certain medical facilities in New York State. These rights include

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82 See Memorandum, supra note 80, at 309.

83 Id. For example, a section of the Banking Law contained provisions concerning acceptance of deposits for credit to executors, administrators, trustees, committees, and guardians but, prior to amendment, failed to "provide for the conservator-conservatee relationship." Id.

84 See id. at 312 (describing Commission's computer search, which unearthed 193 statutory provisions concerning incompetents, "only a few" of which made mention of conservatees).

85 See id. at 311-12. One statement by the Law Revision Commission in its 1981 recommendations to the legislature has perhaps helped to foster the blurring of the conservator/committee distinction discussed supra at note 47 and accompanying text. The Commission said:

The use of the word 'incompetent' . . . implies that a higher degree of disability is required for a declaration of incompetency than for the appointment of a conservator. . . . In practice, if a person's condition were such that either a conservator or a committee could be appointed for him . . . a conservator might be the caretaker of choice since his powers and duties are more flexible . . . [and] because his appointment is less expensive.

Id. This unfortunate statement suggests that the degree of the individual's incapacity is of small significance—and appropriately so.

86 N.Y. PUB. HEALTH LAW § 2803-c(3) (McKinney 1985). This section provides in pertinent part:

3. Said statement of rights and responsibilities shall include, but not be limited to the following:
   a. Every patient's civil and religious liberties, including the right to independent personal decisions and knowledge of available choices, shall not be infringed and the facility shall encourage and assist in the fullest possible exercise of these rights.
   b. Every patient shall have the right to have private communications and consultations with his or her physician, attorney, and any other person.
   c. Every patient shall have the right to present grievances on behalf of himself or herself or others, to the facility's staff or administrator, to governmental officials, or to any other person without fear of reprisal, and to join with other patients or individuals within or outside of the
the right to: present grievances, manage financial affairs, have privacy in treatment, be free from mental and physical abuse, and "to receive adequate and appropriate medical care, to be fully informed of his or her medical condition and proposed treatment unless medically contraindicated, and to refuse medication and treatment after being fully informed of and understanding the consequences of such actions."87 Prior to 1981, subdivision (j) of section 2803-c(3) provided that in event of an adjudication of incompetency, the patient's committee was to exercise these rights

facilities to work for improvements in patient care.

d. Every patient shall have the right to manage his or her own financial affairs, or to have at least a quarterly accounting of any personal financial transactions undertaken in his or her behalf by the facility during any period of time the patient has delegated such responsibilities to the facility.

e. Every patient shall have the right to receive adequate and appropriate medical care, to be fully informed of his or her medical condition and proposed treatment unless medically contraindicated, and to refuse medication and treatment after being fully informed of and understanding the consequences of such actions.

f. Every patient shall have the right to have privacy in treatment and in caring for personal needs, confidentiality in the treatment of personal and medical records, and security in storing personal possessions.

g. Every patient shall have the right to receive courteous, fair, and respectful care and treatment and a written statement of the services provided by the facility, including those required to be offered on an as-needed basis.

h. Every patient shall be free from mental and physical abuse and from physical and chemical restraints, except those restraints authorized in writing by a physician for a specified and limited period of time or as are necessitated by an emergency in which case the restraint may only be applied by a qualified licensed nurse who shall set forth in writing the circumstances requiring the use of restraint and in the case of use of a chemical restraint a physician shall be consulted within twenty-four hours.

i. A statement of the facility's regulations and an explanation of the patient's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of the other patients.

j. A statement that should the patient be adjudicated incompetent and not be restored to legal capacity, or if a conservator should be appointed for the patient, the above rights and responsibilities shall be exercised by the appointed committee or conservator in a representative capacity.

k. Every patient shall have the right to receive upon request kosher food or food products prepared in accordance with the Hebrew orthodox religious requirements . . . .

87 Id. at § 2803-c(3)(e) (emphasis added).
and responsibilities in a representative capacity. In 1981, as part of this wholesale amendment of statutory provisions referring to incompetence, the Legislature amended subsection (j) to allow for a conservator to exercise the rights of the patient.

This amendment, although dissimilar to the other amendments bearing on fiduciary responsibilities, and therefore perhaps inadvertent, unfortunately lends credence to the view that conservators may appropriately make health-care decisions. Presumably it would permit, for example, a conservator to make the decision to refuse medication and treatment on behalf of the conservatee. Moreover, this could be done despite the absence of any adjudication of the conservatee’s incapacity to make that decision himself. The amendment was a serious error on the Legislature’s part: it appears to sanction the making of significant personal decisions by surrogates appointed according to a scheme set up to authorize substitute property management.

4. Summary

Evidence exists, then, to indicate that significant personal decisions are being made under the authority of a statute enacted to authorize surrogate property management. And this evidence may reveal only the “tip of the iceberg”, large numbers of cases in this

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88 See N.Y. PUB. LAW § 2803-c(3)(j) (McKinney 1975) (current version at N.Y. PUB. HEALTH LAW § 2803-c(3)(j) (McKinney 1985)). The “old” section 2803-c(3)(j) states: “A statement that should the patient be adjudicated incompetent and not be restored to legal capacity, the above rights and responsibilities shall be exercised by the appointed committee in a representative capacity.” Id.

89 N.Y. PUB. HEALTH LAW § 2803-c(3)(j) (McKinney 1985). For text of statute, see supra note 86.

90 Indeed, the New York Attorney General apparently has reached just that unfortunate conclusion, in an opinion discussed infra at text accompanying notes 95-98. See 1984 Op. N.Y. ATT’Y GEN. F84-16, at 61 n.4 (Dec. 28, 1984) (“A conservator . . . may be judicially appointed to act as a patient’s health care representative”).

