

## Oklahoma Advance Directive Act: Denying Choice to Those Who Cannot Choose — A Proposal for Legislative and Practical Alternatives\*

### *I. Introduction: Who Can Speak for the Incapacitated in Oklahoma?*

The State of Oklahoma designates end-of-life decision-making authority in the Advance Directive Act (ADA).<sup>1</sup> A person may always make her<sup>2</sup> own end-of-life decisions if she has the ability to decide, or capacity, to do so.<sup>3</sup> The situation is more complex, however, when the person lacks capacity to make such decisions, as demonstrated by the situation of Terri Schiavo.<sup>4</sup> Where a person lacks capacity, the ADA allows for several means of end-of-life decision making. The first statutory method allows a person, the declarant, to make her own end-of-life decisions in advance through the creation of a Living Will.<sup>5</sup> To establish the Living Will, the declarant need only complete the relevant section in the statutory form entitled Advanced Directive for Health Care (ADHC).<sup>6</sup> The second statutory method allows a person, the principal, to designate a Health-Care Proxy (Proxy), the agent, to make decisions in the principal's place.<sup>7</sup>

The principal may also execute a document known as a Durable Power of Attorney (DPOA), which appoints an agent with the ability to make health-care decisions for the principal.<sup>8</sup> If the principal is incapacitated, however, the agent may only make decisions if the grant of authority in the DPOA fulfills

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1. 63 OKLA. STAT. §§ 3101.1-16 (2001 & West, Westlaw through 2006 2d Reg. Sess.).

2. Feminine pronouns will be used as inclusive of both genders for the sake of brevity.

3. Act of May 17, 2006, ch. 171, § 6, 2006 Okla. Sess. Laws 729, 735 (to be codified at 63 OKLA. STAT. § 3101.4(A)).

4. *See generally* Schiavo v. Schiavo, 403 F.3d 1289 (11th Cir. 2005). Schiavo was an incapacitated woman from Florida who required the artificial administration of food and water to live. Schiavo's parents challenged, unsuccessfully in the end, her spouse's efforts to remove the life-sustaining treatment. This case drew widespread attention, both from the media and the federal government, and brought end-of-life decision-making issues to the forefront of the national discourse.

5. *See* Act of May 17, 2006, § 6, 2006 Okla. Sess. Laws at 735 (to be codified at 63 OKLA. STAT. § 3101.4(C)).

6. *See id.*

7. *See id.* at 738.

8. 58 OKLA. STAT. § 1072 (2001).

the conditions of a Proxy appointment.<sup>9</sup> The agent must make these decisions according to the wishes of the principal, if such are known.<sup>10</sup> The Living Will is considered to be authoritative evidence of such desires, if the principal has one.<sup>11</sup> If the principal has not executed a Living Will, other evidence of the principal's decisions may be utilized.<sup>12</sup> If the principal's desires for the situation are unknown, the agent must make the decision in her best reasonable judgement, taking into account the "values of the declarant and what the wishes of the declarant would be based upon those values."<sup>13</sup>

If a person does not utilize one of the statutory means of making end-of-life decisions after incapacitation, the ADA "creates no presumption concerning . . . the use, withholding, or withdrawal of life-sustaining treatment."<sup>14</sup> Under the Oklahoma Hydration and Nutrition for Incompetent Patients Act, however, every incompetent patient is presumed to have directed her health care providers to provide her with life-sustaining hydration and nutrition.<sup>15</sup> Therefore, despite the lack of a "presumption" in the ADA, the likely outcome is that an individual who does not have an ADHC or another allowed method will continue to receive life-sustaining treatment, regardless of her actual wishes.<sup>16</sup>

At first glance, Oklahoma seems to have developed a comprehensive and flexible plan for individuals to either make or delegate end-of-life decisions. Nevertheless, there are two major problems with the Oklahoma ADA and the statutory ADHC that it provides. This note will analyze the Oklahoma ADA and propose legislative revisions while also detailing methods that legal practitioners should apply to increase the ADHC's current usefulness to clients. Part II of this note surveys the history of the ADA, both in the national arena and more directly in Oklahoma. After tracing its statutory evolution, Part III will examine the two major deficiencies of the ADA, its lack of clarity and its lack of flexibility, and analyze the impact those

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9. *Id.* § 1072.1(B)(1)(b).

10. Act of May 17, 2006, § 15, 2006 Okla. Sess. Laws at 744 (to be codified at 63 OKLA. STAT. § 3101.16).

11. *Id.* § 6, 2006 Okla. Sess. Laws at 739 (to be codified at 63 OKLA. STAT. § 3101.4(C)).

12. *Id.* § 15, 2006 Okla. Sess. Laws at 744 (to be codified at 63 OKLA. STAT. § 3101.16).

13. *Id.*

14. *Id.* § 11, 2006 Okla. Sess. Laws at 742 (to be codified at 63 OKLA. STAT. § 3101.12(D)).

15. 63 OKLA. STAT. § 3080.3 (2001).

16. See David Orentlicher, *The Limits of Legislation*, 53 MD. L. REV. 1255, 1280-81 (1994) (discussing the substantial likelihood that physicians will override even the known wishes of a patient if the physician believes the unrequested treatment to be in the patient's best interest). If physicians sometimes will continue treatment, despite the known wishes of a patient to discontinue that treatment, the treatment will almost certainly be continued when the physician does not know of any particular wish of the patient.

deficiencies may currently have on citizens of Oklahoma. In addition, Part IV will provide proposals the Oklahoma legislature should use in reforming the ADA. Lastly, Part V will discuss some current methods legal practitioners should employ to compensate for the deficiencies in the ADHC.

## *II. How We Got Here: Arriving at the ADA*

The Oklahoma ADA has roots extending as far back as the English common law.<sup>17</sup> In order to understand how the statute has come to exist in its present form, it will be necessary to take a closer look at the statute's background. First, this part will examine the evolution of the rights at stake, with particular emphasis accorded to constitutional rights. Second, this part will survey the nationwide attention given to those rights. Lastly, this part will closely analyze the particular evolution of the Oklahoma law on this subject.

### *A. Balancing Rights: An Individual's Autonomy and Privacy vs. the State's Interest in Preserving Life*

In the common law tradition, "even the touching of one person by another without consent and without legal justification was a battery."<sup>18</sup> This concept of bodily integrity extended to the requirement of informed consent prior to application of medical treatment.<sup>19</sup> Therefore, any nonconsensual medical care was a battery and was hence illegal.<sup>20</sup> Carrying this formulation to the next logical step indicates that a person can refuse even lifesaving medical attention.<sup>21</sup> In other words, a person could choose to die by refusing medical care. This legal principle presupposed the ability of the individual to make the decision whether to consent to medical care.<sup>22</sup>

The seminal case discussing the right to refuse treatment in light of an individual's incapacity is *In re Quinlan*.<sup>23</sup> Leaving aside the common law tradition of informed consent, the New Jersey Supreme Court held that the incapacitated individual had a right of privacy under the United States Constitution to terminate treatment.<sup>24</sup> Because this right of privacy exists as

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17. *See Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 269 (1990).

18. *Id.*

19. *Id.*

20. *Id.*

21. *Id.* at 270.

22. *Id.* at 269 (quoting *Schloendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914)) ("Every human being of adult years and *sound mind* has a right to determine what shall be done with his own body . . . ." (emphasis added)).

23. 355 A.2d 647 (N.J. 1976).

24. *Id.* at 663.

an unwritten constitutional doctrine, and is not absolute, the court balanced it against the state's interest in preserving life.<sup>25</sup> The court held that the state's interests in preserving the sanctity of human life and the professional autonomy of physicians were insufficient in comparison with the individual's right of privacy, noting particularly that the state interest weakened as the diagnosis worsened and the required treatment increased.<sup>26</sup> The court then concluded that "[t]he only practical way to prevent destruction of the right is to permit the guardian and family of [the individual] to render their best judgement . . . as to whether she would exercise it in these circumstances."<sup>27</sup> Despite the *In re Quinlan* court's novel constitutional interpretation, most courts continued to reference the common law doctrine of informed consent in right to refuse treatment cases.<sup>28</sup> Some courts applied both the doctrine of informed consent and the constitutional right of privacy.<sup>29</sup>

The United States Supreme Court examined these issues in *Cruzan v. Director, Missouri Department of Health*.<sup>30</sup> When an individual became incapacitated in Missouri, the state required clear and convincing evidence of the person's intent in order for a surrogate to exercise the individual's right to refuse treatment, specifically nutrition and hydration, on the individual's behalf.<sup>31</sup> Missouri had also enacted a Living Will statute as a procedural safeguard in the surrogate decision-making process.<sup>32</sup> The Supreme Court held that this evidentiary requirement was a valid exercise of the state's interest in preserving life.<sup>33</sup> The individual's assumed right to refuse

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25. *Id.* at 663-64.

26. *Id.* at 664.

