BE IT RESOLVED that the American Bar Association encourages the use and recognition of durable powers of attorney for delegating health care decision-making authority in the event of decisional incapacity of the principal. Steps to encourage such use and recognition include:
1. Explicit authorization in state law for recognizing delegations of health care decision-making authority under durable power of attorney laws of the enacting state or that of another state.

2. Procedures to ensure ease of use by the public, with appropriate protections to ensure that delegations of authority are made voluntarily with full appreciation of the consequences.

3. Regulations mandating all health care providers and facilities to (a) have policies in place regarding health care powers of attorney and other advance directives, (b) determine whether or not patients have prepared any such directive, and (c) inform patients of their legal rights to control health care decisions, including the right to appoint an agent or surrogate through a durable power of attorney.

4. Immunity from liability for health care providers who, in good faith and consistent with reasonable medical standards, act in accordance with a health care power of attorney.

5. Educational efforts to ensure that all adults have knowledge of health care powers of attorney and other advance directives and easy access to the means for establishing such directives.
Health care decision-making is an issue that affects every American at one time or another. It always has. But today, the once fairly sharp lines between life and death, health and sickness, and possible interventions are no longer so clear. Medical technology has produced miracles, but the blessings can be mixed for the intended beneficiaries of that technology, and the process of making decisions grows irreversibly more complex.

Health care decision-making issues pose a considerable challenge for the legal system—not because the law is so especially intricate—but because the real issues are more often ones of communication, between patient and family members, and between patient and health care providers. This kind of communication is not easy. Indeed, it is extraordinarily difficult and sensitive because it involves very private, fundamental beliefs and feelings in the context of changing relationships. The relationships among family are changing due to the illness or disability; and on a societal level, the relationships between patients and health care providers are changing due to the specialized, high-technology business growth of the medical profession.

Our legal system has evolved a growing number of legal principles and tools to enable individuals to exercise their autonomy in health care matters. Beginning with the common law right of self-determination and the tort of battery, the law has established and refined principles relating to informed consent, the right to refuse treatment, and the right of privacy. Then, in the mid-1970's, state legislatures became active in developing the concept of the advance directive in the form of the so-called "Living Will." Today, legal practitioners and state legislatures are just beginning to focus attention on a potentially more comprehensive and flexible tool for health care decision-making in the event of incapacity—the durable power of attorney.

All states and the District of Columbia already have general durable power of attorney legislation enabling competent adults to delegate any or all kinds of decisions, as long as not contrary to public policy. The historical function of these laws has been primarily the management of property, but most legal authorities suggest that these laws are perfectly sufficient to enable the delegation of health care decision-making. However, the short-coming of general DPAs is that they lack clear definition of health care decision-making authority, procedures, and protections. This is the chief impediment to their widespread use by the public and acceptance by health care providers. As a result, many more states are likely to consider enacting special health care DPA legislation.
State laws expressly recognizing the use of durable powers of attorney ("DPA"s) for purposes of health care decision-making are a recent phenomenon. Pennsylvania was the first to address health care decision-making in its durable power statute in 1982, by simply adding the power to the list of powers includable in a DPA. California followed shortly in 1983 with the first special health care DPA statute setting forth special rules, procedures, and a model form. As of May 1989, 14 states and the District of Columbia have enacted health care DPA legislation.

Most have chosen the California approach of adopting a special DPA statute. These are:

- California
- District of Columbia
- Idaho
- Illinois
- Indiana
- Nevada
- Rhode Island
- Utah
- Vermont

The others have incorporated health care powers into their general DPA statute. These are:

- Alaska
- New Mexico
- Colorado
- Pennsylvania
- Maine
- Washington

However, Alaska's general DPA statute, enacted in 1988, provides such detailed rules and procedures, including a model form, that it more closely resembles the special health care DPA statutes.