91 Additional objectionable legislative language appears in a recently enacted portion of the Mental Hygiene Law. It is Article 80, entitled “Surrogate Decision-Making for Medical Care and Treatment.” N.Y. MENTAL HYG. LAW §§ 80.01-80.13 (McKinney Supp. 1987). The statute creates an extra-judicial mechanism for consenting to or refusing major medical treatment on behalf of residents of mental hygiene facilities who lack capacity to consent or refuse for themselves. Unfortunately, however, the statute defines as ineligible for its surrogate decisionmaking process those “persons with legal guardians, committees or conservators who are legally authorized, available and willing to make such health care decisions.” Id. at § 80.03(b) (emphasis added).

92 Judicial opinions sometimes refer to conservatees as “incompetent,” thus ignoring the intended distinction. See, e.g., In re Scrivani, 116 Misc. 2d 204, 206, 210, 455 N.Y.S.2d 505, 508, 510 (Sup. Ct. N.Y. County 1982), in which the court noted:
area probably go unreported, yielding the likelihood that large-scale misunderstanding exists but has not been recognized. The evidence of misunderstanding that is apparent, however, should not be ignored; it should be dealt with in a fashion that recognizes that decisions being made by conservators which should not be made by them in some cases, must nonetheless be made by someone. An alternative scheme must be created—one that protects the rights and interests of incapacitated individuals to the fullest extent possible.

III. SOLUTIONS TO THE PROBLEMS

A. In General

Part of the solution lies in scrupulous judicial attention to the uses being made of conservatorships, in particular to the powers being exercised by conservators in making health-care decisions. The decisionmaking power of the conservator should be limited to financial questions, for example, the choice of the third-party payor best able to accommodate the conservatee’s health-care needs. But this is only an incomplete solution because it does not address the underlying problem that still remains: the need for other, more personal health-care decisions to be made.\(^3\) It is easy to understand how courts, conservators, and litigants have slipped into this situation. Someone must fill the decisionmaking void; the very presence of a conservator whose responsibility includes the “personal well-being” of a conservatee is likely to result in that “someone” being the conservator.

This article proposes a solution that addresses the underlying

\[^3\] Other courts distinguish conservators from committees on grounds having nothing to do with the “competence” of the incapacitated individual. See *In re Huf-fard*, 85 Misc. 2d 399, 401-02, 381 N.Y.S.2d 195, 197-98 (Sup. Ct. N.Y. County 1976), in which the court stated, “[i]t was not contemplated that assets of the amount owned by the Conservatee herein would be administered under Article 77 of the Mental Hygiene Law. They would more likely be administered by a committee appointed under Mental Hygiene Law Article 78.”

problem of the need to make health-care decisions. It suggests that the durable power of attorney, already extensively promoted as an alternative to the property-management aspects of conservatorship, be adopted as the ideal method for health-care decisionmaking in the event that a surrogate becomes necessary. People for whom conservators are appointed generally do not lack decision-making capacity for their entire lives. Their incapacity, while sometimes difficult to define, may develop over time or may appear suddenly; often, however, it follows a lifetime of decisionmaking capacity. At some point during that lifetime in which capacity is neither questioned nor questionable, an individual is capable of choosing some trustworthy person to make decisions in the event of his incapacity. Any competent individual is permitted by law to do that now, at least with respect to decisions concerning financial matters. This article takes the position that to exclude from those powers that may be delegated the power to make health-care decisions is utterly unrealistic — since such exclusion ignores the reality that these decisions must be made — and creates the situation in which the interests of the individual are invaded to an unacceptable degree.

B. Durable Power of Attorney

Like most other jurisdictions, New York provides no explicit statutory authorization for the delegation of the power to make health-care decisions. New York’s Attorney General, in an opinion that relies on principles of agency law as well as the legislative history of New York’s durable power of attorney statute, has taken the position that a durable power of attorney “cannot be used to delegate generally to an agent the authority to make health care decisions on behalf of an incompetent principal.” Although the Attorney General recognizes that “the issue is not free from doubt,” he concludes that the most an individual can accomplish

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94 See President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatment 145-47 (1983) [hereinafter cited as President’s Commission Report]. A few states, however, have explicitly authorized delegation of health-care decisionmaking. See, e.g., CAL. CIVIL CODE §§ 2430-2444 (Deering 1986) ("Durable Power of Attorney for Health Care"); DEL. CODE ANN. tit. 16, § 2502(b), (c) (1983) (agent can be appointed to accept or refuse medical treatment for incapacitated principal); PA. CONS. STAT. ANN. § 20-5603(h) (Purdon Supp. 1986) (Power of Attorney to arrange for and consent to medical procedures).


96 Id. at 60.
with a durable power of attorney is “to delegate specifically to an agent the responsibility to communicate the principal’s decision to decline medical treatment under defined circumstances.”

The Attorney General’s opinion unfortunately fails to recognize the distinction between the making of health-care decisions and the other powers it says also cannot be delegated (i.e., the power to vote, the power to marry). Unlike those decisions, decisions concerning health care must be made. To suggest that an individual has the power to delegate other very significant life decisions but cannot delegate to someone he trusts the power to make decisions that must be made leaves the individual at the mercy of decisions made by someone he may well not trust. Moreover, because these decisions must be made, then they must be delegated in those circumstances in which the individual can no longer make them. The sole question, then, is: who does the delegating? The only answer that makes sense is one that allows the individual to do it.

Although the Attorney General is perhaps wrong about the scope of the powers properly delegable under present law, more explicit statutory authorization for such delegation is desirable and perhaps, as a practical matter, necessary. If the best that a health-care provider’s lawyer can say is that sound arguments support the view that an individual may delegate health-care decisionmaking, the provider who honors the decisions of an attorney-in-fact cannot be certain that a court, in subsequent litigation, will not label the provider’s behavior negligent. Doctors and other health-care providers, therefore, who already feel assailed by malpractice litigation or the potential for it, must take risks if they honor the decisions of an attorney-in-fact in the absence of statutory approval of that practice. Their likely unwillingness to take such risks will mean that their patients’ choices will not be respected.

Even a definitive court decision accepting the principle of delegation might not be adequate to assuage the fears of providers.

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97 Id. at 59. Anticipation of all circumstances that could arise, however, is unlikely. Marzen, Medical Decisionmaking for the Incompetent Person: A Comprehensive Approach, 1 Issues in L. & Med. 293, 300 (1986); Columbia Note, supra note 93, at 1001.