27. *Id.*

28. *See, e.g., In re Storar*, 420 N.E.2d 64 (N.Y. 1981); *In re Conroy*, 486 A.2d 1209 (N.J. 1985) (basing the holding solely on the doctrine of informed consent). One important result of basing such decisions on the doctrine of informed consent is that the individual's ability to reject medical treatment is subject to state regulation as it alters the common law. *See Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 269 (1990) (recognizing the state's right to compel clear and convincing evidence as a procedural requirement). If the decisions were based on the constitutional right of privacy, states might not be able to exercise the wide discretion they now currently enjoy in this issue. *Cf. Roe v. Wade*, 410 U.S. 113 (1973) (expanding right of privacy to include woman's choice to terminate pregnancy); *Griswold v. Connecticut*, 381 U.S. 479 (1965) (expanding right of privacy to include issues of contraception).

29. *See, e.g., Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417 (Mass. 1977). The U.S. Supreme Court assumed such a right in *Cruzan*. *Cruzan*, 497 U.S. at 279.

30. 497 U.S. 261.

31. *Id.* at 280, 282.

32. *Id.* at 268. For the text of the Missouri statute, see MO. REV. STAT. § 459.010-.055 (2000).

33. *Cruzan*, 497 U.S. at 280.

treatment through a surrogate was not overly burdened by the requirement of clear and convincing evidence of her intent.<sup>34</sup> The Court found that the standard of proof functioned to “instruct the factfinder concerning the degree of confidence our society thinks he should have in the correctness of factual conclusions for a particular type of adjudication,”<sup>35</sup> and “serve[d] as a ‘societal judgment about how the risk of error should be distributed between the litigants.’”<sup>36</sup> In other words, the higher standard of proof is permissible given the heightened importance of the issues at stake, namely the life of an incapacitated individual. Announced in 1990, this decision was issued against a backdrop of various contemporary state statutes concerning end-of-life decision making. The following addresses the nationwide attention given to these issues.

### *B. Nationwide Attention*

The National Conference of Commissioners on Uniform State Laws passed the Uniform Rights of the Terminally Ill Act (Uniform Rights Act) in 1985.<sup>37</sup> This act was modified by the version enacted in 1989.<sup>38</sup> The first of the two main revisions to the Uniform Rights Act allowed a declarant to appoint an agent to make decisions regarding whether to withdraw or withhold life-sustaining treatment.<sup>39</sup> The second revision allowed a list of other people, in priority order, to consent to the withholding or withdrawing of life-sustaining treatment, even without a declaration by the qualified individual.<sup>40</sup> These acts foresaw the rise of end-of-life decision making as a national issue and provided the basic plan by which many states addressed the subject of the right of privacy in death. Moreover, these acts helped shape the requirements for the exercise of that right. Several states adopted the 1985 version of the Uniform Rights Act.<sup>41</sup> Six jurisdictions, including Oklahoma, substantially adopted the 1989 version.<sup>42</sup> Twenty-six other jurisdictions, while not adopting

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34. *Id.* at 283.

35. *Id.* at 282 (quoting *Addington v. Texas*, 441 U.S. 418, 423 (1979)).

36. *Id.* at 283 (quoting *Santosky v. Kramer*, 455 U.S. 745, 755 (1982)).

37. UNIF. RIGHTS OF THE TERMINALLY ILL ACT (1985), Historical Notes (repealed 1989), 9C U.L.A. 339 (2001).

38. UNIF. RIGHTS OF THE TERMINALLY ILL ACT (1989), Historical Notes, 9C U.L.A. 311 (2001).

39. *Id.* § 2, 9C U.L.A. 318-20.

40. *Id.* § 7, 9C U.L.A. 328-29.

41. UNIF. RIGHTS OF THE TERMINALLY ILL ACT (1985), Table of Jurisdictions Wherein Act Has Been Adopted, 9C U.L.A. 339. The six states are Alaska, Arkansas, Iowa, Missouri, Nebraska, and North Dakota. *Id.*

42. UNIF. RIGHTS OF THE TERMINALLY ILL ACT (1989), Table of Jurisdictions Wherein Act Has Been Adopted, 9C U.L.A. 311. The six jurisdictions are Montana, Nevada, Ohio,

either version of the Uniform Rights Act, have adopted either a living-will or natural-death statute.<sup>43</sup> The remainder of the states have either adopted the Uniform Health-Care Decisions Act or some other legislation authorizing the use of an ADHC.<sup>44</sup>

After the Supreme Court's decision in *Cruzan*, a significant number of states enacted legislation on the issue of life-sustaining treatment.<sup>45</sup> Due to the expanding legal issues at stake, however, the legislation was "fragmented, incomplete, and sometimes inconsistent."<sup>46</sup> Therefore, the National Conference of Commissioners on Uniform State Laws enacted a new statute, the Uniform Health-Care Decision Act (Uniform Decisions Act), in 1993.<sup>47</sup> This statute was intended to clear up the interstate legislative confusion and allow for a nationwide approach.<sup>48</sup> Unfortunately, only eight states enacted the Uniform Decisions Act, thereby limiting the effectiveness of the national approach.<sup>49</sup> Consequently, the real task of understanding a state's laws on end-of-life decision making must entail analyzing the state statutory scheme and history.

### C. Oklahoma's Efforts

Oklahoma's first attempt to require evidence of an individual's intent with regard to end-of-life decision making was called the Oklahoma Natural Death Act (Natural Death Act).<sup>50</sup> Enacted in 1985,<sup>51</sup> this statute was even more

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Oklahoma, Rhode Island, and the U.S. Virgin Islands. *Id.* See generally Oklahoma Rights of the Terminally Ill or Persistently Unconscious Act, ch. 114, 1992 Okla. Sess. Laws 364 (codified as amended at 63 OKLA. STAT. §§ 1301.1-.16 (2001 & West, Westlaw through 2006 2d Reg. Sess.)).

43. UNIF. RIGHTS OF THE TERMINALLY ILL ACT (1989), Adoption of Other Living Wills or Natural Death Acts, 9C U.L.A. 313. The twenty-six jurisdictions are Arizona, Colorado, Connecticut, the District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Kansas, Louisiana, Maryland, Minnesota, New Hampshire, New York, North Carolina, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming. *Id.*

44. See UNIF. HEALTH-CARE DECISIONS ACT, Prefatory Note, 9 U.L.A. pt. IB, at 84 (2005).

45. *Id.*

46. *Id.*

47. *Id.*, Historical Notes, 9 U.L.A. pt. IB, at 83.

48. *Id.*, Prefatory Note, 9 U.L.A. pt. IB, at 84.

49. *Id.*, Table of Jurisdictions Wherein Act Has Been Adopted, 9 U.L.A. pt. IB, at 83. The eight states are Alabama, Alaska, California, Delaware, Hawaii, Maine, Mississippi, and New Mexico. *Id.*

50. See 63 OKLA. STAT. §§ 3101-3111 (1991), *repealed by* Oklahoma Rights of the Terminally Ill or Persistently Unconscious Act, ch. 114, § 20, 1992 Okla. Sess. Laws 364, 375.

51. Oklahoma Natural Death Act, ch. 64, 1985 Okla. Sess. Laws 223 (codified as amended at 63 OKLA. STAT. §§ 3101-3111 (1991)).

limited than Oklahoma's present provisions. An individual's ADHC was only effective if she "qualified."<sup>52</sup> The Natural Death Act defined qualification as the period when an individual was terminally ill and had communicated the existence of the ADHC to medical personnel.<sup>53</sup> An individual was terminally ill if she was going to die within hours or days.<sup>54</sup> The Natural Death Act made no provision for individuals in a persistent vegetative state. Furthermore, the act did not provide for a Proxy of any kind.

Procedurally, the Natural Death Act required the declarant to additionally and specifically sign the portion of the document relating to the withdrawal of nutrition and hydration and to have the ADHC notarized.<sup>55</sup> The instructions recorded in the ADHC were considered dispositive of the declarant's wishes if the declarant had executed the document after she became qualified under the Natural Death Act.<sup>56</sup> If the document was executed prior to qualification, then the instructions in the ADHC were only to be considered as evidence of the declarant's wishes.<sup>57</sup> The medical personnel were also required to confirm the instructions in the ADHC with competent patients.<sup>58</sup> According to the Natural Death Act, there was no presumption about a person's wishes outside of what was recorded in the ADHC.<sup>59</sup>

In 1992, Oklahoma enacted the Rights of the Terminally Ill or Persistently Unconscious Act (RTIPUA), which was largely an adoption of the 1989 version of the Uniform Rights Act, though it bore some differences.<sup>60</sup> The first major difference between the RTIPUA and the Uniform Rights Act was the definition of "terminal condition." The RTIPUA defined terminal condition as "an incurable and irreversible condition that, *even with the administration of life-sustaining treatment*, will, in the opinion of the attending physician *and another physician*, result in death within six months."<sup>61</sup> The Uniform Rights Act (1989), by contrast, defined a terminal condition as "an incurable and irreversible condition that, *without the administration of life-sustaining treatment*, will, in the opinion of the

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52. See 63 OKLA. STAT. § 3103(D).