These statutes are not the only legislative provisions relevant to the use of DPAs for health care decisions. Of the 40 jurisdictions that have Living Will laws, the following 14 have provisions in their Living Will law recognizing the authority of an appointed proxy or agent to make decisions regarding the withholding of life-sustaining procedures under limited circumstances:

- Arkansas
- Iowa
- Colorado*
- Louisiana
- Delaware
- Minnesota
- Florida
- Texas
- Hawaii
- Utah*
- Idaho*
- Virginia
- Indiana*
- Wyoming

*These four states have also enacted health care DPA acts

The state of New York has a unique statute prescribing very detailed rules and procedures for issuing orders not to
resuscitate a patient in the event of cardiopulmonary failure (i.e., "Do Not Resuscitate," or "DNR" decisions). Included is the option of appointing a proxy through a power of attorney. However, the single-decision scope of authority is exceedingly limited, and, like Living Will statutes, confined to the context of terminal illness or irreversible coma.

Statutory health care DPAs are still in their infancy, and future legislation is certain to break down some of the existing distinctions and forge new approaches to proxy decision-making. Part of the fuel for this movement has been the growing realization that the wave of Living Will legislation, experienced since the mid-1970's, falls far short of meeting all health care decision-making needs. Almost all Living Will acts apply only in the context of terminal illness or irreversible coma, and all are troubled by formidable problems concerning definitions of "terminal" condition, "imminent death," "life-sustaining procedures," or other elements that are key to their operation. At root, a Living Will directive attempts to foresee and prescribe one's wishes for circumstances that are inherently unforeseeable.

Health care DPAs avoid many of these limitations by establishing a decision-maker, chosen by the principal, who can weigh all the circumstances as they occur and make health care decisions for the decisionally incapacitated principal, as close to the values and wishes of the principal as practically possible.

The American Bar Association is already on record endorsing the "Uniform Rights of the Terminally Ill Act", passed by the National Conference of Commissioners on Uniform State Laws ("NCCUSL") in 1985. The Act is intended to promote uniform legislation for recognizing and implementing Living Wills. However, this Act, even with amendments adopted by NCCUSL in 1988, does not provide for the appointment of a health care decisions agent generally, outside the context of terminal illness.

NCCUSL adopted a "Model Health Care Consent Act" in 1982 that includes a provision for proxy health care decision-makers. However, as a "model" rather than a "uniform" act, NCCUSL has not been recommended to the ABA for adoption. The existing "Uniform Durable Power of Attorney Act" (1979) and the new "Uniform Statutory Power of Attorney Act" (1988) are both silent on health care decision-making delegations.
This proposal encourages the use and recognition of durable powers of attorney for health care decisions. It further suggests several steps that could be taken to achieve this goal, ranging from explicit statutory recognition and protections to prevent abuse to mandatory facility/provider policies, immunity, and educational efforts. The underlying importance and impact of this proposed policy is to enhance and preserve individual autonomy and privacy in the increasingly complex sphere of health care.

Respectfully submitted,

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Commission on Legal Problems of the Elderly

L. Henry Gissel, Jr.
Real Property, Probate, and Trust Law Section

Don M. Jackson
Senior Lawyers Division

August 1989

6163A
1. Summary of Recommendation(s).

Encourages the use and recognition of durable powers of attorney for delegating health care decision-making authority and suggests five steps for accomplishing this goal.

2. Approval by Submitting Entity.

May 19, 1989, approved by Commission.
May 12, 1989, approved by Senior Lawyers Division.
April, 1989, approved by Section on Real Property, Probate and Trust Law.

3. Previous submission to the House or relevant Association position.

The ABA has previously endorsed the Uniform Durable Power of Attorney Act (1979) and the Uniform Rights of the Terminally Ill Act (1985).

4. Need for Action at This Meeting.

The Commission is developing educational materials.

5. Status of Legislation. (If applicable.)

No federal legislation. Fourteen states and D.C. have enacted health care power of attorney laws. Many more are considering such legislation.

6. Cost to the Association. (Both direct and indirect costs.)

None.

7. Disclosure of Interest. (If applicable.)

None
8. **Referrals.**

Commission on the Mentally Disabled  
Section on Family Law  
Section on General Practice  
Section on Individual Rights and Responsibilities  
Section on Science and Technology  
Section on Young Lawyers

9. **Contact Person.** (Prior to meeting.)

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10. **Contact Person.** (Who will present the report to the House.)

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