99 See Columbia Note, supra note 93, at 1008-30 and President's Commission Report, supra note 94, at 146-47 for discussions of the arguments in favor of delegation of health-care decisionmaking in the absence of explicit statutory authorization.

100 See Columbia Note, supra note 93, at 1010-11.

101 See id. at 1011.
Witness, for example, the ongoing debate concerning the legal validity of a living will in New York State. It is quite clear that the New York Court of Appeals, in In re Storar, reaffirmed the principles of autonomy and self-determination underlying the concept of the living will; the court, however, offered little guidance concerning the way to give effect to those rights of autonomy and self-determination when the patient can no longer exercise them himself. The most that can be said about Storar is that in that case the court found “compelling” the proof of Brother Fox’s wishes. The Court of Appeals apparently felt satisfied with the reliability of the evidence — its reliability as an indicator of what Brother Fox would have said had he been able to express his wishes. Accordingly, it seems that in any other case in which “it is claimed that a person, now incompetent, left instructions to terminate life sustaining procedures when there is no hope of recovery” and in which there exists equally reliable proof — oral or written — of the person’s choices, a New York court, applying Storar, would find it appropriate to honor that person’s wishes. The difficulty is that Storar is essentially all that can be relied upon when one asserts that living wills are valid in New York State. Because the Legislature has not enacted a statute governing living wills, and because the court in Storar set forth no guidelines to answer any number of questions that might arise in a particular situation, no one can be sure what type of document would pass the test of va-
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validity in New York State. Too many questions have been left open: What formalities must be observed in order to create a valid living will? For how long a time is such a document valid? How precise must the language be in describing the circumstances under which treatment is refused? Accordingly, although the Court of Appeals in Storar reaffirmed the principles of autonomy and self-determination and was sufficiently impressed, on the facts of that case, with the reliability of the evidence of the patient's wishes to give effect to those wishes, those advising health-care providers cannot articulate clearly for their clients how to recognize whether a living will is valid or invalid. By contrast, in states in which statutory authority for living wills exists, requirements for validity are set forth precisely. Similarly, statutes enacted to authorize the delegation of health-care decisionmaking to an agent can establish the particular requirements that must be met in order to make the delegation valid and to protect the rights of the principal in the event that the agent is called upon to exercise the delegated power.

No sound reason not to authorize such delegation exists. The question that remains is: what safeguards and requirements should be written into a statute authorizing the delegation of health-care decisionmaking?

IV. PROPOSAL

Although numerous issues could be, and have been, discussed in connection with the durable power of attorney for health-care

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110 It should be noted that 35 states and the District of Columbia have enacted legislation that "institutes formalities and standards" for "Living Wills." See generally Marzen, supra note 97, at 293-94 & nn.1, 2 (general listing of statutes).


112 See, e.g., CAL. CIVIL CODE § 2432 (Deering 1986) (requirements and form for durable power of attorney to make health care decisions). One commentator notes an additional reason why a precise statutory scheme is desirable, observing that California's statute "requires that a principal must expressly authorize the agent to make medical decisions. The power may not be implied from a 'general power of attorney,' authorizing the agent to perform 'all acts' for the principal. This precaution is warranted to prevent inadvertent delegation of medical decisionmaking authority." COLUMBIA Note, supra note 93, at 1022-23 (footnote omitted).

113 See, e.g., KAN. STAT. ANN. § 65-28,103(c) (1985) (principal can add specific directions to Living Will).
decisionmaking,\textsuperscript{114} this article focuses primarily on those issues that are most significant: the determination of decisionmaking incapacity and the establishment of the standards by which an agent makes decisions on his principal’s behalf. Parts A and B below discuss these issues at length; part C addresses briefly several other issues; and part D makes several suggestions concerning the language and form of any document granting the authority to make health-care decisions.

A. Decisionmaking Capacity

1. The Issues

Presumably, no valid delegation of health-care decisionmaking may occur unless at the time of the delegation the principal is competent to make it. Accordingly, procedural requirements intended to assure that the individual has the competence to execute a durable power of attorney should be incorporated into any statute authorizing delegation of health-care decisionmaking. Living will statutes, already in existence in a number of jurisdictions, generally include such requirements;\textsuperscript{115} they are not particularly controversial and need not be discussed in depth.

Another much thornier problem concerning decisionmaking capacity exists, however. Assuming the existence of a valid delegation from principal to agent, and also assuming some deterioration in the principal’s decisionmaking capacity\textsuperscript{116} subsequent to the delegation, at what point in the process of deterioration should the agent be consulted, and how should that point be described? A number of the statutes authorizing living wills and durable powers of attorney prescribe the language to be used in documents governed by them.\textsuperscript{117} This article does not debate the desirability of this practice; to the extent that a “form” document is required, however, its language should reflect that the optimal balance has

\textsuperscript{114} See, e.g., Columbia Note, supra note 93.


\textsuperscript{116} President’s Commission Report, supra note 94, at 121 & n.1. In some cases the absence of decisionmaking capacity will be obvious (i.e., the patient is comatose). Of concern here are the cases in which capacity appears to be impaired or diminished rather than absent. See, e.g., In re Spring, 380 Mass. 629, 405 N.E.2d 115 (1980).

been struck between protection of both the principal's interest in autonomy and the interest of the principal and others in the expeditious, inexpensive exercise of the delegated power. At what point, then, should health-care providers seek their answers concerning treatment choices from the agent rather than the principal, and what language should be used to aid the providers in identifying this point?

The paramount interest to be protected is the individual's interest in autonomy. The opportunity to delegate, in and of itself, protects that interest: presumably an individual making such a delegation chooses his agent carefully, with an eye toward delegating this power to someone he can trust will endeavor to replicate his own decisionmaking process. Nonetheless, once the agent rather than the principal is making the decisions, the chance of an "erroneous" decision — erroneous in the sense that it in fact is not faithful to the principal's wishes — increases. Too hasty a resort to the agent, therefore, threatens the principal's autonomy. By contrast, excessive reluctance to resort to the agent may result in "erroneous" decisions being made by an individual incapable of being true to his own wishes. What, then, should be the definition of decisionmaking incapacity?