53. *Id.* § 3102(7).

54. *Id.* § 3102(8).

55. *Id.* § 3103(C)-(D).

56. *Id.* § 3107(C).

57. *Id.* § 3107(D).

58. *Id.* § 3107(B).

59. *Id.* § 3110(A).

60. Oklahoma Rights of the Terminally Ill or Persistently Unconscious Act, ch. 114, 1992 Okla. Sess. Laws 364 (codified as amended at 63 OKLA. STAT. §§ 1301.1-.16 (2001 Supp. 2005)).

61. 63 OKLA. STAT. § 3101.3 (2001) (emphasis added).

attending physician, *result in death within a relatively short time.*<sup>62</sup> Changing the requirement that death occur within “a relatively short time” to requiring death within “six months” seemed to indicate a broader class of individuals to whom the statute would apply.

On the other hand, the differences in the RTIPUA also indicated the Oklahoma legislature’s desire to limit the applicability of the statute. Requiring that death occur within the time frame of six months, “even with the administration of life-sustaining treatment,”<sup>63</sup> seriously reduced the class of individuals to whom the statute would apply, because in order to die while receiving life-sustaining treatment, an individual would need to be far more ill than an individual who would die soon without such treatment. Further, the requirement that two doctors agree on the diagnosis, though most likely a wise provision, limited the applicability of the statute to individuals about whom two medical professionals can agree. Lastly, even the time frame of *six* months demonstrated a legislatively imposed outer limit on who could qualify under the RTIPUA.

Other differences between the RTIPUA and the Uniform Rights Act also merit mention. The RTIPUA added the concept of “persistently unconscious” as another triggering condition for the ADHC, which widened the applicability of the document.<sup>64</sup> Conversely, the RTIPUA limited the declarant to declaring her wishes solely through the ADHC.<sup>65</sup> The Uniform Rights Act allowed declarants to designate another individual to make those decisions.<sup>66</sup> As a result of these changes, the RTIPUA significantly modified the statutory form to include a persistently unconscious provision, a Proxy section, and a provision governing the result of a conflict between the decision of the Proxy and the instructions in the Living Will.<sup>67</sup> Lastly, the RTIPUA omitted the Uniform Rights Act provision of a priority list for who may give consent if the individual in question has not made a declaration of intent.<sup>68</sup> This exclusion limited the applicability of the RTIPUA to those individuals who had made an effective declaration, as compared to the potential applicability of the Uniform Rights Act to anyone, whether she had made a declaration or not. Overall, the RTIPUA diminished the flexibility and

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62. UNIF. RIGHTS OF THE TERMINALLY ILL ACT (1989) § 1, 9C U.L.A. 316 (2001) (emphasis added).

63. 63 OKLA. STAT. § 3101.3.

64. *Id.*; see also 63 OKLA. STAT. § 3101.4 (Supp. 1994) (amended 1995).

65. 63 OKLA. STAT. § 3101.16 (2001).

66. UNIF. RIGHTS OF THE TERMINALLY ILL ACT (1989) § 2, 9C U.L.A. 319-20 (2001).

67. 63 OKLA. STAT. § 3101.4 (2001).

68. See generally UNIF. RIGHTS OF THE TERMINALLY ILL ACT (1989) § 7, 9C U.L.A. 328-29 (2001).

applicability of the Uniform Rights Act, while extending its provisions to the persistently unconscious.

The RTIPUA was amended three times between 1992 and 2003.<sup>69</sup> The first amendment, enacted in 1995, added a section to the ADHC allowing for specific organ donation and mandating that medical professionals unwilling to provide the declarant's requested treatment provide such treatment pending transfer to a willing provider.<sup>70</sup> The 1998 amendment added a requirement that transfer of a patient to a willing physician is required if the current attending physician is unwilling to comply with the declarant's instructions in the ADHC.<sup>71</sup> The 2003 amendment changed the signature lines on the ADHC to initial spaces and updated the year on the form from "19\_\_" to "20\_\_."<sup>72</sup>

The amendments prior to 2004 were relatively minor. In 2004, however, Oklahoma made major changes, especially to the ADHC.<sup>73</sup> The Living Will section was completely reformatted.<sup>74</sup> The section was broken into two parts, with one covering life-sustaining treatment generally and the other covering nutrition and hydration specifically.<sup>75</sup> Additionally, the 2004 amendment significantly altered the Proxy section by removing the declarant's instructions to the Proxy.<sup>76</sup> These instructions had previously contained essentially the same questions as the Living Will section, but were specifically directed to the Proxy.<sup>77</sup> Most importantly, the 2004 amendment removed the provision that allowed the declarant to indicate whether her wishes should control in case those wishes conflicted with her Proxy's decision in a particular

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69. See Act of May 26, 2003, ch. 270, 2003 Okla. Sess. Laws 1102; Act of Apr. 28, 1998, ch. 164, 1998 Okla. Sess. Laws 511; Act of Apr. 13, 1995, ch. 99, 1995 Okla. Sess. Laws 388.

70. Act of Apr. 13, 1995, ch. 99, §§ 1-2, 1995 Okla. Sess. Laws at 390-92 (codified at 63 OKLA. STAT. § 3101.4 (2001); *id.* § 3101.9 (Supp. 1997) (amended 1998)).

71. Act of Apr. 28, 1998, ch. 164, § 1, 1998 Okla. Sess. Laws at 512 (codified at 63 OKLA. STAT. § 3101.9 (2001)).

72. Act of May 26, 2003, ch. 270, § 1, 2003 Okla. Sess. Laws at 1103-06 (codified at 63 OKLA. STAT. § 3101.4(B) (Supp. 2003) (amended 2004)).

73. See Act of Apr. 27, 2004, ch. 166, 2004 Okla. Sess. Laws 754.

74. See *id.* § 1, 2004 Okla. Sess. Laws at 754-56 (codified at 63 OKLA. STAT. § 3101.4(B) (Supp. 2005) (amended 2006)).

75. *Id.* The 2006 amendment to the RTIPUA rendered these changes to the ADHC moot. See *infra* text accompanying note 86.

76. Act of Apr. 27, 2004, ch. 166, § 1, 2004 Okla. Sess. Laws at 756-57 (codified at 63 OKLA. STAT. § 3101.4(B) (Supp. 2005) (amended 2006)).

77. See 63 OKLA. STAT. § 3101.4(B) (Supp. 2003).

circumstance.<sup>78</sup> This removal and its potential ramifications are discussed in detail below.<sup>79</sup>

In 2006, Oklahoma amended the RTIPUA again, changing the act's name to the Advance Directive Act (ADA) and making four significant alterations.<sup>80</sup> The first change was the addition of a new triggering situation — the end-stage condition, which is defined as “a condition caused by injury, disease, or illness, which results in severe and permanent deterioration indicated by incompetency and complete physical dependency for which, to a reasonable degree of medical certainty, treatment of the irreversible condition would be medically ineffective.”<sup>81</sup> Secondly, the amendment provides that a declarant who has been diagnosed as pregnant may refuse treatment through the ADHC if she “specifically authorized, in her own words, that during a course of pregnancy, life-sustaining treatment . . . shall be withheld or withdrawn.”<sup>82</sup> Thirdly, the amendment provided a standard for physicians making determinations under the ADA.<sup>83</sup> The standard provides that, “the physician shall use his or her best judgment applying with ordinary care and diligence the knowledge and skill that is possessed and used by members of the physician's profession in good standing engaged in the same field of practice at that time, measured by national standards.”<sup>84</sup>

The 2006 amendment's most important change, however, was a complete revision of the ADHC.<sup>85</sup> The form now presents the end-of-life decisions organized by triggering situation, as opposed to a life-sustaining treatment

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78. Act of Apr. 27, 2004, ch. 166, § 1, 2004 Okla. Sess. Laws at 757 (codified at 63 OKLA. STAT. § 3101.4(B) (Supp. 2005) (amended 2006)). The deleted provision read as follows:

IV. Conflicting Provision

I understand that if I have completed both a living will and have appointed a health care proxy, and if there is a conflict between my health care proxy's decision and my living will, my living will shall take precedence unless I indicate otherwise.

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(initials)

*Id.*

79. *See infra* Part III.A.1.

80. Act of May 17, 2006, ch. 171, §§ 3-15, 2006 Okla. Sess. Laws 729, 733-44 (to be codified at 63 OKLA. STAT. §§ 3101.1-.4, .8-.16)

81. *Id.* § 5, 2006 Okla. Sess. Laws at 734 (to be codified at 63 OKLA. STAT. § 3101.3(4)).

82. *Id.* § 7, 2006 Okla. Sess. Laws at 740 (to be codified at 63 OKLA. STAT. § 3101.8(C)).

83. *Id.* § 9, 2006 Okla. Sess. Laws at 741-42 (to be codified at 63 OKLA. STAT. § 3101.10(B)).