At the outset, it should be clear that any reference to the term "incompetence" should be avoided in the effort to create such a definition. To conclude that decisionmaking incapacity sufficient to trigger the agent's authority does not exist until the principal reaches the point of "incompetence" is unsatisfactory. First, the word itself carries too much baggage, suggesting a need for resort to the cumbersome legal machinery,

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with all of its costs, that the use of a power of attorney seeks to avoid. Moreover, use of the term "incompetence" reintroduces the issue of stigmatization, therefore perhaps creating a disincentive to execution of a durable power of attorney. Accordingly, any language written to describe the degree of incapacity that will make appropriate the agent's exercise of power should avoid the term "incompetence."

In their 1977 article in the American Journal of Psychiatry,\[10\] Roth, Meisel, and Lidz describe five "tests" of decisionmaking capacity\[20\] and illustrate the confusion and difficulty encountered in

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\[1\] See supra text accompanying notes 27-34.

\[10\] Roth, Meisel & Lidz, Tests of Competency to Consent to Treatment, 134 Am. J. Psychiatry 279 (Mar. 1977).

\[20\] See id. at 280-82. The authors use the term "competency." See id. at 279. This
efforts to apply these tests. They emphasize, however, that in any situation, and whichever "test" is chosen, the question of impaired decisionmaking capacity is much less likely to arise in the absence of a treatment refusal by the individual whose capacity is at issue: physicians' bias in favor of treatment that they recommend may cause them to consider somehow less relevant the mental state of a person who, regardless of a perhaps diminished decisionmaking capacity, has made the "right" decision.

The test the authors label "most respectful of the autonomy of patient decision making" is titled "Evidencing a Choice." This test requires merely that the individual choose; no evaluation of the quality of his decision (i.e., others' view of the appropriateness of the outcome of his decisionmaking process) need be undertaken. The authors consider this a "low" test of capacity because it "does not fully assure patients' understanding of the nature of what they consent to or what they refuse . . . ."

The second test is titled "'Reasonable' Outcome of Choice." It evaluates an individual's "capacity to reach the 'reasonable,' the 'right,' or the 'responsible' decision." This test, which is "biased in favor of decisions to accept treatment," is considerably less respectful of individual autonomy than the first.

A third test, titled "Choice Based on 'Rational' Reasons," looks to "whether the patient's decision is due to or is a product of mental illness." The authors are relatively critical of this test, in part because it can "too easily become a global indictment of the [decisionmaking capacity] of mentally disordered individuals," and in part because of the "difficulty of distinguishing rational from irrational reasons and drawing inferences of causation between any irrationality believed present and the valence (yes or no) of the patient's decision."

article uses the term "decisionmaking capacity" instead.

1 See id. at 280-82.
2 See id. at 281.
3 Id. at 280 (footnote omitted).
4 Id.
5 Id.
6 Id.
7 Id. (footnotes omitted).
8 Id. at 281.
9 Id.
10 Id. (footnotes omitted).
11 Id.
12 Id.
A fourth test is titled "The Ability to Understand." It focuses on the individual's ability "to understand the risks, benefits, and alternatives to treatment," requiring a level of understanding that "would be manifested by a reasonable person provided a similar amount of information." Choices that seem "unwise" would survive this test so long as the individual making them shows "sufficient ability to understand information about treatment, even if in fact he or she weighs this information differently from the attending physician."

The fifth and final test is that of "Actual Understanding." Application of this test confers on the physician "an obligation to educate the patient and directly ascertain whether he or she has in fact understood. If not, according to this test the patient may not have provided informed consent." To explain this test the authors compare it with the fourth one:

Unlike the ability-to-understand test, in which the patient's comprehension of material of a certain complexity is used as the basis for an assumption of comprehension of other material of equivalent complexity (even if this other material is not actually tested), the actual understanding test makes no such assumption. It tests the very issues central to patient decision making about treatment.

The authors' conclusion, after describing and evaluating these five tests, is that the test of decisionmaking capacity actually applied "combines elements of all of the tests," with "the circumstances in which [capacity] becomes an issue determin[ing] which elements of which tests are stressed and which are underplayed." But their most significant conclusion is that, in practice, "a test of [capacity] is applied that will permit the treatment to be administered irrespective of the patient's actual or potential understanding."

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133 Id. at 281.
134 Id.
135 Id. at 282.
136 Id. at 281.
137 Id. at 282.
138 Id. (footnote omitted).
139 Id.
140 Id.
141 Id.
142 Id. at 283.
When there is a favorable risk/benefit ratio to the proposed treatment in the opinion of the person determining [capacity] and the patient consents to the treatment, there does not seem to be any reason to stand in the way of administering treatment. To accomplish this, a test employing a low threshold of [capacity] may be applied to find even a marginal patient competent so that his or her decision may be honored . . . [W]hen the risk/benefit ratio is favorable and the patient refuses treatment, a test employing a higher threshold of [capacity] may be applied . . . Under such a test even a somewhat knowledgeable patient may be found incompetent so that consent may be sought from a substitute decision maker and treatment administered despite the patient’s refusal.\(^{143}\)

Such a situation, in which only the “wrong” decision triggers an inquiry into decisionmaking capacity, is of course threatening to the individual’s interest in autonomy. It is also potentially threatening to the health care provider: the consent to treatment by an individual with impaired decisionmaking capacity is no more “valid” than his refusal.\(^{144}\) Moreover, once the inquiry is triggered, and the individual’s capacity is scrutinized, the result of the inquiry will be influenced by the evaluator’s underlying attitudes concerning the importance of individual autonomy in the first place.\(^{145}\)

Those evaluators to whom individual autonomy is paramount will be more likely to draw the lines that preserve the individual’s capacity to make his own choices;\(^{146}\) those evaluators whose views are

\(^{143}\) Id.