84. *Id.*

85. *See id.* § 6, 2006 Okla. Sess. Laws at 735-40 (to be codified at 63 OKLA. STAT. § 3101.4(C)).

section and a nutrition and hydration section.<sup>86</sup> There are three options presented under each triggering situation: (1) refusing life-saving treatment, but accepting hydration and nutrition; (2) refusing life-saving treatment, hydration, and nutrition; and (3) accepting life-saving treatment, hydration, and nutrition.<sup>87</sup> Each triggering situation section also has an option pointing the reader to a fourth section, wherein the declarant may set out more detailed instructions.<sup>88</sup> The instructions for this section inform the declarant that she may describe individual triggering situations or provide more specific instructions regarding the pre-defined triggering situations.<sup>89</sup> The amendment also includes a statement in the Proxy section that provides that a declarant deliberately declines to appoint a proxy by not appointing a Proxy in that section.<sup>90</sup> Having thus examined the history of the present ADA, the analysis of the statute itself may proceed.

### *III. The Denial of Choice: Limitations of the ADHC*

Legal decisions, particularly those in the context of end-of-life decision making, must be made in an adequate manner. Adequacy in end-of-life decision making refers to two goals. The first goal of adequacy is objective effectiveness, or in other words, ordered decision making. To achieve objective effectiveness, the decision must allow the individual to obtain the result she intended. The second goal is legal validity. To achieve legal validity, end-of-life decisions must conform to the evidentiary and procedural requirements established by law. These goals form the basis of an adequate legal decision in the end-of-life context.

Clarity and flexibility are the minimum requirements for adequate decision making, or in other words, achieving the goals of objective effectiveness and legal validity.<sup>91</sup> First, the individual must be able to understand the situation

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86. *Id.*, 2006 Okla. Sess. Laws at 736-37.

87. *Id.*, 2006 Okla. Sess. Laws at 736-38.

88. *Id.*

89. *Id.*, 2006 Okla. Sess. Laws at 738.

90. *Id.*

91. See Jason Scott Johnston, *Uncertainty, Chaos, and the Torts Process: An Economic Analysis of Legal Form*, 76 CORNELL L. REV. 341, 357 (1991) (discussing the perfect legal decision as having precise clarity and flexibility); Spencer Overton, *Rules, Standards, and Bush v. Gore: Form and the Law of Democracy*, 37 HARV. C.R.-C.L. L. REV. 65 (2002) (discussing the respective benefits of clarity and flexibility in legal decision making); Steven L. Schwarcz, *A Fundamental Inquiry into the Statutory Rulemaking Process of Private Legislatures*, 29 GA. L. REV. 909, 928-33, 989 (1995) (identifying clarity and flexibility, among others, as two prime constraints on the legislative decision-making process); Robert Ziff, *For One Litigant's Sole Relief: Unforeseeable Preclusion and the Second Restatement*, 77 CORNELL L. REV. 905, 923-24 (1992) (recognizing the tension between clarity and flexibility, but also acknowledging the

that requires the decision and the choices available to her. Others must then be able to understand the individual's decision in the context of that situation. These requirements relate to the element of clarity. Clarity furthers the goal of objective effectiveness by permitting the individual to express her choice accurately and by allowing those implementing the individual's decision to interpret her choice. Clarity also furthers the goal of legal validity by ensuring that the decision conforms to the legal requirements and will be understood by those in authority.

Secondly, the individual must have valid legal options that reflect her range of choice. This requirement relates to the concept of flexibility. Flexibility furthers the goal of objective effectiveness by allowing the individual to make a decision that reflects her choice. If the range of available legal choices does not include what an individual desires, the decision is not objectively effective as to that individual. Flexibility also furthers the goal of legal validity, though in an indirect fashion by furthering the element of clarity. The more options that are presented to an individual, the greater the range of choice will be. Consequently, the individual will be able to more accurately select an option that reflects her choice. This increased clarity furthers both goals of adequate decision making as discussed above.

As the analysis below demonstrates, the Oklahoma ADA is deficient in both clarity and flexibility. As a result of these deficiencies, Oklahomans are required to make critical decisions without the aid of the clarity and flexibility necessary to make the decisions in an adequate manner. First, citizens of Oklahoma must contend with the lack of clarity in the ADA, which reduces both the individual's ability to understand the nature of the life-and-death issues at stake and the communicative value of the decision between the individual and those in authority. Secondly, citizens are confronted by a narrow, or inflexible, range of options regarding substitute decision makers. This lack of flexibility limits the ability of the individual to make the legal decision that accurately reflects her desire in that situation. These two deficiencies are examined in detail in the following analysis.

#### *A. Clarity in Language*

One of the two major deficiencies of the ADA is lack of clarity. This part will analyze the statute's clarity in two areas: (1) the standard of capacity, and (2) the definition and application of the triggering situations.

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need to balance the two components of decision making).

### 1. *Standard of Capacity*

The first area in which the ADA is unclear centers on the standard of capacity, or lack thereof, required for the instructions in the ADHC to become operative. The ADA provides that an advance directive becomes operative when “1. [i]t is communicated to the attending physician; and 2. [t]he declarant is no longer able to make decisions regarding administration of life-sustaining treatment.”<sup>92</sup> Under the ADHC form, the individual’s “attending physician and another physician” are responsible for “determin[ing] that [the individual is] *no longer able to make decisions* regarding [her] medical treatment.”<sup>93</sup> This formulation is not defined in the ADHC itself, nor in the remainder of the ADA.<sup>94</sup> Several issues stem from this construction.

First, it is unclear what standard the two physicians are meant to use to determine whether an individual can make decisions regarding her medical treatment. This standard could range from a complete lack of cognitive activity to even the most minor degree of temporarily reduced capacity. Further, an individual might make decisions against her best interests. The Oklahoma legislature has not given any guidance as to what standard of capacity physicians should use in these situations.<sup>95</sup> This lack of a standard forces physicians to be influenced by other motivations, such as fear of liability, in making their decisions whether to honor a declarant’s ADHC.<sup>96</sup>

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92. 63 OKLA. STAT. § 3101.5(A) (2001).

93. Act of May 17, 2006, § 6, 2006 Okla. Sess. Laws at 735 (emphasis added) (to be codified at 63 OKLA. STAT. § 3101.4(C)).

94. The ADA defines a “qualified patient” as a declarant “determined to be incapable of making an informed decision regarding health care, including the provision, withholding, or withdrawal of life-sustaining treatment, by the attending physician and another physician who have examined the patient.” *Id.* § 5, 2006 Okla. Sess. Laws at 735 (to be codified at 63 OKLA. STAT. § 3101.3(10)). This definition, however, only clarifies what the physicians must determine insofar as it adds a descriptive term — the decision must be “informed.” The definition is still minimal in spite of this adjective.

95. The ADA does offer a standard for physicians in making decisions, but does not specifically guide the physicians in regard to determining capacity. *See id.* § 9, 2006 Okla. Sess. Laws at 741-42 (to be codified at 63 OKLA. STAT. § 3101.10(B)).

96. *See* Thomas L. Hafemeister, *End-of-Life Decision Making, Therapeutic Jurisprudence, and Preventive Law: Hierarchical v. Consensus-Based Decision-Making Model*, 41 ARIZ. L. REV. 329, 354 (1999) (discussing the legal and financial interests as potential motivations for medical staff to disregard declarants’ wishes); Adam M. Milani, *Better Off Dead than Disabled?: Should Courts Recognize a “Wrongful Living” Cause of Action When Doctors Fail to Honor Patients’ Advance Directives?*, 54 WASH. & LEE L. REV. 149, 167-69 (1997) (identifying and discussing fear of liability and desire for less control over professional actions as reasons for physicians’ failure to honor advance directives); Orentlicher, *supra* note 16, at 1280-99 (discussing evidence demonstrating that physicians override patients’ wishes and

If the physician does not honor the ADHC, the document's effectiveness is negated. This particular shortcoming is remedied somewhat by the fact that an individual who still has some measure of decision-making ability would be able to communicate her desires. Whether those wishes are followed is another matter altogether.

The second issue this "standard" raises is what test of capacity a subsequent judicial body might use. In the same way that physicians must make this determination without a clearly articulated standard of capacity, a judicial body would likely have difficulty in determining such a question in any consistent manner.<sup>97</sup> A determination of capacity is generally a question of fact,<sup>98</sup> but the court could apply a different standard of capacity than the medical personnel and come to the opposite conclusion. Because of the subsequent judicial uncertainty, the determination of capacity by the doctor may also be uncertain and unreliable for the purposes of removing life-sustaining treatment. Thus, the lack of clarity concerning the standard of capacity negatively impacts the doctor-patient relationship in regard to the objective effectiveness of the individual's decision. Furthermore, the uncertainty potentially could result in the misapplication of an ADHC, thus negating its legal validity and effectiveness as well.

## 2. Triggering Situations

The second area where the ADA is unclear is the definition of the triggering situations. The ADHC comes into effect when the declarant can no longer make decisions about her treatment.<sup>99</sup> By its own terms, however, the ADHC only applies to three specified situations: (1) a declarant with a terminal condition, (2) a declarant who is persistently unconscious, and (3) a

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identifying fear of malpractice and desire to maintain professional authority, among others, as potential motivations).

97. The Oklahoma Hydration and Nutrition for Incompetent Patients Act does provide a standard of clear and convincing evidence for judicial determination of whether an individual, when competent, made a decision to refuse treatment. *See* Act of May 17, 2006, § 2, 2006 Okla. Sess. Laws at 732 (to be codified at 63 OKLA. STAT. § 3080.4(A)(2)). Nevertheless, this standard also does not explain how the court should determine competency.

98. *See* 58 OKLA. STAT. § 41 (2001) (providing that testamentary capacity is a question of fact for the trial court); *In re* Estate of Sneed, 1998 OK 8, ¶ 9, 953 P.2d 1111, 1115 (holding that whether a testator had testamentary capacity is a question of fact); *In re* Guardianship of Campbell, 1966 OK 99, ¶ 8, 450 P.2d 203, 210 (Lavender, J., concurring) (noting that a ward's mental capacity is a question of fact, but not a question raised in the case); *Girdner v. Girdner*, 1959 OK 50, ¶ 26, 337 P.2d 741, 746 (holding that the capacity to execute a deed is a question of fact); *Russell v. State*, 1974 OK CR 194, ¶ 6, 528 P.2d 336, 339 (holding that the question of whether a criminal defendant lacks the capacity to commit a crime is one of fact).

99. 63 OKLA. STAT. § 3101.5(A)(2) (2001).

declarant with an end-stage condition.<sup>100</sup> A terminal condition is defined as “an incurable and irreversible condition, that, even with the administration of life-sustaining treatment, will, in the opinion of the attending physician and another physician, result in death within six months.”<sup>101</sup> Persistently unconscious is defined as “an irreversible condition, as determined by the attending physician and another physician, in which thought and awareness of self and environment are absent.”<sup>102</sup> An end-stage condition is defined as “a condition caused by injury, disease, or illness, which results in severe and permanent deterioration indicated by incompetency and complete physical dependency for which, to a reasonable degree of medical certainty, treatment of the irreversible condition would be medically ineffective.”<sup>103</sup>

These three definitions are the only aid that the ADA gives to physicians and to subsequent legal tribunals in determining when the ADHC should be effective. Unfortunately, there is no existing caselaw in Oklahoma regarding the meaning of these phrases. These definitions, though potentially broad and flexible, may have drawbacks. First, the definitions of these qualifying conditions, while perhaps articulated as specific medical concepts, may hold little meaning for the layperson. Without clarification, declarants may not understand the qualifying conditions in the same manner as the legislature. More importantly, declarants may not understand the qualifying conditions in the same manner as the physicians applying the definitions. This potential breakdown in the understanding of these terms could have drastic consequences for declarants whose lives may hinge on this interpretation. With issues of this magnitude, certainty in meaning of terms is vital for effective communication via the ADHC.

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100. See Act of May 17, 2006, § 6, 2006 Okla. Sess. Laws at 736-37 (to be codified at 63 OKLA. STAT. § 3101.4(C)). Prior to the 2006 amendment, the effectiveness of the ADHC was predicated on a declarant having one of two triggering conditions — a terminal condition or persistent unconsciousness. 63 OKLA. STAT. § 3101.3(10) (2001). The amendment’s addition of the “end-stage condition” was presumably made in response to a recent Oklahoma attorney general opinion. The Oklahoma Attorney General had stated that the statute was unconstitutional because it limited the ability to refuse treatment to declarants with terminal conditions or persistent unconsciousness. 36 Okla. Att’y Gen. Op. No. 06-7, ¶¶ 14-25 (Apr. 6, 2006), 2006 WL 981042. The statute did not permit a declarant with an incurable but nonterminal disease, such as Alzheimer’s disease, to refuse treatment through her ADHC. *Id.* The 2006 amendment directly addressed this concern by adding a third triggering situation, the end-stage condition. Act of May 17, 2006, § 6, 2006 Okla. Sess. Laws at 737 (to be codified at 63 OKLA. STAT. § 3101.4(C)); see also *id.* § 5, 2006 Okla. Sess. Laws at 734 (to be codified at 63 OKLA. STAT. § 3101.3(4)).

101. Act of May 17, 2006, § 5, 2006 Okla. Sess. Laws at 735 (to be codified at 63 OKLA. STAT. § 3101.3(12)).

102. *Id.*, 2006 Okla. Sess. Laws at 734 (to be codified at 63 OKLA. STAT. § 3101.3(7)).

103. *Id.* (to be codified at 63 OKLA. STAT. § 3101.3(4)).

Secondly, even though physicians are granted statutory immunity for actions “in accord with reasonable medical standards,”<sup>104</sup> they may still face certain negative consequences for allowing an individual to exercise her right to refuse treatment through the ADHC. The protection may not apply if it is determined that the physician did not act within reasonable medical standards. Even if the protections do apply, potential negative consequences might include frivolous lawsuits or disciplinary inquiries. A narrow interpretation of the triggering terms would limit the number of individuals for whom the ADHC is effective. The fewer the number of individuals exercising their right to refuse treatment through the ADHC, the less of a chance that a physician will face negative consequences. This is especially true because the ADA does not provide a penalty for physicians who continue to treat individuals who have an effective ADHC.<sup>105</sup> Instead, physicians who are unwilling to comply with a declarant’s instructions in her ADHC must arrange to transfer care of that patient to a physician who is willing to comply with the declarant’s instructions.<sup>106</sup> Despite that provision, the reality is that doctors may err on the side of caution because the ambiguous definitions of the triggering conditions give them the leeway to protect themselves.

#### *B. Flexibility with Substitute Decision Makers*

The second major deficiency of the ADA, in addition to the lack of clarity, is its inflexible treatment of substitute decision makers. This part will address the statute’s flexibility with respect to three areas: (1) the ability of declarant to grant true decision-making authority to her Proxy, (2) the ability of the declarant to grant current authority to her Proxy, and (3) the lack of a provision of substitute decision makers for nondeclarants.

##### *1. Granting Decision-Making Authority to the Proxy*

The first area in which the ADA is inflexible involves the ability of the declarant to grant meaningful decision-making authority to her Proxy. One of the major changes included in the 2004 amendment was the removal of the “Conflicting Provision.”<sup>107</sup> The pre-2004 ADHC allowed the declarant to indicate whether the instructions of the Living Will or the decision of the Proxy should “take precedence,” if the instructions in the Living Will differed

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104. *Id.* § 9, 2006 Okla. Sess. Laws at 741 (to be codified at 63 OKLA. STAT. § 3101.10(B)).

105. *See id.* § 10, 2006 Okla. Sess. Laws at 742 (to be codified at 63 OKLA. STAT. § 3101.11).

106. *Id.* § 8, 2006 Okla. Sess. Laws at 741 (to be codified at 63 OKLA. STAT. § 3101.9).

107. *Compare* 63 OKLA. STAT. § 3101.4(B) (Supp. 2003) *with* 63 OKLA. STAT. § 3101.4(B) (Supp. 2005).

from the decision of the Proxy.<sup>108</sup> Though not explicitly stated, the removal of this provision seems to indicate that the Proxy has no discretion whatsoever and must solely carry out the declarant's instructions regarding life-sustaining treatment as indicated in the Living Will.

This lack of discretion on the part of the Proxy is in direct conflict with section 3101.16 of the ADA. This section states:

An individual making life-sustaining treatment decisions . . . for a declarant shall make such decisions based on the known intentions, personal views and best interests of the declarant. If evidence of the declarant's wishes is sufficient, those wishes shall control. If there is not sufficient evidence of the wishes of the declarant, the decisions shall be based on the reasonable judgement of the individual so deciding about the values of the declarant and what the wishes of the declarant would be based upon those values.<sup>109</sup>

The tension between these sections might be relieved if the declarant did not complete the Living Will portion of the ADHC, but did appoint a Proxy. Then, presumably, there would be insufficient evidence of the declarant's wishes and the appointed Proxy would have to make a decision according to the standards detailed above. Also, assuming that a completed Living Will is sufficient evidence of the declarant's wishes, it would seem the Proxy would not have discretion.

Nonetheless, the tension is not fully relieved by these considerations because of the nature of the ADHC as a document. The ADHC can be characterized generally as a forecasting tool for health-care decisions.<sup>110</sup> Making decisions in advance is commendable, but an individual cannot foresee all future events and situations. The situations covered by the ADHC are arguably specific, but even within those categories, there is room for a

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108. 63 OKLA. STAT. § 3101.4(B) (Supp. 2003). See *supra* note 78 for the text of the conflict resolution provision.