\(^{145}\) Compare Lane v. Candura, 6 Mass. App. Ct. 377, 376 N.E.2d 1232 (Mass. App. Ct. 1978) with Dep’t of Human Services v. Northern, 563 S.W.2d 197 (Tenn. Ct. App.), appeal dismissed, 436 U.S. 923 (1978). In Lane, the patient refused to consent to amputation of her gangrenous foot. See Lane, 6 Mass. App. Ct. at 381, 376 N.E.2d at 1234. The court held that “the irrationality of her decision does not justify a conclusion that [the patient] is incompetent in the legal sense. The law protects her right to make her own decision to accept or reject treatment, whether that decision is wise or unwise.” Id. at 383, 376 N.E.2d at 1235-36. In Northern, however, a similarly afflicted patient who refused consent to amputation was adjudicated incompetent for the purposes of deciding whether the procedure should be performed. See Northern, 563 S.W.2d at 214 (Drowota, J., concurring). The court concluded, “[w]hile this finding was made more difficult by Miss Northern’s apparent ability to grasp facts not related to the condition of her foot, it is nonetheless correct.” See id. The Lane opinion, then, arguably reflects a philosophy more protective of individual autonomy than that of the Northern decision.

\(^{146}\) In answering a question about forced medical intervention, Thomas Szasz has said: “I have no objection to medical intervention vis-a-vis persons who are not protesting . . .
more paternalistic will draw lines that enable achievement of the outcome that appears to be in the individual's best interests. That the outcome of an inquiry into decisionmaking capacity can depend so heavily on the evaluator's personal philosophy is troubling; it need not, however, be quite so troubling if a durable power of attorney exists.

2. A Resolution of the Issues

This article suggests that one way of coping with the problems inherent in finding a test of capacity that adequately protects the principal's interests is to require that the agent, who has been chosen by the individual whose capacity is at issue, concur in the determination that the principal lacks decisionmaking capacity.

Roth, Meisel, and Lidz, and the courts in those cases raising issues of capacity, appear to be discussing a different sort of situation: one in which taking the decision out of the individual's hands is likely to mean giving that decision to a stranger or at best to a relative or friend whose appropriateness as a surrogate deci-

[for example,] somebody who is lying in bed catatonic and the mother wants to get him to the hospital and the ambulance shows up and he just lies there." McDonald, And Things Get Rough, PSYCHIATRIC NEWS, Nov. 5, 1975, at 13-14 (1975) (quoted in Roth, Meisel & Lidz, supra note 119, at 280).

147 The court in Lane v. Candura quoted the testimony of two psychiatrists whose views concerning Mrs. Candura's competence differed:

When asked to explain why his opinion differed from that of Dr. Kelley, Dr. Zeckel answered, "I think it is just a personal philosophy type of thing where I believe the person[s] themselves ought to be given the benefit of the doubt as to what they want to do with their lives, whereas, Dr. Kelley, I guess, is more protective. I can't really speak for him but his general philosophy is different from mine." Dr. Kelley stated . . . "You know, it comes down really to a philosophical [difference], I hope there is no psychiatric argument in this case. It's the right of a patient to decide they want to die and I spend all my life trying to keep people alive so I take quite a different view."


148 Just as there is no single perfect test of competency, there is no single perfect tester of competency. But surely the issue is not one of purely medical or legal expertise. See generally Meisel, supra note 1, at 450-53. Cf. Rogers v. Comm'r of Dep't of Public Health, 390 Mass. 489, 501, 458 N.E.2d 308, 314 (1983) (legal adjudication of patient incapacity necessary before physician can override patient's refusal of treatment); Rivers v. Katz, 67 N.Y.2d 485, 496, 495 N.E.2d 337, 343, 504 N.Y.S.2d 74, 80 (1986) (determination of capacity "uniquely a judicial, not a medical function").

149 See, e.g., the State Commissioner of Human Services, as in Department of Human Services v. Northern, 563 S.W.2d 197 (Tenn. Ct. App. 1978), or the Executive Director of the Harlem Valley Psychiatric Center, as in Rivers v. Katz, 67 N.Y.2d 485, 495 N.E.2d 337, 504 N.Y.S.2d 74 (1986).
sionmaker has never been recognized by the individual.\textsuperscript{150} In such cases, to err on the side of the individual would be preferable because of the absence of any showing that the proposed surrogate is one whom the individual would have chosen. Accordingly a "low" test of capacity would, as Roth, \textit{et al.} noted, be most respectful of individual autonomy.

The same considerations do not apply to situations in which the individual has chosen to delegate his health-care decisionmaking to an agent. Safeguards adequate to protect individual autonomy are built into the principal-agent relationship: by choosing the proper agent, the principal has more of an opportunity to protect his autonomy to the extent he wishes to protect it.\textsuperscript{161}

Presumably, making the choice to delegate health-care decisionmaking signifies the individual's confidence in the agent, an element lacking in the above cases. Part of that confidence, of course, is a trust that the agent will make the choices that the individual would have made (or at least is the party most likely to be able to do that). Any individual, then, who chooses to appoint such an agent should be advised: 1) to choose someone who will respect his views concerning health-care decisions, and 2) to discuss those views in detail with the agent. Moreover, the individual should be advised to choose an agent who will not be anxious to usurp the principal's power to make his own decisions, that is, someone who will decline to exercise the delegated power unless he is persuaded that sufficient incapacity exists.