109. Act of May 17, 2006, § 15, 2006 Okla. Sess. Laws at 744 (to be codified at 63 OKLA. STAT. § 3101.16).

110. Justine A. Dunlap, *Mental Health Advance Directives: Having One's Say?*, 89 KY. L.J. 327, 355 (2001) (stating "[a]ny kind of advance directive addresses future situations and attempts to anticipate the decisions that those situations will require"); see also Lorraine M. Bellard, *Restraining the Paternalism of Attorneys and Families in End-of-Life Decision-Making While Recognizing that Patients Want More than Just Autonomy*, 14 GEO. J. LEGALETHICS 803, 805 (2001) (discussing the problems of using the ADHC as a predictive tool); Rebecca Dresser, *Precommitment: A Misguided Strategy for Securing Death with Dignity*, 81 TEX. L. REV. 1823, 1836, 1845 (2003) (discussing the problems of using the ADHC as a predictive tool). Though the latter two articles take a negative view of the ADHC's ability to function as a predictive tool, they speak of it as such.

myriad of scenarios. Simply initialing one of three options cannot possibly convey what the declarant would wish in each of those slightly varied situations. The possibility of a situation arising that the declarant did not consider does exist. In such a situation, the declarant's actual wishes might contradict the instructions she gave in the ADHC. This is where the conflicting provision would allow a declarant to vest the final decision-making authority in a person, as opposed to a document. Obviously, the person appointed as Proxy will not be infallible, but she will have the flexibility to examine the situation from the present, instead of in the distant and perhaps unforeseeable future.

## 2. *Granting Current Authority to the Proxy*

The second area in which the ADA is inflexible is the ability of the declarant to grant current authority to her Proxy. The authority of the Proxy is conditioned on the effectiveness of the ADHC.<sup>111</sup> In other words, if the ADHC is not effective yet, the Proxy has no authority to make decisions on behalf of the declarant. As previously noted, the ADHC becomes effective upon a determination that "the declarant is no longer able to make decisions regarding [her own medical treatment]."<sup>112</sup> For the sake of brevity, this determination will be referred to as "incapacity" for the remainder of this section.

The ADHC limits the Proxy's authority to when the declarant is incapacitated. Facially, this limitation would seem logical and obvious. Why would the declarant need someone to make decisions if she could make those decisions for herself? The difficulty is not in the limitation itself, but rather in the *lack of choice* the limitation implies. An individual may only care to appoint a substitute decision maker for situations *after* she is incapacitated. Oklahoma allows the individual to take this action through the appointment of a Proxy.

Alternately, another individual may want to appoint a substitute decision maker for situations both *before* and *after* incapacity. If this latter individual wishes to appoint different individuals for each respective time period, the current state of the law meets her needs. Oklahoma does provide a way for an individual to appoint a substitute decision maker who would have authority prior to incapacity. This provision requires a separate grant of authority under

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111. Act of May 17, 2006, § 6, 2006 Okla. Sess. Laws at 738 (to be codified at 63 OKLA. STAT. § 3101.4(C)) ("If my attending physician and another physician determine that I am no longer able to make decisions regarding my medical treatment, I direct my attending physician . . . to follow the instructions of \_\_\_\_\_, whom I appoint as my health care proxy.").

112. 63 OKLA. STAT. § 3101.5(A)(2) (2001).

the DPOA provision.<sup>113</sup> If the latter individual wishes to appoint the same individual for both before and after incapacity, the current state of the law requires her either to execute both a DPOA and a ADHC naming the same person,<sup>114</sup> or to execute a DPOA that conforms to the requirements of the Proxy grant.<sup>115</sup> While an attorney-in-fact under a DPOA grant can cross-function as a Proxy, a Proxy cannot serve both functions.<sup>116</sup> This inconsistency demonstrates the inflexibility of the ADA.

### 3. *Substitute Decision Makers*

The third area in which the ADA is inflexible is the lack of provision for substitute decision makers for nondeclarants. The ADA only mentions nondeclaring individuals in two sections. Section 3101.12 indicates that the ADA “creates no presumption concerning the intention of an individual who has revoked or has not executed an [ADHC] with respect to the use, withholding, or withdrawal of life-sustaining treatment.”<sup>117</sup> The other mention occurs in section 3101.2, which states that “the proper role of the court is to settle disputes and to act as the proxy decision-maker of last resort when *no other proxy is authorized by the individual* or is otherwise authorized by law.”<sup>118</sup> Because the ADA does not create a presumption regarding the nondeclarant’s wishes, the statute appears to indicate that a nondeclaring individual’s wishes must be determined by the decision maker of last resort — the court. This reading is supported by the fact that Oklahoma law does not provide another means by which an individual can appoint a decision maker for decisions regarding life-sustaining treatment, thereby rendering moot the allowance for a decision maker “otherwise authorized by law.”<sup>119</sup>

Despite the current statutory provision, there may be other individuals, such as family members, who have knowledge of the nondeclarant’s wishes regarding life-sustaining treatment. Furthermore, these knowledgeable individuals may care deeply about ensuring that the nondeclarant’s wishes are carried out. By not providing for “otherwise authorized” decision makers,

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113. 58 OKLA. STAT. § 1072 (2001).

114. This would be required if the individual did not construct the DPOA grant to conform to the Proxy requirements, as required by title 58, section 1072.1(B)(1)(b) of the Oklahoma Statutes for an attorney-in-fact to make decisions regarding life-sustaining treatment.

115. In this case, the grant would conform to the requirements of section 1072.1.

116. Neither the ADA nor the DPOA provision currently allows the grant authorizing a Proxy to also imbue that individual with DPOA-authority.

117. See Act of May 17, 2006, § 11, 2006 Okla. Sess. Laws at 742 (to be codified at 63 OKLA. STAT. § 3101.12(D)).

118. *Id.* § 4, 2006 Okla. Sess. Laws at 733 (emphasis added) (to be codified at 63 OKLA. STAT. § 3101.2(A)(3)).

119. *See id.*

Oklahoma has effectively silenced the only individuals that might have knowledge of the nondeclarant's desires. Moreover, the state has rendered silent anyone who currently lacks capacity to execute an ADHC or who loses such capacity prior to the execution of an ADHC. In contrast, authorization of nonappointed individuals as substitute decision makers is not foreign to Oklahoma law. In fact, in section 3102A of the ADA, Oklahoma provides that "a legal guardian, attorney-in-fact with health care decision authority, *or a family member*" may give informed consent to experimental treatment in certain circumstances.<sup>120</sup> The section then goes on to provide a list of such family members, in priority order.<sup>121</sup>

If these family members can give informed consent to experimental treatment, the rationale for preventing them from making decisions regarding life-sustaining treatment for nondeclarants is unclear. The decisions are related, as both regard exceptional medical situations and the acceptance or rejection of treatment. Moreover, the provision for otherwise authorized decision makers is within the ADA itself. This placement indicates there is a place for such decision makers in the field of treatment decisions. On the other hand, the decisions can be distinguished. Consent to experimental treatment is attempting to preserve life, whereas decisions regarding life-sustaining treatment may hasten death. That distinction may justify preventing nonappointed individuals from making such decisions, even though they might know the nondeclarant intimately. Some, though not all, nondeclarants may *benefit* from the exclusion of nonappointed individuals. Despite this protection for some nondeclarants, the ADA imposes silence on interested individuals, both the nondeclarants and their families, who should have a voice, although perhaps not the final say.

#### *IV. Where to Go from Here: Suggestions for Legislative Correction of the ADA*

Having analyzed the clarity and flexibility of the ADA and ADHC, the deficiencies discovered deserve further attention due to the complicated nature

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120. 63 OKLA. STAT. § 3102A(A) (Supp. 2005) (emphasis added).

121. The list is as follows:

1. The spouse, unless the patient has no spouse, or is separated, or the spouse is physically or mentally incapable of giving consent, or the spouse's location is unknown or the spouse is overseas, or the spouse is otherwise not available;
2. An adult son or daughter;
3. Either parent;
4. An adult brother or sister; or
5. A relative by blood or marriage.

*Id.*

of the questions involved and the gravity of the subject matter. First, this part will discuss reasons why the legislature should take action to correct these problems. Second, this part will suggest potential legislative solutions.

*A. The Importance of Legislative Correction*

Many of the previous problems identified for legislative correction of the ADA and ADHC could be accomplished by means of individuals modifying the existing form by adding instructions. After all, the statute only requires the ADHC to be “in substantially the following form.”<sup>122</sup> Nevertheless, two reasons counsel against relying on individuals to modify the form on their own and necessitate uniform legislative revision. This part will examine those two reasons briefly.

First, there is widespread public dissemination of the ADHC form.<sup>123</sup> No doubt, this is partially due to the recent publicity this issue has seen.<sup>124</sup> Accordingly, many individuals are acquiring and filling out the ADHC without the benefit of legal counsel. While an individual may not need counsel to answer the questions asked by the form, she may need counsel to understand what the questions are asking. It would be irresponsible to assume that all citizens who acquire and execute an ADHC on their own comprehend all of the legal questions and standards at stake. Since it is unlikely that all individuals will seek legal assistance for purposes of executing the ADHC, the form should be as simple and “user-friendly” as possible. The most effective way to keep the ADHC “user-friendly” for all potential declarants, regardless of representation by counsel, is for the legislature to revise it in a uniform fashion for the entire state.

Second, a statutory form should be universally utilized. In other words, the ADHC should be relatively uniform across the board. This is needed because medical professionals must be able to analyze the declarant’s end-of-life wishes quickly and accurately. If everyone has modified forms, the interpretive task becomes much more difficult. Whether the modifications come from attorneys or from the individuals themselves, the result is the same.

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122. Act of May 17, 2006, § 6, 2006 Okla. Sess. Laws at 735 (to be codified at 63 OKLA. STAT. § 3101.4(C)).

123. The ADHC is available from various public entities and services, usually through an organization’s website. *See, e.g.*, Caring Connections, National Hospice and Palliative Care Organization, Oklahoma Advance Directive, <http://www.caringinfo.org/files/public/Oklahoma.pdf> (last visited June 22, 2006); Oklahoma Bar Association, Advance Directive for Health Care, <http://www.okbar.org/public/brochures/advanced3.pdf> (last visited June 22, 2006); Oklahoma Department of Human Services, Advance Directive for Health Care, <http://www.okdhs.org/aging/Documents/87-07W.pdf> (last visited June 22, 2006).

124. *See generally* Richard Jerome, *What to Do About Terri*, PEOPLE, Feb. 14, 2000, at 77.

Instead of one statutory form for everyone, everyone will have her own form based loosely on the statutory ADHC. Instead of this unnecessary diversity, if the ADHC was corrected, only minor modifications would have to be made, and greater uniformity and ease of interpretation would result. Thus, to keep the interpretive task simple for medical personnel, the Oklahoma legislature should revise the ADHC so that individuals will not need to modify the form.

### *B. Clarity in Language*

The first major deficiency of the ADA is a lack of clarity. Clarity is important to achieve the goals of objective effectiveness and legal validity.<sup>125</sup> Clarity furthers these goals by enabling the individual to understand the situation that calls for the decision and the options the decision presents. Clarity also enables the individual to effectively communicate her decision and allows others to correctly interpret her choices. There are two main areas in which this lack of clarity is present and can be improved by legislative revision: (1) the standard of capacity and (2) the definition and application of the triggering conditions.

The first area in which the ADA is unclear is the level of decision-making ability, or mental capacity, an individual must have or lack to render the ADHC operative. As discussed previously, the ADA's guidance on this matter is marginal.<sup>126</sup> The Oklahoma legislature could resolve this ambiguity by setting out a more detailed standard of capacity in these situations. Though the Uniform Rights Act and the Uniform Decisions Act use the same formulation as the ADA in the ADHC,<sup>127</sup> all parties concerned would benefit from a clearly defined standard of capacity, especially one that is susceptible to judicial review and comment.

One option for the legislature would be to use the definition of "capacity" in the Uniform Decisions Act, which provides, "'Capacity' means an individual's ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health-care decision."<sup>128</sup> This definition has the benefit of being tailored specifically to the situation of life-sustaining treatment. Furthermore, the definition contains more factors and elements of the decision-making process to interpret than the current standard set forth in the ADHC.<sup>129</sup> The proposed solution

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125. *See supra* Part III.

126. *See supra* Part III.A.1.

127. UNIF. RIGHTS OF THE TERMINALLY ILL ACT (1989) § 2, 9C U.L.A. 319 (2001); UNIF. HEALTH-CARE DECISIONS ACT § 2(c)-(d), 9 U.L.A. pt. IB, at 93 (2005).

128. UNIF. HEALTH-CARE DECISIONS ACT § 1(3), 9 U.L.A. pt. IB, at 89.

129. Maine and New Mexico have expanded even further on the Uniform Decisions Act definition. *Id.* § 1, Action in Adopting Jurisdictions, 9 U.L.A. pt. IB, at 91-92. Maine's version

would allow medical professionals the ability to make principled decisions honoring declarants' wishes.

In addition, if the Uniform Decisions Act standard of capacity was incorporated into Oklahoma's ADA, judicial bodies reviewing a determination of capacity made by medical personnel would have a tangible starting point.<sup>130</sup> Because capacity is a question of fact,<sup>131</sup> courts will review the question of capacity independently of the medical personnel's evaluation.<sup>132</sup> Regardless of whether the review is independent, the use of a clearly defined standard of capacity would provide a known foundation for judicial review of the medical determination. Because this standard would also apply to judicial determinations of capacity, the determination made by medical personnel would become more certain and reliable for the purpose of removing life-sustaining treatment.

The second area in which the ADA is unclear is the meaning and interpretation of the triggering conditions. There are three primary methods by which this ambiguity might be clarified. First, the Oklahoma legislature could define the terms more narrowly and specifically. A narrow definition of the triggering conditions, however, would limit the flexibility of the ADA

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provides:

"Capacity" means the ability to have a basic understanding of the diagnosed condition and to understand the significant benefits, risks and alternatives to the proposed health care and the consequences of foregoing the proposed treatment, the ability to make and communicate a health care decision and the ability to understand the consequences of designating an agent or surrogate to make health-care decisions.

*Id.*, 9 U.L.A. pt. IB, at 92. Although it is unclear whether the additional language establishes a higher or lower standard of capacity than the Uniform Decisions Act formulation, the Maine version does provide more factors to consider in interpreting the definition. Whether the additional factors are beneficial is questionable, but either provision is superior to the current lack of a definition of "capacity" in the Oklahoma ADA.

130. For discussions of various judicial standards of capacity from both statutory and common law origins, see William M. Altman et al., *Autonomy, Competence, and Informed Consent in Long Term Care: Legal and Psychological Perspectives*, 37 VILL. L. REV. 1671, 1678-85 (1992); Jessica Wilen Berg et al., *Constructing Competence: Formulating Standards of Legal Competence to Make Medical Decisions*, 48 RUTGERSL. REV. 345, 360-62 (1996); and Samantha Weyrauch, Comment, *Decision Making for Incompetent Patients: Who Decides and by What Standards?*, 35 TULSA L.J. 765, 784-85 (2000). The Oklahoma legislature should be able to avoid the entire question by using a well-defined standard of capacity in the ADA and making it applicable to medical personnel as a medical determination and to the courts in the form of a question of fact.

131. See *supra* note 98 and accompanying text.

132. See 12 OKLA. STAT. §§ 556-557 (2001) (providing that questions of fact will be tried to the fact finder, whether the fact finder is the court or the jury, as provided in other substantive law).

and ADHC by denying the declarant any opportunity to indicate her personal wishes.

The 2006 amendment used a second option, which emphasized the declarant's ability to define the triggering conditions in the fourth subpart of the Living Will section in the ADHC. This subpart now allows declarants to "describe other conditions in which [they] would want life-sustaining treatment or artificially administered nutrition and hydration provided, withheld, or withdrawn."<sup>133</sup> This provision has great potential to allow the declarant to specifically indicate situations in which she would want the instructions in the ADHC to become operative. The legislature could further emphasize this possibility by indicating that the interpretation of the triggering conditions is delegated to the doctor by default, but that the declarant can supplement that interpretation with specific information, if she chooses to do so. This solution maintains the document's flexibility, while ensuring that declarants understand that the document can be personalized to suit their individual wishes. On the other hand, this option allows declarants to define the triggering conditions in potentially less helpful terms than the existing definitions. Declarants might use nonmedical terminology or overly generalize their wishes. Medical professionals would then have to interpret and apply these inarticulate definitions. Furthermore, such an allowance for declarant-drafted terms would drastically reduce the uniformity of the ADHC, making the interpretive task much harder for medical personnel.

A third and, perhaps, more effective option would be for the legislature to provide a series of specific, identified conditions that the declarant could select if she wished to make it the triggering condition of the ADHC. This list of conditions could include recognized terminal illnesses and conditions and different states of cognitive awareness. This solution has the benefit of uniformity because every ADHC would have the same finite list of conditions for medical personnel to interpret. Moreover, the declarant would have the ability to personalize the document to reflect her wishes regarding triggering conditions, while still maintaining the clarity necessary for interpretation.

### *C. Flexibility with Substitute Decision Makers*

The second major deficiency of the ADA is a lack of flexibility. Flexibility serves to further the goals of objective effectiveness and legal validity.<sup>134</sup> Flexibility furthers these goals by allowing the individual to choose an option that embodies her desire in the situation. There are three main areas in which

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133. Act of May 17, 2006, ch. 171, § 6, 2006 Okla. Sess. Laws 729, 738 (to be codified at 63 OKLA. STAT. § 3101.4(C)).

134. *See supra* Part III.

this lack of flexibility is present and can be improved by legislative revision: (1) the ability of a declarant to grant decision-making authority to her Proxy, (2) the ability of the declarant to grant current authority to her Proxy, and (3) the lack of a provision of substitute decision makers for nondeclarants.