A requirement that both agent and physician concur that the principal is incapacitated helps to cure the physician's potential "bias" in favor of treatment identified by Roth, Meisel, and Lidz.\textsuperscript{162} An individual who particularly fears usurpation of his own decisionmaking power can protect himself by, in effect, choosing for himself the evaluator of his capacity or incapacity. He can choose someone whose philosophy concerning autonomy reflects his own.\textsuperscript{163}

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\item \textsuperscript{150} See, \textit{e.g.}, Lane v. Candura, 6 Mass. App. Ct. 377, 376 N.E.2d 1232 (Mass. App. Ct. 1978). In \textit{Lane}, not only was there an absence of such recognition, but also a marked difference in views concerning treatment between Mrs. Candura and her daughter, the party petitioning to be her guardian.
\item \textsuperscript{161} This scheme, of course, is not perfect. No one can be certain how the agent will act when faced with the choice; nonetheless, it is more protective of autonomy than a system in which a stranger is likely to be the evaluator.
\item \textsuperscript{162} See \textit{supra} note 122 and accompanying text.
\item \textsuperscript{163} Allowing the individual to revoke the agency even when incapacitated, as some stat-
Once these safeguards exist, the language describing the degree of incapacity that must exist can be relatively simple, requiring merely the concurrence of agent and physician in the determination that the principal has become incapacitated to make health-care decisions. Such a scheme is neither cumbersome nor stigmatizing, and it helps to prevent “ganging up” on patients whose decisions do not objectively appear to be in their best interests.

B. Standards for Agents’ Decisionmaking

1. Best Interests Versus Substituted Judgment

Courts too numerous to cite have quoted the language made famous by Judge Cardozo in Schloendorff v. Society of New York Hospital: that every person “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.” Often this language is quoted in support of the principle that a competent adult is entitled to refuse recommended medical treatment despite the opinions of others that such treatment is in his best interests. The individual’s right to refuse, however, can in some situations be overridden by the state’s interest, resulting in treat-

utes do, see, e.g., CAL. HEALTH & SAFETY CODE § 7189(a) (Deerring Supp. 1986); DEL. CODE ANN. tit. 16, § 2504(a) (1983), would provide additional protection against the “renegade agent” who too readily concurs that the principal’s “wrong” decision signifies his incapacity. See Columbia Note, supra note 93, at 1023-24 (discussing two such statutory provisions). Allowing such revocation, however, could “seriously disrupt a course of treatment” authorized by the agent. President’s Commission Report, supra note 94, at 152. The President’s Commission concludes that “when disputes arise about such things as the choice made by a proxy or an attempted revocation by an apparently incapacitated principal, a review process [in institutional and perhaps, if necessary, judicial proceedings] will be an important safeguard for the patient’s interests.” Id. If, however, the principal “knows that foregoing a treatment is likely to bring about a period of incompetence prior to death, during which [he] might ask for the treatment,” id. at n.95, he should be entitled to make his directives irrevocable.

184 See infra text accompanying note 190; infra text following note 188 (discussing requirement that agent act in good faith).
185 See, e.g., infra text accompanying notes 169-78 (discussing “idiosyncratic” decisions).
186 211 N.Y. 125, 105 N.E. 92 (1914).
187 Id. at 129-30, 105 N.E. at 93.
The state interests most commonly asserted are: the preservation of life, the prevention of suicide, the protection of innocent third parties, and the protection of the ethical integrity of the medical profession.\textsuperscript{159}

Courts faced with deciding cases concerning individuals who lack decisionmaking capacity generally agree that such individuals have the same rights as those who are presently competent. The problem in these situations, however, is how to give effect to the rights of the individual no longer capable of exercising them. Since the individual is incapacitated, decisions with respect to that individual's medical treatment must be made by a surrogate.

The major issue to be addressed in any surrogate-decision-making situation is the standard by which the surrogate, whoever he may be, makes his decisions. Does the surrogate choose the treatment that appears objectively to be in the "best interests" of the incapacitated individual, or does the surrogate attempt to replicate the individual's own decisionmaking process, thus reaching the outcome the individual would have reached were he capable of deciding?\textsuperscript{161}

No single answer to this question suits all situations. The appropriate answer is heavily dependent upon the identity of the surrogate decisionmaker and the closeness of the surrogate's relationship with the individual.\textsuperscript{162} If, for example, the surrogate is an official of the jurisdiction's department of social services,\textsuperscript{163} chances are that he will know little or nothing that would enable him to replicate the individual's decisionmaking process in any meaningful way. If, on the other hand, the surrogate is a person to whom Veatch refers as a "bonded guardian" because of his close relationship to the individual, the likelihood that the individual's

\textsuperscript{159} See, e.g., Comm'r of Correction v. Myers, 379 Mass. 255, 266, 399 N.E.2d 452, 458 (1979) (finding state's interest in orderly prison administration sufficient to outweigh prisoner's right to refuse hemodialysis).


\textsuperscript{161} This process is known as "substituted judgment." See infra text accompanying notes 165-67.


\textsuperscript{163} See Department of Human Services v. Northern, 563 S.W.2d 197, 205-06 (Tenn. Ct. App. 1978) (Commissioner of Department appointed by court to act on behalf of patient).
own decisionmaking can be replicated is greatly increased.164

"Substituted judgment," the term for surrogate decisionmaking that attempts to replicate the individual's decisionmaking process,165 adheres more closely to the principle of autonomy than a scheme requiring the surrogate to look to the objective "best interests" of the individual. In order for this process of substituted judgment to be meaningful, however, the surrogate must have or be able to obtain substantial familiarity with the views and desires of the incapacitated individual. Veatch argues that "bonded guardians," such as close family members or friends appointed by the court to make decisions for incapacitated individuals, are in a particularly good position to know what those individuals would have wanted.166 His argument concerning bonded guardians is even more powerful in the agency context. When an individual expressly delegates to another his own power to make health-care decisions he is, in effect, choosing his own bonded guardian. If any situation is appropriate for the substituted judgment standard, then, agency is that situation.167 Moreover, substituted judgment would seem the only sensible standard to apply in the agency context: if a best interests standard were to be applied, there would be no need for an agent to be appointed in the first place.

2. Breadth of Agent's "Substituted Judgment" Authority: Protection of Idiosyncratic and Altruistic Views

An issue that arises under the substituted judgment standard is the breadth of the agent's authority under that standard. The agent's discretion under this standard should certainly be no greater than the principal's would be were he capable of making decisions. The principal cannot delegate a power broader than the

164 The best interests and substituted judgment standards are not the only ones that could be employed. The New York Court of Appeals, in In re Storar, declared that the dispositive element is the patient's own wish concerning the particular situation or treatment at issue; in other words, the court recognized the "living will." See In re Storar, 52 N.Y.2d 363, 379-80, 420 N.E.2d 64, 72, 438 N.Y.S.2d 266, 274. The requirement that the individual specify his wishes about every conceivable situation is impossible to meet; moreover, such a requirement is at odds with agency principles.

165 See President's Commission Report, supra note 94, at 132.

166 See Veatch, supra note 162, at 444-47.

167 Such an approach would require rejection of the court's analysis in Storar. In Storar, the fact that the wishes of Brother Fox were well known was dispositive. He had not specifically appointed an agent to carry out his wishes prior to his incapacity. See Storar, 52 N.Y.2d at 371-72, 379, 420 N.E.2d at 68, 72, 438 N.Y.S.2d at 268, 274.
Accordingly, the rights of the individual as exercised by the agent must be limited by the various state interests articulated above.

A more significant question is whether the agent’s authority should be as broad as the principal’s would be were he able to decide for himself. A principal deciding for himself might wish to be somewhat idiosyncratic or altruistic in his choices; such choices are often respected despite their apparent lack of regard for the best interests of the individual making them. For example, a victim of breast cancer who chooses to forego recommended surgical treatment even though the spread of disease in the absence of surgery is likely to result in death might prevail in a lawsuit challenging her right to refuse. Similarly, a victim of trauma who is in need of a blood transfusion but wishes to refuse the transfusion for religious reasons might prevail in a lawsuit challenging his right to refuse. Both these choices could be described as “idiosyncratic” in that they would not be made by a majority of the individuals facing such decisions. Moreover, they do not appear objectively to be in the best interests of the party making them.

Other individual choices, ones which might be described as “altruistic,” are also likely to be respected. People choosing to offer themselves as subjects of research are permitted to do so provided certain guidelines, which are intended to minimize coercion and maximize the exchange of information, are followed by the researchers. Surrogate consent for experimentation, by contrast, is more precisely and narrowly regulated. Accordingly, those lacking capacity to consent for themselves — e.g., fetuses and children — are the subjects of special regulations designed to protect their

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169 See In re Yetter, 62 Pa. D. & C.2d 619, 624 (1973). The court noted Mrs. Yetter’s refusal of surgery was “irrational,” but concluded that an individual should have the greatest possible protection to further his own desires. See id.


171 Using the term in the non-pejorative sense. See for hear/ B. Elliott & R. Goulding, Komodo Dragon, on Bob and Ray—the Two and Only (record album).


173 See id. at §§ 46.201-211 (fetuses) & 46.401-.409 (children); see also N.Y. Comp. Codes R. & Reg. tit. 14, § 27.10(b)(2) (1986) (patients in Mental Hygiene facilities).
interests when surrogates offer them for experimentation.174

Should the agent who believes that his principal would have made an idiosyncratic or altruistic choice be permitted to make that choice on the principal's behalf? Or should the agent's power to make a substituted judgment be more narrowly circumscribed than the principal's authority would be? As a surrogate decision moves closer to the idiosyncratic and farther from a result consistent with the majority view, the fear that the decision may be erroneous — erroneous in the sense that it is unfaithful to the principal's wishes — grows. Because of this potential for error, one could argue that the agent's discretion should be much more limited than the principal's, thus reducing the protection afforded to idiosyncratic choices. The major problem with this approach, however, is that it fails to address the needs of a principal who chooses his agent precisely because he wishes to protect an idiosyncratic view — a decision to forego hemodialysis175 or radical surgery176 or transfusion.177 A solution to this problem would be to require the principal to list with specificity his wishes if they seem idiosyncratic. Unfortunately, however, such a solution restores the dilemma inherent in the drafting of a living will: the impossibility of anticipating all the potential scenarios that could be played out in the future.178 Of course, a principal should not be discouraged from listing particular situations and the treatment he would choose or forego (for example, the Jehovah's Witness who would refuse all blood products), but any absolute requirement of such specificity would seem to defeat the purposes of agency.

At first glance, the issue of altruistic choices may seem a

174 See supra note 159; see also 45 C.F.R. §§ 46.301–306 (1985) (research on prisoners). Section 46.302 explains that additional safeguards are necessary to protect prisoners because they "may be under constraints because of their incarceration which could affect their ability to make a truly voluntary and uncoerced decision whether or not to participate as subjects in research." 45 C.F.R. § 46.302 (1985).

175 See In re Spring, 380 Mass. 629, 405 N.E.2d 115 (1980). In Spring, the court found the "critical" factor to be that the incapacitated patient would not wish to be treated. See id. at 643, 405 N.E.2d at 122. Yet the court wished to emphasize that this finding should be subject to future, expedient review because even the "possibility of some change of circumstance might warrant reconsideration." Id. at 645, 405 N.E.2d at 123.


178 See Columbia Note, supra note 93, at 1001.
clearer one that that of idiosyncratic choices. The decision to offer oneself as a subject of research is not like other health-care decisions: it is a decision easily avoided rather than one that must be made. Simply put, one need not offer oneself for experimentation. One's surrogate, therefore, need not concern himself with that issue.

All this may be true in situations involving research that lacks a therapeutic component, that is, research whose sole object is the benefit of others. Much medical research, however, has therapeutic as well as nontherapeutic components: although its results contribute to a body of medical knowledge, it also offers innovative treatment to someone who may be desperately ill. Barney Clark, the first recipient of a permanent artificial heart, was the subject of such research; there are countless others. When the proposed subject of therapeutic research lacks the capacity to decide about participating, one alternative is to foreclose the opportunity to participate. This would protect the incapacitated individual from being used as an experimental tool, possibly against his will. Another alternative is to permit an agent to consent to some types of experimentation but not all. The third alternative, of course, is to permit the agent the full range of altruistic choices available to the principal.