The first area in which the ADA is inflexible is the lack of provision for resolving conflict between the instructions in the Living Will and the Proxy's decision about the declarant's wishes. This problem could be easily resolved by reinserting the conflict provision that the 2004 amendment removed.<sup>135</sup> This solution would preserve the presumption that the instructions in the Living Will control, while also allowing the declarant to choose whether her Proxy can have the final say, thereby increasing the flexibility of the ADHC.

The second area in which the ADA is inflexible is the inability of the Proxy to make decisions prior to the determination by medical professionals that the declarant cannot make decisions for herself. This problem could be remedied by looking to the Uniform Decisions Act, which provides a clause indicating when the grant of authority to the Proxy becomes effective.<sup>136</sup> The default setting is that the grant becomes effective only after the declarant cannot make decisions. However, the Uniform Decisions Act, by means of a check box, permits the declarant to indicate whether the grant becomes effective immediately. The inclusion of this option would preserve the presumption that the Proxy's authority springs from the declarant's inability to make her own decisions, but would give the declarant flexibility to have a current substitute decision maker.

The third area in which the ADA is inflexible is the lack of provision of decision makers for nondeclarants. A statutory revision in this area is especially important because *only* the legislature can remedy this situation. A nondeclarant cannot receive the benefit of a substitute decision maker except by becoming a declarant. While that may appear to be an easy solution, some individuals may currently lack capacity to appoint a substitute decision maker, and other individuals may lose such capacity prior to making an appointment. These individuals are silenced unless concerned individuals take their cases to the court. Although the ADA has made the court the

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135. See *supra* note 78 for the text of the conflict resolution provision.

136. UNIF. HEALTH-CARE DECISIONS ACT § 4, 9 U.L.A. pt. IB, at 101 (2005). The clause states: "My agent's authority becomes effective when my primary physician determines that I am unable to make my own health-care decisions unless I mark the following box. If I mark this box [ ], my agent's authority to make health-care decisions for me takes effect immediately." *Id.*

“proxy decision-maker of last resort,”<sup>137</sup> there may be other options besides relying on the last resort.

The Oklahoma legislature could rectify this problem by adding a list of decision makers in priority order to the life-sustaining treatment portion of the ADA, as opposed to limiting such a list to the experimental treatment section.<sup>138</sup> The benefit of this solution is the certainty that would result. Everyone would know exactly who has the authority to speak on behalf of a nondeclarant. Counterbalancing the benefit of certainty, however, is the consequence such a solution would have on the effect the ADA has on a nondeclarant. Currently, the ADA does not presume a nondeclarant wants or does not want life-sustaining treatment.<sup>139</sup> This lack of a presumption guarantees that the nondeclarant will continue to receive life-sustaining treatment. If interested parties were allowed to have the final say as a matter of course, the ADA would not offer the same protection to nondeclarants. In effect, such a change might *require* an individual to execute an ADHC in order to ensure she receives life-sustaining treatment upon incapacity. Shifting the burden of executing documents to maintain life may not be the best course of action.

A more moderate solution would create a rebuttable presumption in regard to the nondeclarant’s wishes based on the testimony of interested individuals. Under this solution, the court would still be the proxy decision maker for nondeclarants, but there would be a procedural method for interested individuals to speak and to be heard.<sup>140</sup> The evidence and views of the interested individuals would create only a *rebuttable* presumption of the nondeclarant’s wishes, so the individuals would not have the final say in the nondeclarant’s care situation. Moreover, because multiple individuals would have the opportunity to speak in such a proceeding, the rights of the

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137. Act of May 17, 2006, § 4, 2006 Okla. Sess. Laws at 733 (to be codified at 63 OKLA. STAT. § 3101.2(A)(3)).

138. The particular contents and order of such a list are outside the scope of this discussion, but are important questions.

139. *See supra* text accompanying note 14.

140. Considering the nature of the life-and-death interests at stake, this procedural protection might also benefit from an expedited scheduling and action. A format for such an expedited process can be found in timing requirements provided in judicial bypass options available for minors seeking abortions. *See, e.g.*, MISS. CODE ANN. § 41-41-55(3) (2005) (“Court proceedings under this section . . . shall be given such precedence over other pending matters as is necessary to insure that the court may reach a decision promptly, but in no case shall the court fail to rule within seventy-two (72) hours of the time the application is filed.”) Despite potential complications with court docket scheduling, this requirement would insure the court’s decision as proxy decision maker of last resort would be reached in a timely manner, which is especially important when considering these life and death matters.

nondeclarant would be better protected than under the first solution discussed above. Furthermore, this solution would permit currently incapacitated individuals — those that cannot execute an ADHC — to speak through interested individuals. This solution attempts to balance the tension between protecting a nondeclarant's rights to treatment and providing her with a voice in her treatment decisions.

*V. Until We Get There: Suggestions for Practitioners Offering  
the ADHC to Clients*

As previously discussed, the ADA and ADHC are deficient with respect to clarity and flexibility. The practical danger of these deficiencies is that a client's desires may not be honored. This result may occur because of insufficient clarity to communicate the client's decisions or insufficient flexibility to allow for the client's actual choice, or because the document is not given appropriate legal effect. The Oklahoma legislature should clarify and improve the statute and form. Nevertheless, there are individuals currently in need of the planning options the ADA offers who may not be able to wait for a legislative solution. This section will suggest several methods legal practitioners should use to maximize the ADHC's effectiveness in communicating their clients' decisions to medical personnel and to ensure that the document will be given its proper legal effect.

*A. Explaining the ADHC to Clients*

The first suggestion for legal practitioners utilizing the ADHC is to ensure that the client fully understands the issues at stake and the nature of the document. Clients cannot make informed decisions without fully understanding all of the facts. A client's understanding of when the document is effective is of particular importance. Legal practitioners should communicate that the document is only effective when the client's "attending physician and another physician determine that [the client is] no longer able to make decisions regarding [her] medical treatment,"<sup>141</sup> and when a triggering situation covered by the instructions in the ADHC has occurred.<sup>142</sup> The client must also understand the limited nature of appointing a Proxy, both in scope of authority and as to when the grant becomes effective. A legal practitioner should inform the client of the availability of the DPOA grant to provide for situations the Proxy grant does not cover. When the client understands these

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141. Act of May 17, 2006, § 6, 2006 Okla. Sess. Laws at 735 (to be codified at 63 OKLA. STAT. § 3101.4(C)).

142. *Id.*, 2006 Okla. Sess. Laws at 736-37.

limitations, then the legal practitioner may choose to proceed with the next suggestion.

### *B. Alterations to the Documents*

The ADA provides that the ADHC “may be in *substantially* the following form” prior to laying out the statutory form.<sup>143</sup> Therefore, the legal practitioner should be able to modify the form somewhat to achieve the clarity and flexibility that may be lacking.<sup>144</sup> Remember, however, that the form ought to remain recognizable and easily interpreted by medical professionals. Several specific options may be beneficial to increase clarity and flexibility. The best option for increasing clarity is to actually use the fourth part of the Living Will, which allows declarants to “describe other conditions . . . [or] give more specific instructions.”<sup>145</sup> The declarant might use this section to describe her understanding of the standard of capacity or the triggering situations. The declarant could even include examples of situations in which she would want the life-sustaining treatment instructions given in the first three parts of the Living Will to be followed. One simple option for increasing flexibility in the document is to reinsert the conflict resolution provision. This would allow the declarant to choose whether her instructions or the Proxy’s decision would control in the situation. This reinsertion could be made either in the Proxy section of the ADHC or in the fourth part of the Living Will. Making these alterations to a statutory form will definitely entail more work and individualized drafting. In consideration of the matters at stake, however, such extra work is surely worthwhile.

## *VI. Conclusion*

The complexity involved in applying an individual’s right to refuse treatment, even life-sustaining treatment, to specific life situations requires a statutory scheme that is both clear and flexible. Unfortunately, for the citizens of Oklahoma, the Oklahoma ADA is ambiguous and inflexible. It is imperative that Oklahoma correct the ADA to give greater choice to those who

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143. *Id.*, 2006 Okla. Sess. Laws at 735 (emphasis added).

144. See 36 Okla. Att’y Gen. Op. No. 06-7, ¶¶ 4-9 (Apr. 6, 2006), 2006 WL 981042 (stating that the form set out in the statute is merely a guideline and that any form with the same elements will serve the same purpose). *But see* Act of May 17, 2006, § 6, 2006 Okla. Sess. Laws at 735 (to be codified at 63 OKLA. STAT. § 3101.4(B)) (providing that an ADHC not in the form set out in the statute will be ineffective as to the withdrawal or withholding of nutrition and hydration unless it specifically addresses that issue in either the declarant’s own words or a separately identified section of the document)

145. Act of May 17, 2006, § 6, 2006 Okla. Sess. Laws at 738 (to be codified at 63 OKLA. STAT. § 3101.4(C)).

cannot choose for themselves. Until such corrective action occurs, legal practitioners should attempt to give their clients the greatest clarity and flexibility possible under the current statutory scheme.

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