Veatch suggests that the decisions of those to whom he refers as "bonded guardians" be "reviewed under a reasonableness standard." He would, therefore, permit them the "discretion to deviate from the most reasonable course, provided their judgments about what is in the patient's interest or what is consistent with the patient's desires can be tolerated by the reasonable person." Moreover, Veatch would not label a decision unreasonable "simply because it lack[s] popular acclaim; substantial leeway must be given decisions soundly based on tolerable values and beliefs." A primary focus when treatment is refused by a guardian would be the gravity of the burden to be inflicted by the proposed treatment.

As noted above, a number of Veatch's arguments with respect to bonded guardians fit very nicely into the agency framework: the

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179 Veatch, supra note 162, at 449.
180 Id.
181 Id.
182 Id. at 455-56 (footnotes omitted).
agent would appear to be the ideal bonded guardian. Although one could argue that the agent’s discretion should be broader than that of a bonded guardian because the agent has been selected by the principal, perhaps from among a number of individuals who would have been eligible for selection by a court as a bonded guardian, Veatch’s standard appears to be a sensible and practical one in that it permits the agent to exercise substituted judgment by selecting from among a range of choices yet limits those choices by a familiar standard that is readily capable of application.

This standard would, for example, operate to prevent an agent from refusing treatment that would “with great certainty and simplicity restore a seriously ill [principal] to normal health . . . .” If, however, the benefits of a particular treatment are questionable in view of the grave burdens it would impose, the agent’s decision to forego that treatment seems reasonable. And although Veatch addresses himself to treatment refusal situations, his reasonableness standard would appear to work equally well in situations in which an innovative or experimental therapy is one of the treatment choices offered to the agent: if reasonable people would disagree about the benefits of the treatment as compared with its risks, the agent’s choice of the experimental therapy should be respected.

In summary, then, the agent making a decision on behalf of his incapacitated principal should, first, adhere to any particular decisions and enforce any particular directives the principal made while capable of doing so. In fact, to protect the inviolability of such choices, the principal should be encouraged to set them forth in the document appointing his agent. In the likely event that such decisions either do not exist or do not govern the situation that arises, the agent should enforce the decision he believes the principal would have made in these circumstances; here, the agent’s decisionmaking authority would be limited by a reasonableness standard.

C. Other Issues

Other issues that may be raised in connection with the durable

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183 See supra text accompanying notes 165-67.
184 Veatch, supra note 162, at 449.
185 Cf. id. at 451 (discussing reasonable choice of agent to refuse treatment resulting in minimal benefits and grave burdens).
power of attorney for health-care decisionmaking include: 1) the frequency with which a principal must reaffirm his choices concerning both the identity of his agent and any particular decision he expects that agent to enforce; 2) the requirement that agents and health-care providers act in good faith; and 3) the question whether those who act in accordance with a durable power of attorney should be immunized from liability. Requiring the principal to renew or reaffirm his choices every few years would seem sensible as it would ensure that he took the opportunity to "reconsider the instructions or designation in light of changed circumstances or opinions." 187

The issues of good faith and immunity are more complex. Some of the statutes authorizing living wills immunize from civil and criminal liability physicians who act in good faith188 in accordance with the statute or valid directive executed pursuant thereto. Other statutes, while speaking in terms of "immunity," include a requirement that reasonable care be exercised by the health-care provider189 in order for him to be immune from liability. At least as far as tort liability is concerned, such a statute would appear to give the health-care provider no greater "immunity" than that afforded by general principles of negligence law.

Certainly all actors, agents as well as health-care providers, should be expected to act in good faith. Whether they should be immunized from liability, or at least immunized from liability for all acts involving ordinary negligence rather than gross negligence or more egregious conduct, is a question of policy beyond the scope of this article. Today's climate of caution prompted by fear of lawsuits may create a greater need for confidence on the part of those being asked to engage in behavior with no long history of reassuring outcomes. On the other hand, to the extent that the potential for liability stimulates responsible behavior, the fear of such liability is healthy and should not be eliminated.

D. Summary

The following language is suggested as the heart of any docu-
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ment granting authority to make health care decisions.

If my agent and my physician concur in the determination that I have become incapable of making my own health-care decisions, my agent shall have the power to enforce any health-care decisions I made while I was able to do so. Additionally, my agent shall have the power to make decisions he in good faith believes I would have made for myself concerning selection, acceptance, demand for, or refusal of diagnostic or therapeutic procedures and concerning choices among health-care providers.¹⁹⁰ This language should be followed by a description of any particular health-care decisions the principal wishes the agent to enforce, for example, a demand that nutritional support be continued or a demand that ventilatory support be withdrawn in the event of permanent vegetative coma. Such a document would enable the principal to combine the specificity of a living will with the flexibility of appointing an agent,¹⁹¹ thus protecting particular decisions without being limited by a requirement that all possible future scenarios be anticipated.

V. Conclusion

Usurpation of personal decisionmaking power under the authority of the conservatorship statute offends not only legislative intent but also long-held, fundamental principles of personal rights. This article has attempted to show that such usurpation should not and need not be tolerated.

¹⁹⁰ Numerous discussions with, and suggestions from, Charlotte Buchanan, Esq., gave rise to this language.

¹⁹¹ The New York State Bar Association and the Association of the Bar of the City of New York have jointly recommended enactment of legislation that would authorize both living wills and delegation of health-care decisionmaking authority. NEW YORK STATE BAR ASSOCIATION and ASSOCIATION OF THE BAR OF THE CITY OF NEW YORK, Memorandum in Support of Health Care Decisions Legislation (April 3, 1986). Concern for Dying, an educational council that encourages use of the living will, urges that both a living will and durable power of attorney be executed by individuals wishing to declare in advance their wishes concerning health care. 12 Concern Newsletter no. 3. at 2 (Fall 1986). See also Martyn & Jacobs, Legislating Advance Directives for the Terminally Ill: The Living Will and Durable Power of Attorney, 63 NEB. L. REV. 779, 802-03 (1984) (advocating using living will together with durable power of attorney). Combining the features of both a living will and a durable power of attorney in one document would enable access by any concerned party to all the principal’s advance directives, thus reducing the possibility that action contrary to the principal’s wishes will be taken owing to unavailability of the evidence of those wishes.